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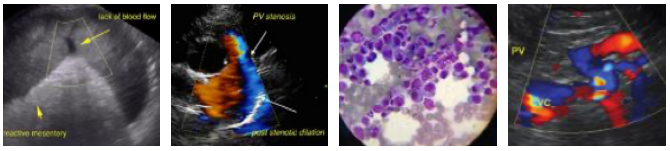


**PATIENT**
Uma Thurman Dark

**SPECIES**
Canine

**BREED**
Rottweiler

**SEX**
Female, spayed

**AGE**
4 Yrs. 4 months

**WEIGHT**
100.6 lbs.

**INTERPRETED BY**
Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)

**IMAGING PERFORMED BY**
Dr. Maggiulli

**HOSPITAL NAME**
Willamette VH

**REFERRING VET**
Dr. Maggiulli

**INVOICE**
14356

**DATE**
12/14/22

## PRESENTING CLINICAL SIGNS

History: History of IBD well controlled on diet. Presented for a 1 week of diarrhea that progressed from yellow to hemorrhagic. Pt has vomited multiple times in past 24 hours, including through cerenia injection. Progressive hyporexia. Pt does wander yard and could possible eat things off the ground. NG tube placed and 250ml fluid removed (bile tinged)
Abnormal PE/Chem/CBC/UA Results: CBC: hemoconcentration/dehydration - HCT 57.2% (37.2-61.7), RBC 8.8 M/uL (5.65-8.87) Chem17: WNL Lytes: WNL. K 3.8, Na 152. vcheck cPL = 441, consistent with pancreatitis 5am PCV/TS = 58%, 7.0 Baseline cortisol: 4.62 ug/dL - not addisonian 3 view abdominal radiographs: some gas in portions of SI but without dilation (appears to move with recumbency change), some gas in colon. vcheck cPL = 441, consistent with pancreatitis PCV/TS = 58%, 7.0

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended with anechoic urine. No masses, inflammatory changes or calculi are observed. The region of the trigone is normal.

The left kidney is subjectively normal size; normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (7.44 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

### *Adrenal Glands*

The region of the adrenal glands is evaluated. No obvious pathology is observed.

### *Spleen*

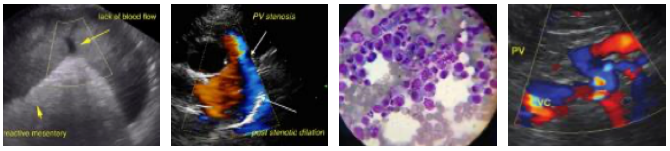
The spleen is normal in size (2.89 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

### *Liver*

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. The gallbladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal.

### *Gastrointestinal*

The gastric lumen is mildly to moderately fluid distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract appears patent. The small intestinal



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lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. No obvious obstructive disease is noted.

### *Pancreas*

A portion of the pancreas is obscured by the gastric distention. In the visualized portions, no obvious abnormalities are seen.

### *Free Abdomen*

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

## ULTRASONOGRAPHIC FINDINGS

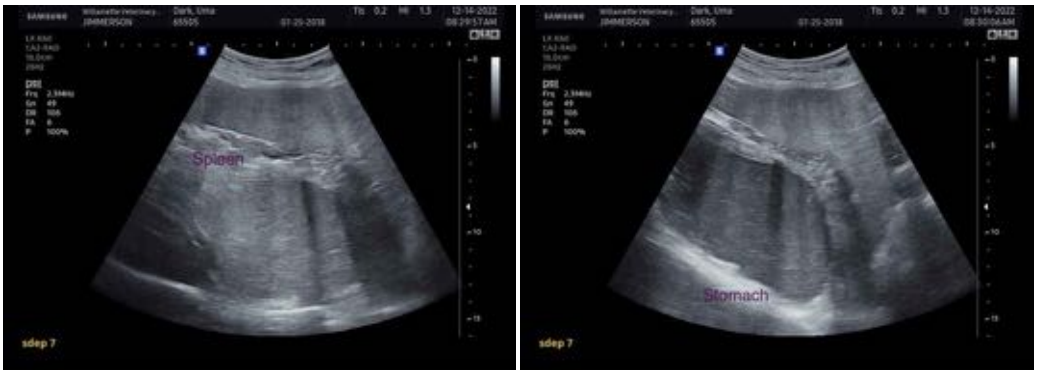
- The gastric distention is most consistent with a functional ileus. An obvious gastric outflow tract obstruction is not definitively visualized in the study.

*An obvious cause for the patient's clinical signs is not identified in this study. Considerations include primary gastrointestinal disease (i.e., infectious/parasitic, inflammatory bowel disease flare up, food allergy/intolerance, dietary indiscretion), low-grade pancreatitis, underlying metabolic issue, other.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the patient's clinical history, consider the following:

1. A fecal evaluation for ova/Giardia.
2. Fecal PCR panel for infectious diseases.
3. Malabsorption panel including serum cobalamin, folate, TLI and PLI.
4. Initiation of a probiotic and fiber supplement (i.e., Metamucil or Konsyl).
5. Hydrolyzed protein or limited antigen diet, if not already receiving one.
6. Supportive care for inflammatory bowel disease flare up is recommended while awaiting test results. If clinical signs do not improve with supportive measures, consider obtaining GI biopsies (i.e., endoscopic or surgical).



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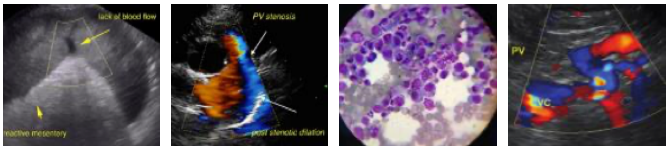

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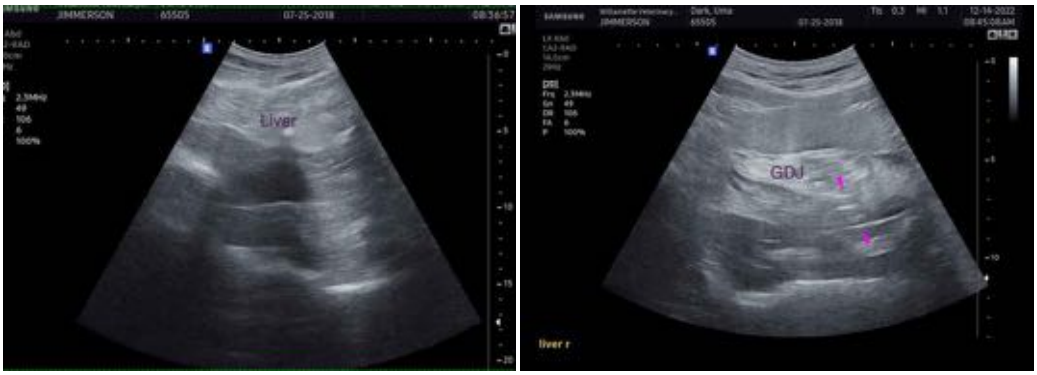


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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