



**PATIENT PRESENTING CLINICAL SIGNS**

**Bubba Enterline** History: Diarrhea began 3 weeks ago. Owner fed bland diet/gave probiotic, threw up a corn cob about 3 weeks ago. Drinking excessively. Decreased appetite x 2-3 days. Owner noticed pale MM. UTI diagnosed this Saturday -started Clindamycin and he had his last dose 3/14.

**SPECIES**

Canine

Abnormal PE/Chem/CBC/UA Results: Diarrhea, frank blood on rectal exam.  
Rads: Abdomen: decreased serosal detail, some gas within SI, thickened SI wall. Intestinal loop in caudal abdomen that has an odd appearance. Some heterogeneous material within stomach. Subjectively microhepatica.

**BREED**

Bulldog

Thorax: mild pleural effusion. Normal heart silhouette

**SEX**

Intact Male

Bloodwork: PCV/TS: 15%/2.0  
PT: NO COAG  
PTT: 141  
pO2: 97.6  
cSO2: 93.1  
Bicarbonate: 9.5

**AGE**

6.5 years

TCO2: 9.2  
pH: 7.02  
Na:139  
K: 2.2  
Ca io: 0.61

**WEIGHT**

25.3 kg

Lactate: 7.0  
Glucose: 200  
Hct: 12

**INTERPRETED BY**

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

**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 distended with anechoic urine. No masses, inflammatory changes or calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

**IMAGING PERFORMED BY**

Dr. de Cordon

The region of the prostate is not visualized due to its pelvic location.

**HOSPITAL NAME**

Mason Dixon  
Animal EH

The left kidney is normal in size (6.36 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 (7.06 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.

**REFERRING VET**

Dr. de Cordon

**Adrenal Glands**

The left adrenal gland is normal in size (0.56 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.

**INVOICE**

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The right adrenal gland is in normal size (1.85cm at cranial pole) (0.79 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule,

**DATE**

3.16.23

cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

### ***Spleen***

The spleen is normal in size (1.42 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 to moderately distended with echogenic fluid. The wall is normal to moderately thickened (up to 0.97 cm) with apparent retention of the normal layering pattern. The pyloric outflow tract appears patent. The small intestinal lumen is segmentally fluid-distended (mild). The small intestinal wall is normal to moderately thickened (up to 0.69 cm) with retention of the normal layering pattern. In some segments, there is evidence of mucosal speckling/fogging. Discreet masses are not identified. The colonic wall is normal. The colonic lumen contains diarrheic stool. There is no obvious evidence of an obstructive pattern.

### ***Pancreas***

The base and limbs of the pancreas are visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic 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***

The mesentery throughout the abdomen is hyperechoic. Trace free fluid is observed. The abdominal lymph nodes are normal/not visible.

### ***Other***

Pleural effusion is noted.

## **ULTRASONOGRAPHIC FINDINGS**

### **Primary Findings**

- Diffuse peritonitis – rule out septic versus sterile.
- The gastric and small intestinal wall thickening is most consistent with an inflammatory process, with a lower possibility of emerging neoplasia. Mild diffuse ileus is suspected.

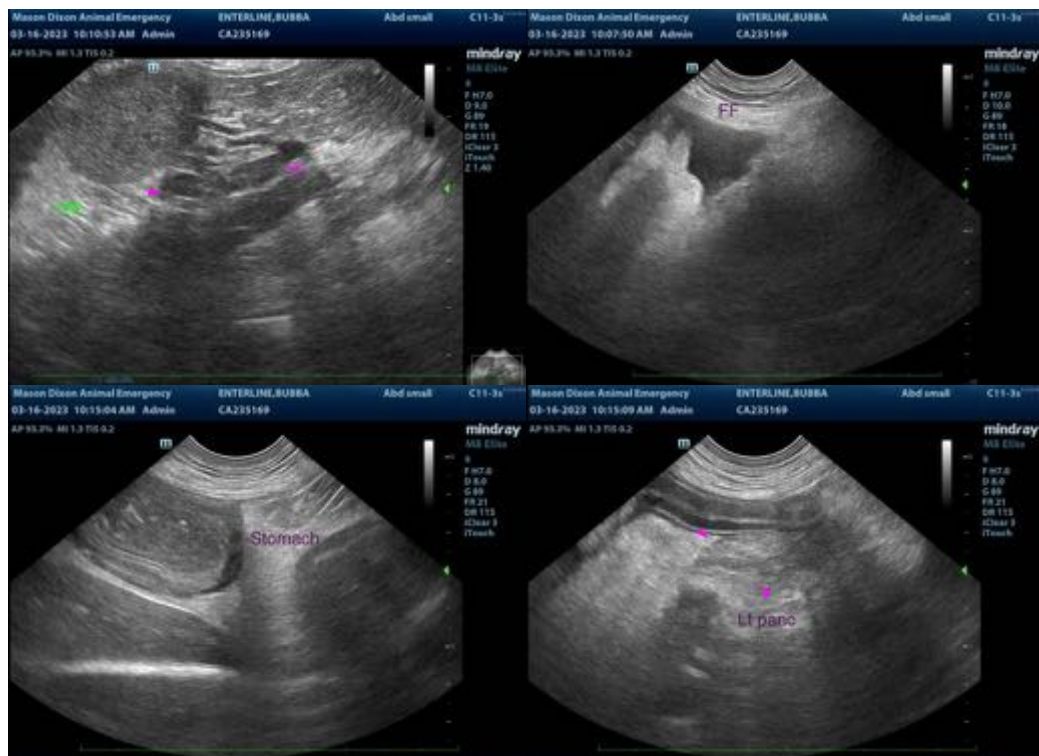
### **Secondary Findings**

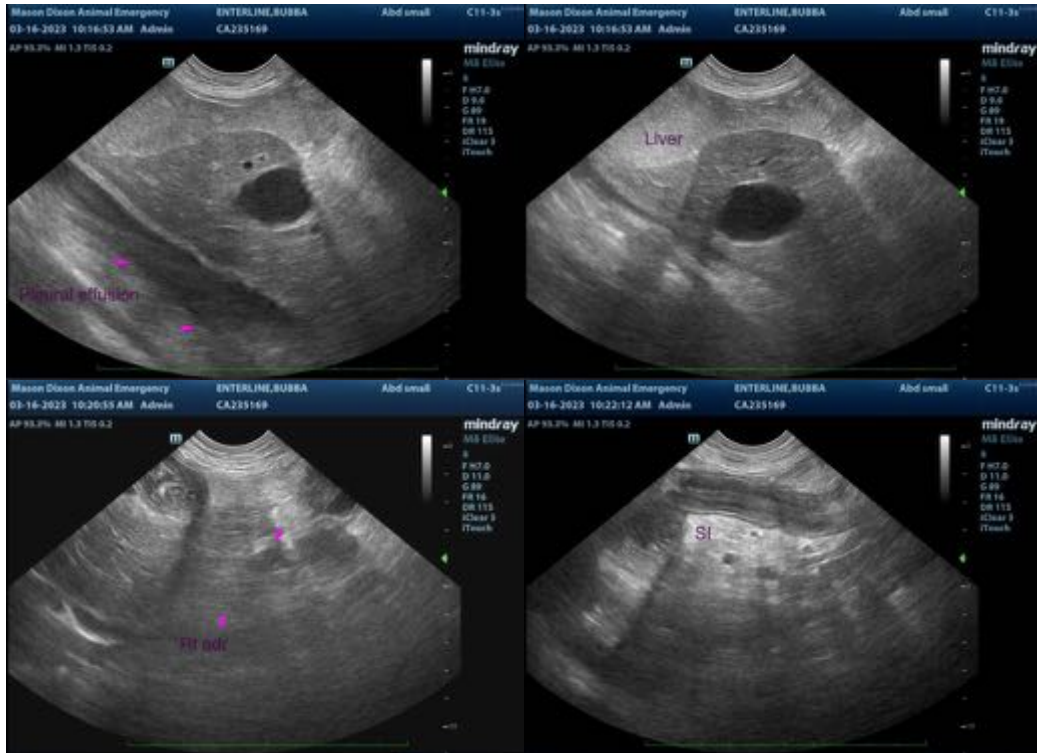
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

\*An obvious cause for the patient's clinical history and constellation of clinical signs and lab/sonographic abnormalities is not definitively identified.

### INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Baseline lab work, including a CBC, chemistry panel, urinalysis and T4 is recommended (if not already performed). If clotting times are prolonged, consider investigating for underlying causes of coagulopathy (i.e., rodenticide toxicity, sepsis, hepatic disease, DIC). If clotting status is stabilized, fluid analysis and cytologic evaluation of the pleural and abdominal fluid should be considered.
- In the meantime, if coagulopathy is present, consider administration of fresh frozen plasma, vitamin K and other supportive measures (i.e., blood transfusion).
- Also consider a slide agglutination test to assess for autoagglutination.
- A reticulocyte count should also be submitted to assess for RBC regeneration.





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)  
[info@SonoPath.com](mailto:info@SonoPath.com)