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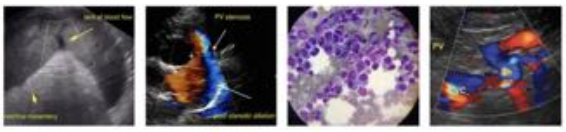


Charleston Mobile Veterinary Services
IMAGING PERFORMED BY
CharlestonMobile.Net 800.403.5408

PATIENT

Rosalie Sampson

SPECIES

Canine

BREED

Pitbull Terrier

SEX

Spayed Female

AGE

3/29/2018

WEIGHT

53 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

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

HOSPITAL NAME

Foxbank VH

REFERRING VET

Ashley Parsons

INVOICE

12201

DATE

2.10.23

PRESENTING CLINICAL SIGNS

Clinical Exam Findings:
-Patient presents for lethargy and consistent vomiting.
-BAR. E+/D+. U/D normal as far as O knows. No D/S.
-O states that P has been vomiting at least twice a week for a few months. This week, however, P has been throwing up daily, at least 3 times. P will usually throw up about 8-9h after eating and it will usually be whole, undigested food or water.
-O mentions that there is an accompanying cough that sounds similar to a cat hairball cough followed by P running out of breath. O states that P will run out of breath after playing with housemates or exerting herself.
-O states that P has anxiety and will also get out of breath after anxiety inducing events. P will look visibly uncomfortable and drool excessively prior to these events.

Food: Purina Dog Chow Complete Adult Beef Flavor 1c
Medications: None
Prevention: Proheart12/Provecta
Current Medications: 24mg Cerenia (2 PO q24h); 1gm Sucralfate (has not started yet); RX for Royal Canin Hydrolyzed Protein and Hill's z/d

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. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 3-4 cm, are normal.

The left kidney is normal in size (5.73 cm in length) with a normal shape, architecture and 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 in size (6.56 cm in length) with a normal shape, architecture and 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 left adrenal gland is normal in size (0.58 cm at cranial pole) (0.54 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is in normal size (1.06 cm at cranial pole) (0.57 cm at caudal pole) with a normal shape and 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 (1.65 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 gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is mildly distended with ingesta. 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. The colonic lumen contains shadowing fecal material. There is no obvious evidence of an obstructive pattern.

Pancreas

The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. One to two prominent mesenteric lymph nodes are visualized (the largest measuring 2.03 cm in length). The nodes are normal in shape and echogenicity.

Other

A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Retained ingesta within the gastric lumen. This finding could be consistent with a motility disorder. Gastrointestinal motility disorders can be primary in origin or may be secondary to microscopic gastrointestinal disease (i.e., inflammatory bowel disease, food allergy/intolerance, infectious/parasitic disease) or an underlying metabolic issue.

- The prominent mesenteric lymph nodes are most consistent with reactive nodes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A malabsorption panel, including serum cobalamin and folate, TLI and PLI, and a resting cortisol level is recommended.

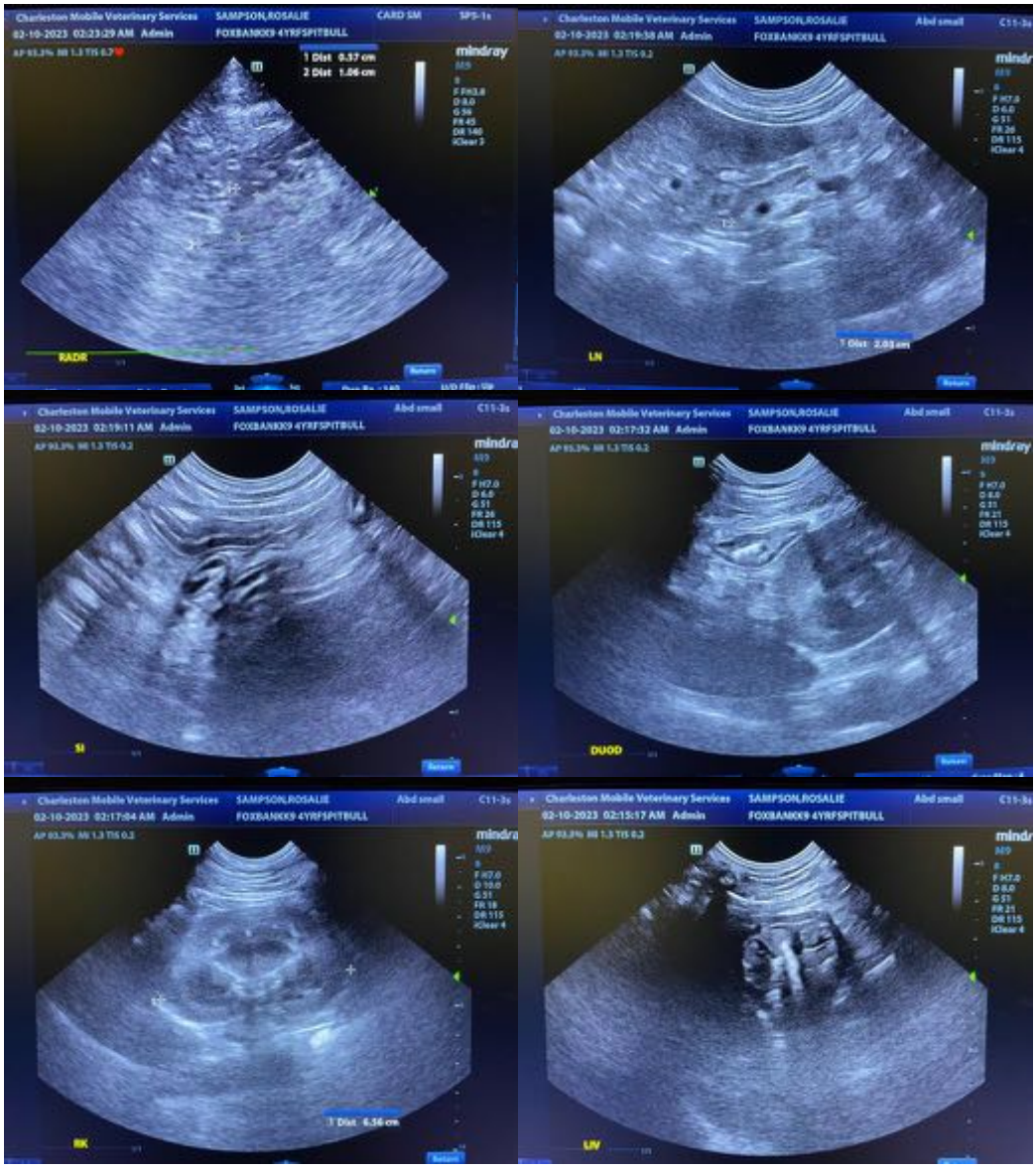
- Also consider transitioning to a hydrolyzed protein or limited antigen diet.

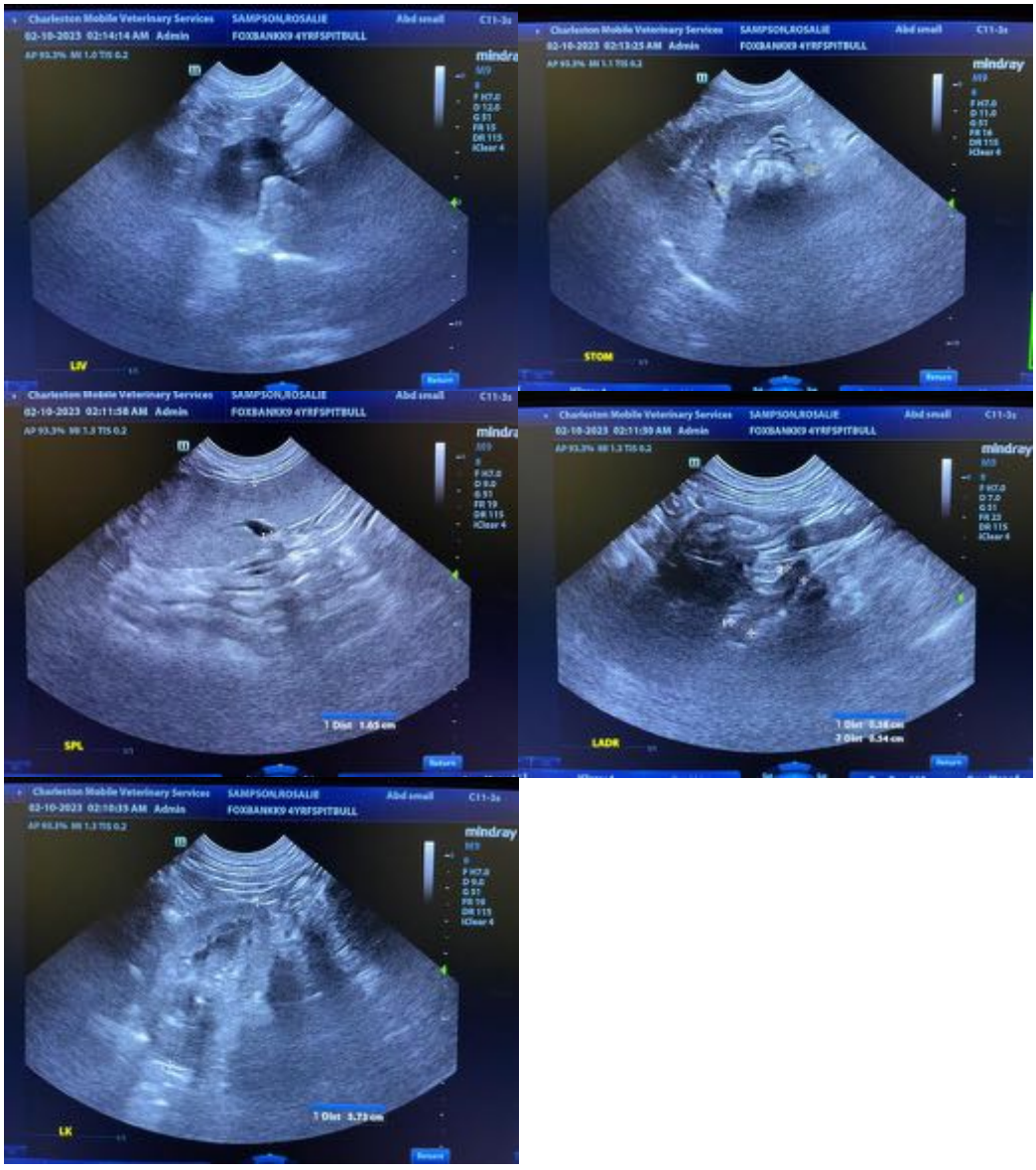
- A fecal evaluation for ova and Giardia is also recommended (if not already performed).

- Consider a trial with a promotility agent (i.e., metoclopramide) as empirical treatment for a motility disorder. If no improvement is seen within 5-7 days of initiating therapy, the drug should be discontinued.

- Initiation of probiotic may also be beneficial.

- Ultimately, GI biopsies (i.e., endoscopic or surgical) may be necessary to get a definitive diagnosis.





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.

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