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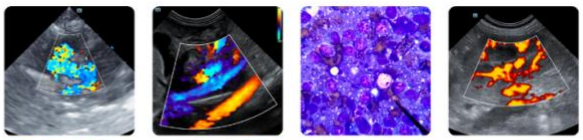

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Bailey Stricklin

SPECIES

Canine

BREED

Golden Retriever

SEX

Female Spayed

AGE

03-01-2018

WEIGHT

37.8

INTERPRETED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

IMAGING PERFORMED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME

Blue Pearl MtP ER

REFERRING VET

Dr Marcario

INVOICE

22639

DATE

3-2-26

PRESENTING CLINICAL SIGNS

Presented the ER yesterday for an esophageal foreign body. Paper towels were found within the stomach at the time of the scope, and were removed endoscopically. Since then, the patient has been retching and regurgitating. Thoracic radiographs reveal an air-dilated esophagus. There is also concern for aspiration.

Clinical Exam Findings: Bailey is a 8y/o FS Golden Retriever representing tonight for vomiting after an endoscopy earlier today. When P first got home, she seemed groggy still from the sedation. Around 8pm, O fed P 1/2 can of RCGI and gave 40mg Omeprazole. P vomited all the food shortly afterwards. P is unable to get comfortable and constantly clearing her throat which has gurgle sound. O called around 11:30pm to ask for advice since P was still vomiting and uncomfortable. O was instructed to give the Reglan that was due. P vomited shortly after. P has been pacing the house and unable to keep water down.

On presentation tonight Bailey is BARH

EENT mmb pink <2 bilateral nasal discharge
CV/R no murmur/arrhythmia panting, referred upper airway noise. loud stridulous breathing.
abd palp not overtly painful on palpation
MS/N ambulatory x4
UG nsf
PLNs wnl
integ nsf
Current Medications: ATH Phylyte 150ml/hr IV ondansetron 0.5mg/kg IV Q8H CRI famotidine at 8 mg/kg/day CRI Metoclopramide at 2mg/kg/day Unasyn 30mgf/kg Q8H Enroflox 10mgkg IV Q24H torb 0.2mg/kg IV acepromazine 0.03mg/kg IV (0.1ml) PRN

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 3 cm, are normal.

The left kidney is normal in size (7.86 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal- to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (7.76 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal- to mild loss of 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 (0.70 cm at cranial pole) (0.72 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 normal in size (0.69 cm at cranial pole) (0.62 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.

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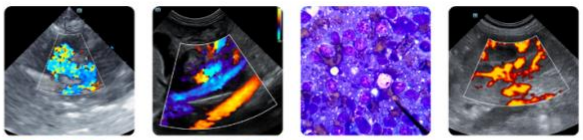

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Spleen

The spleen is subjectively normal-in-size, with a normal capsular contour. There is appropriate echogenicity and echotexture. A 1.48 x 0.93 cm hyperechoic- to heterogenous nodule is observed approximately mid-body. 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. The portal vein to caudal vena cava ratio is approximately 1: 1.

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/not seen.

Gastrointestinal

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 is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. 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.

Lymph Nodes

The abdominal lymph nodes are normal/not visible.

Free Abdomen

There is no obvious evidence of free fluid.

Other

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Minor bilateral nonspecific age-related renal changes
- The splenic nodule trends toward the benign (i.e., myelolipoma). However, an emerging tumor cannot be completely excluded.

*The abdomen is otherwise structurally unremarkable.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Continued empirical treatment for esophagitis and aspiration is recommended. If clinical signs persist, further work-up may be indicated.
- Regarding the splenic nodule, consider a recheck ultrasound in 2-3 months to assess for growth of the lesion. Fine-needle aspiration can also be considered at any point (assuming normal clotting status).

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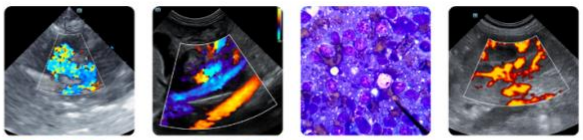

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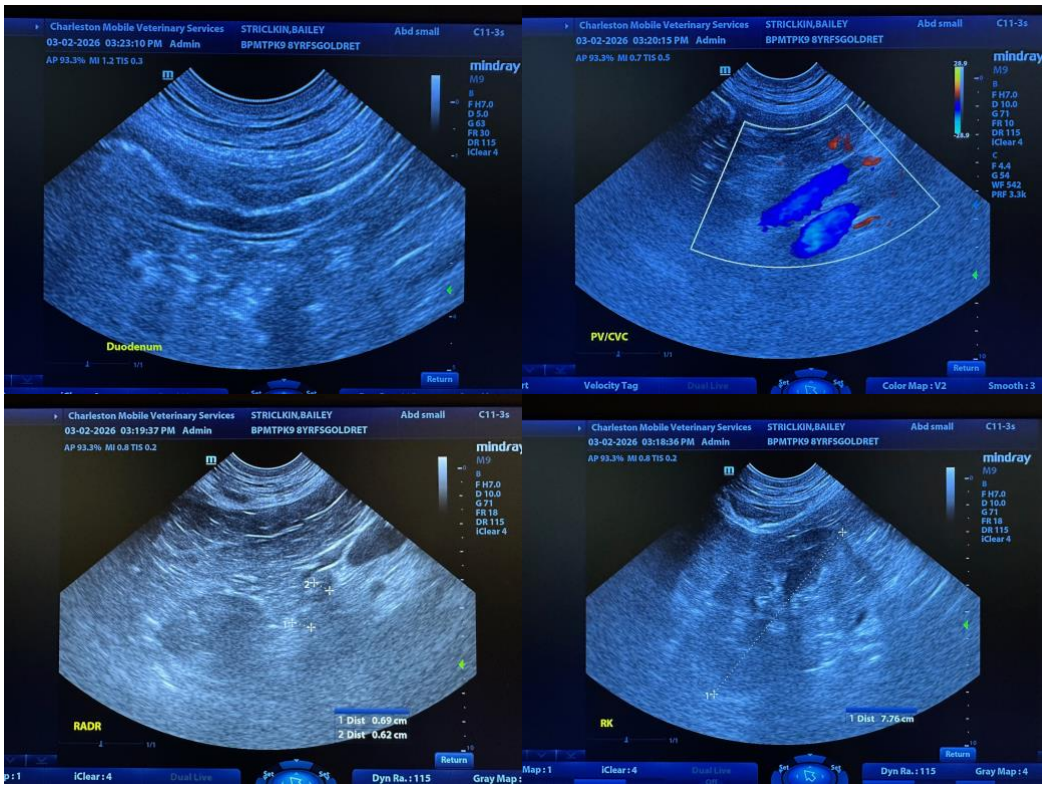

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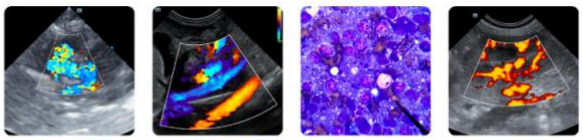

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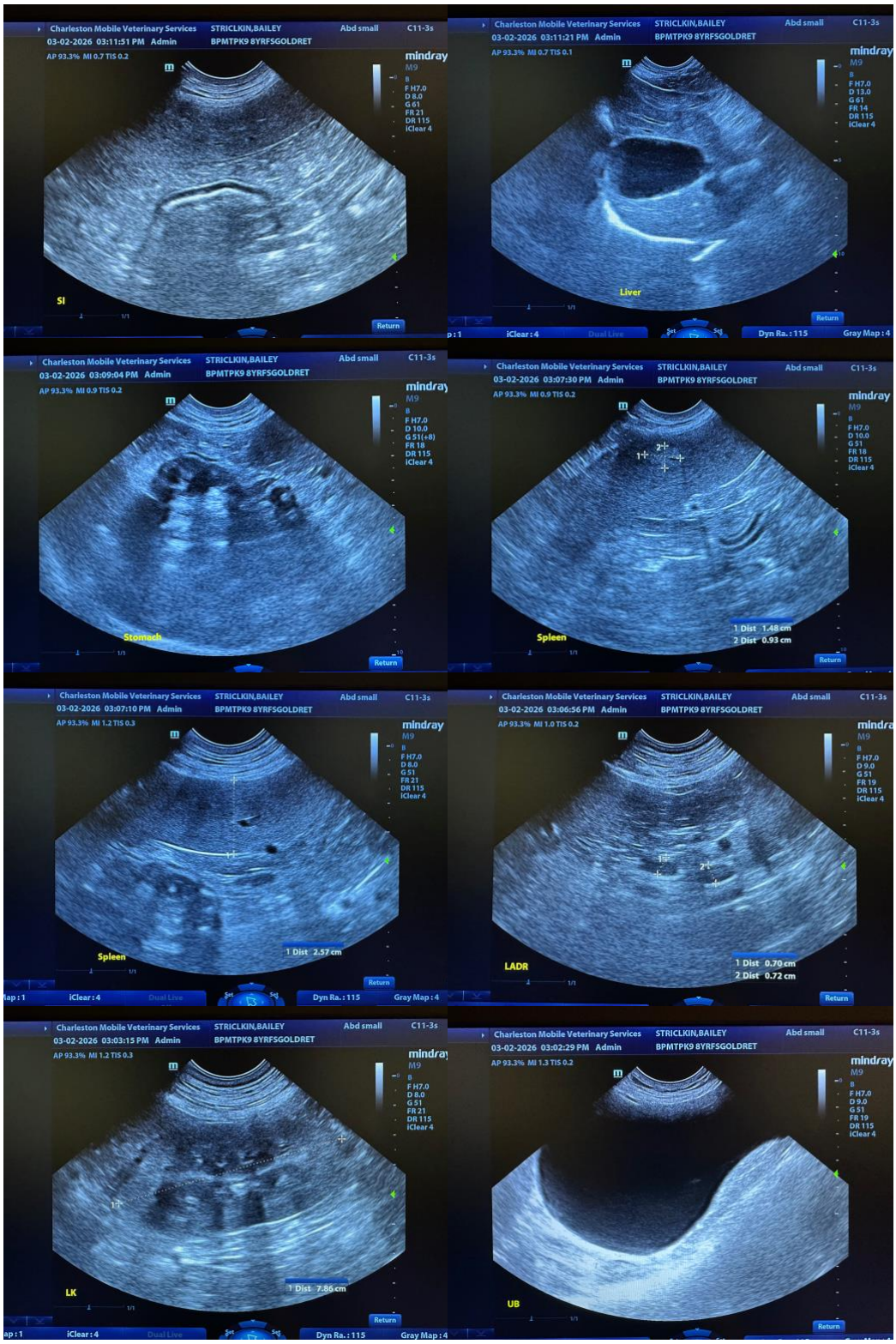

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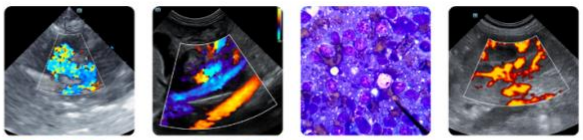

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com