

**DATE**

12/21/21

PRESENTING CLINICAL SIGNS

Recheck.

History: Presenting Complaint: Vomiting; Diarrhea. Date: 12-19-2021 Notes: Rufio is a 6 y/o MN Chihuahua who presents for vomiting, diarrhea, and pain - last night diarrhea greater than 13x with blood last few hours - mucoid, small volume, increased volume, pink red, speckled - no eaten since 8 pm yesterday, not drinking as much - Vomiting since Wednesday, 1-2 times a day, yesterday once, food to green yellow, and then food - GB removed 4 weeks ago, surgeon not concerned - FB: did get into some bird poop, no known FB ingestion - turns away from food - Toxin no known exposure - Medical history: gall bladder removed, previous pancreatitis, and HGE Medications: - Ursodiol 1/4 tab (250 mg) PO SID - Gabapentin 50 mg as needed - Cerenia last night - Proheart Injection, Simparica trio. Assessment: Vomiting, diarrhea (pancreatitis vs FB obstruction vs metabolic disease vs gastroenteritis vs neoplasia vs other). Plan: Recommended hospitalization, bloodwork, AXR, IVF, and supportive care. Owner elects to move forward with treatment plan. O informs last time he was hospitalized for pancreatitis had to have feeding tube placed. Discussed with owner if he does not return to eating, he may require an NG tube placed, however, at this time would give other medications a chance to work before considering placed an NG tube.

PATIENT

Rufio Kharmats

SPECIES

Canine

BREED

Chihuahua mix

SEX

Male, neutered

Current Medications: Buprenex, Metronidazole, Ondansetron, Gabapentin, Ursodiol, Pantoprazole, Provable.

Lab Results: ALP 526 on 12/19 and down to 318 on 12/20. Hx of mild ALP elevation.

Radiographs: Xray Abdomen 2 View Poor abdominal detail, gas dilated colon, no overt FB or signs of obstruction.

AGE

12/19/21

Date of Previous IntraPet Ultrasound: 5-27-21; 11-8-21.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

WEIGHT

11.7 lbs.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

The urinary bladder and visible portion of the pelvic urethra are normal for the degree of luminal distension. The urine is anechoic with no evidence of debris. Cystic calculi and discrete masses are not observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The prostate is normal in size (1.03 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal in size (4.53 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is minimal loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. A hyperechoic medullary band is observed adjacent to the corticomedullary junction. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal size (4.46 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 hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.60 cm at cranial pole) (0.54 cm at caudal pole) (1.98 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

INTERPRETED BY

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Diplomate ACVIM
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IMAGING PERFORMED BY

Rachel Brillhart RDMS

HOSPITAL NAME

Animal Emergency
Hospital

REFERRING VET

Dr. Thompson

INVOICE

12757

The right adrenal gland is normal size (0.61 cm at cranial pole) (0.56 cm at caudal pole) (1.73 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.15 cm in width at the level of the hilus) with a normal capsular contour. The parenchyma is subtly mottled in appearance. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and homogeneous in appearance. There is a slight increase in portal markings. No distinct focal lesions are observed. Vascular is of normal volume with no evidence of congestion. A cholecystectomy was performed approximately 1 month ago. The mesentery in the region of the fossa is mildly hyperechoic. The common bile duct is borderline dilated (0.43 cm in diameter). There is no obvious evidence of an intraluminal obstruction.

Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal 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 obstructive disease is noted.

Pancreas

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely hyperechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen

There is no evidence of free fluid. The mesentery surrounding the liver is mildly hyperechoic. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- An obvious cause for the patient's clinical signs is not identified in this study. There is no obvious evidence of a foreign body/obstruction.
- The pancreatic changes are suggestive of remodeling/fibrosis. Low-grade inflammation may be present, particularly if the patient is uncomfortable on cranial abdominal palpation.
- Cranial abdominal peritonitis, likely secondary to recent cholecystectomy and/or acute gastroenteritis.

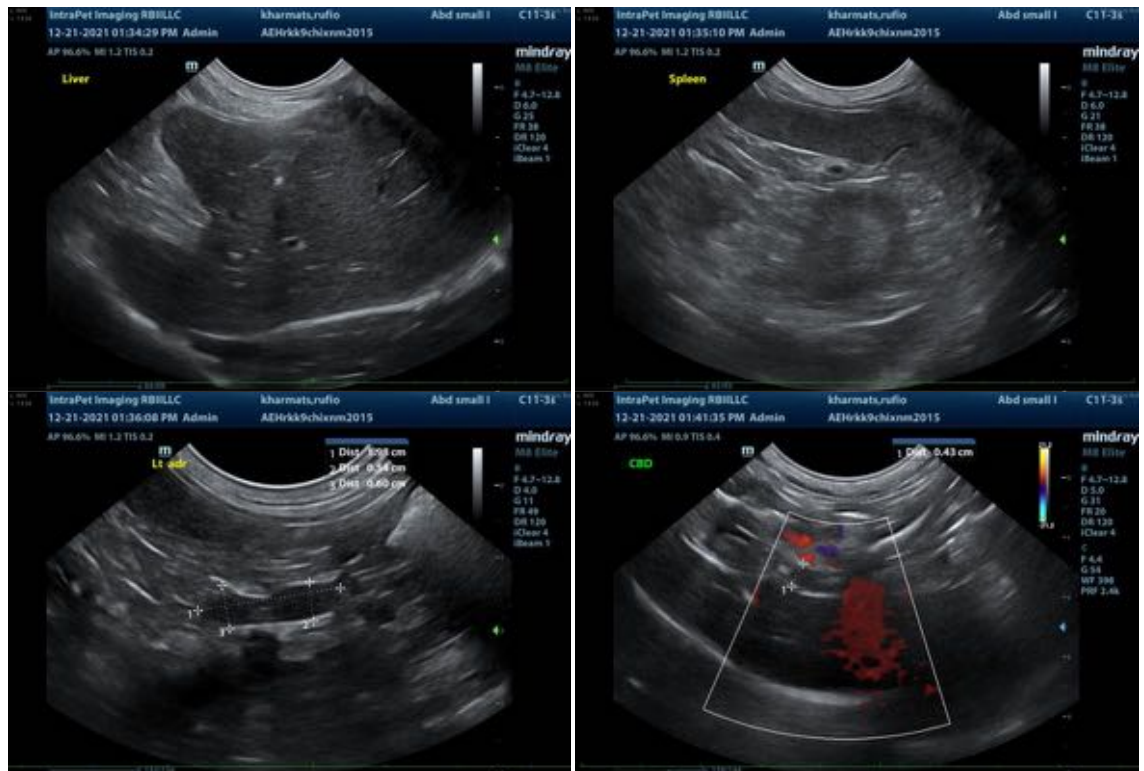
Secondary Findings:

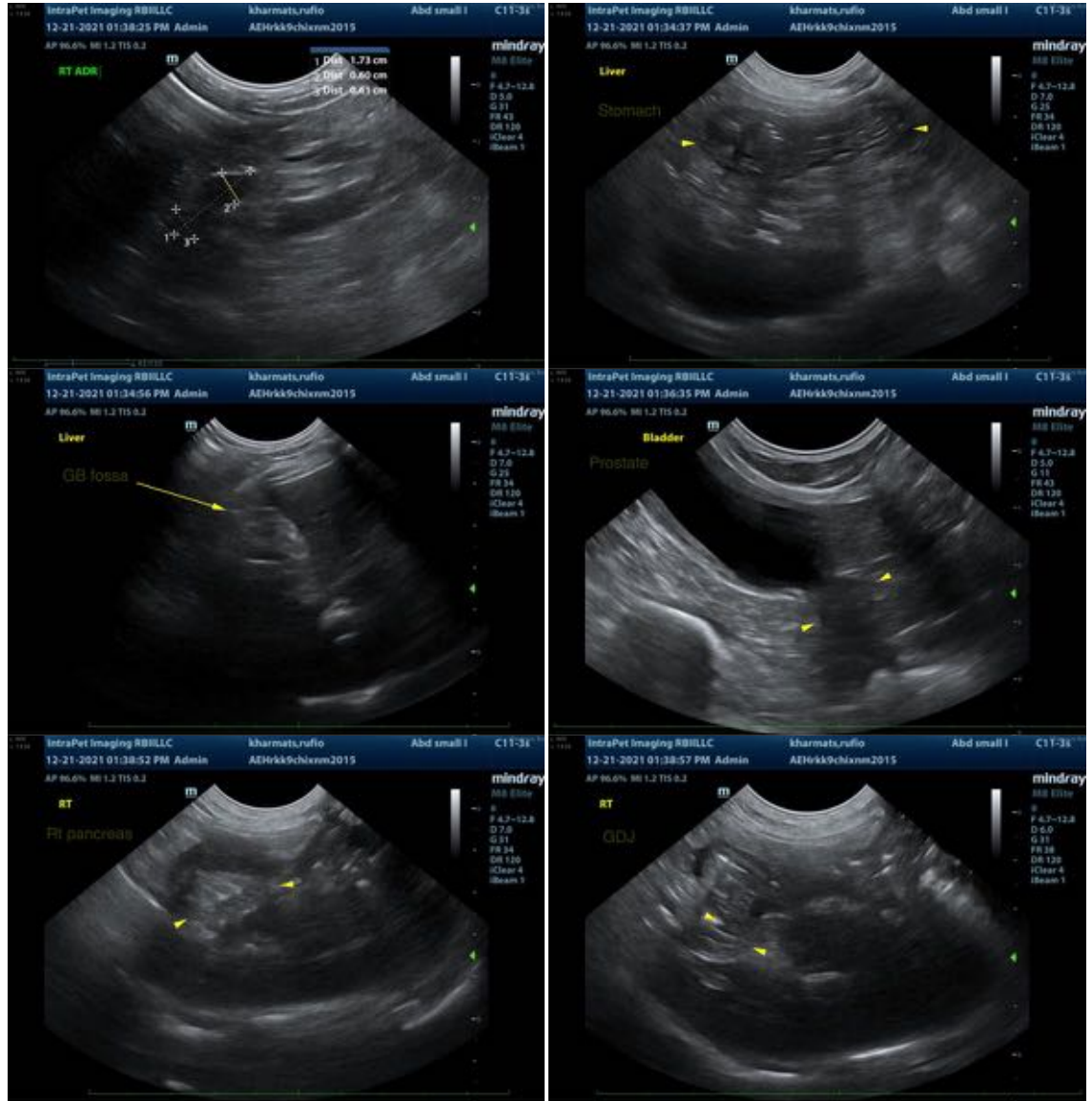
- Minor age-related renal changes with dystrophic mineralization.

- The splenic parenchyma changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis or splenitis with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).
- The increase in hepatic portal markings are suggestive of an inflammatory process. However, they may be a normal variant for this patient. Correlation with the patient's lab values is recommended.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A fecal evaluation for ova/Giardia +/- fecal PCR infectious disease panel
- cPLI (+/- full GI panel) can also be considered to assess for pancreatitis.
- Given the recent vomiting, also consider 3-view thoracic radiographs to assess for aspiration pneumonia.
- Supportive care for acute gastroenteritis is recommended. If clinical signs do not improve within 24-72 hours of supportive care, a more advanced GI workup may be warranted.





The information and recommendations provided are based on the images presented by the referring veterinarian. 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.

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