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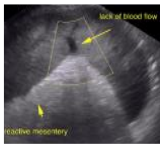
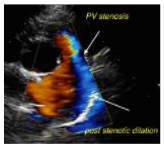
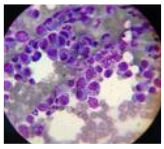
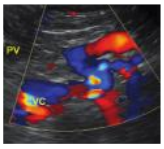

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Yuki Sadlon

SPECIES
Canine

BREED
Australian Shep. Mix

SEX
Spayed Female

AGE
9 mos

WEIGHT
19 lbs

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

IMAGING PERFORMED BY
Dr. Goodman

HOSPITAL NAME
Evandale-Blue Ash PH

REFERRING VET
Dr. Wehmer

INVOICE
10604

DATE
3/23/22

PRESENTING CLINICAL SIGNS

History: Intermittent vomiting and soft stool starting 3/14/22. Hospitalized for a day and a half with IVFT, ondanestron, famotidine and bland food. CBC/Chem/Lytes/UA run in house, results attached. Appetite improved and vomiting was better. On 3/18 the eating decreased again and did ondanestron tabs at home through the weekend. Continued to not eat well over the weekend, even with the ondansetron. Presented on 3/22 for hospitalization with IVFT, started amoxi tri clav, metronidazole and sucralfate. Sent PLI to lab and returned normal. Ravenous when fed chicken and rice in the clinic. Went home with IVC in and returned today for continued hosp with IVFT and ultrasound. Drooled on way home last night which has subsided from earlier puppy days. This started again in the past 2 to 4 weeks. She did vomit after they got home and it was undigested. In the past with her drooling in the car, she has never vomited though and this was new. She did eat 3 small meals last night and kept these down. Her energy is better. Ate a small amount of chicken and rice in clinic and was very interested. Slept most of the time in the clinic.

Abnormal PE/Chem/CBC/UA Results: 3/23/22, PE: H & L wnl, abdomen soft nonpainful. Rectal: stool on glove slightly soft, quiet demeanor overall.
CBC unremarkable. SDMA 20. Urine Specific Gravity 1.020. Spec cPL normal.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are 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 1 cm, are normal.

The left kidney presented normal size (4.28 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.

The right kidney presented normal size (4.33 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 left adrenal gland is normal size (0.30 cm at cranial pole) (0.40 cm at caudal pole) (1.82 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.

The right adrenal gland is normal size (0.54 cm at cranial pole) (0.35 cm at caudal pole) (1.71 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 (1.55 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.

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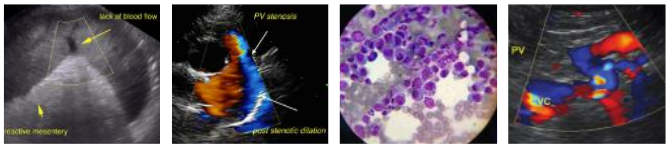

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Liver
The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary 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.

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 suspected to be 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 or overt infiltrative disease is noted.

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
Trace free fluid is suspected. Two to three prominent mesenteric lymph nodes are visualized, the largest measuring 1.63 cm in length.

ULTRASONOGRAPHIC FINDINGS

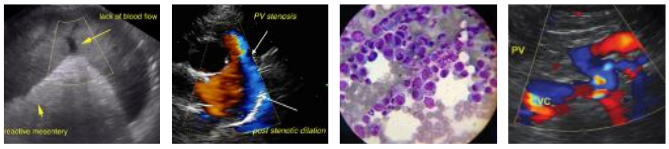
Primary Findings

- If the patient was fasted for the study, the presence of ingesta in the gastric lumen would suggest delayed gastric emptying, which can be a primary disorder or secondary to underlying gastrointestinal or metabolic diseases.
- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the history of drooling and vomiting of undigested food, three-view thoracic radiographs are recommended to assess for possible esophageal disease.
- Other diagnostic considerations include the following:

1. Fecal evaluation for ova and Giardia
2. Cobalamin and folate levels
3. A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended.
4. Limited antigen diet trial



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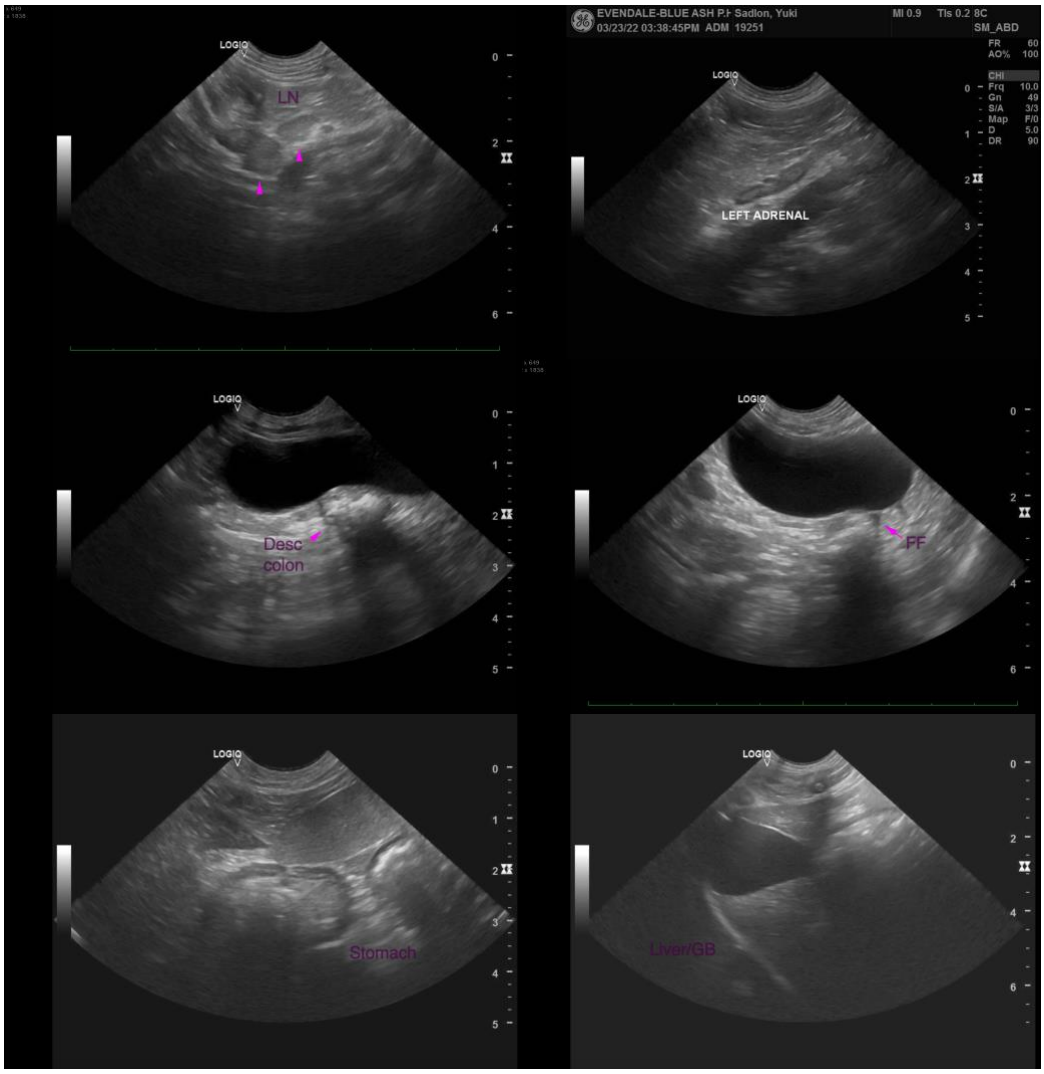
5. Consider pre-and postprandial serum bile acids to assess for occult hepatic dysfunction.

6. If reduced gastric motility is of concern, consider empirical treatment for gastric motility disorder with metoclopramide. If no improvement in the patient's clinical signs is seen within 5-7 days of initiating therapy, the medication should be discontinued.

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



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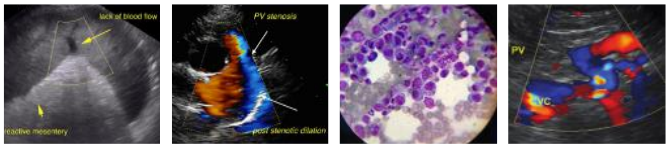

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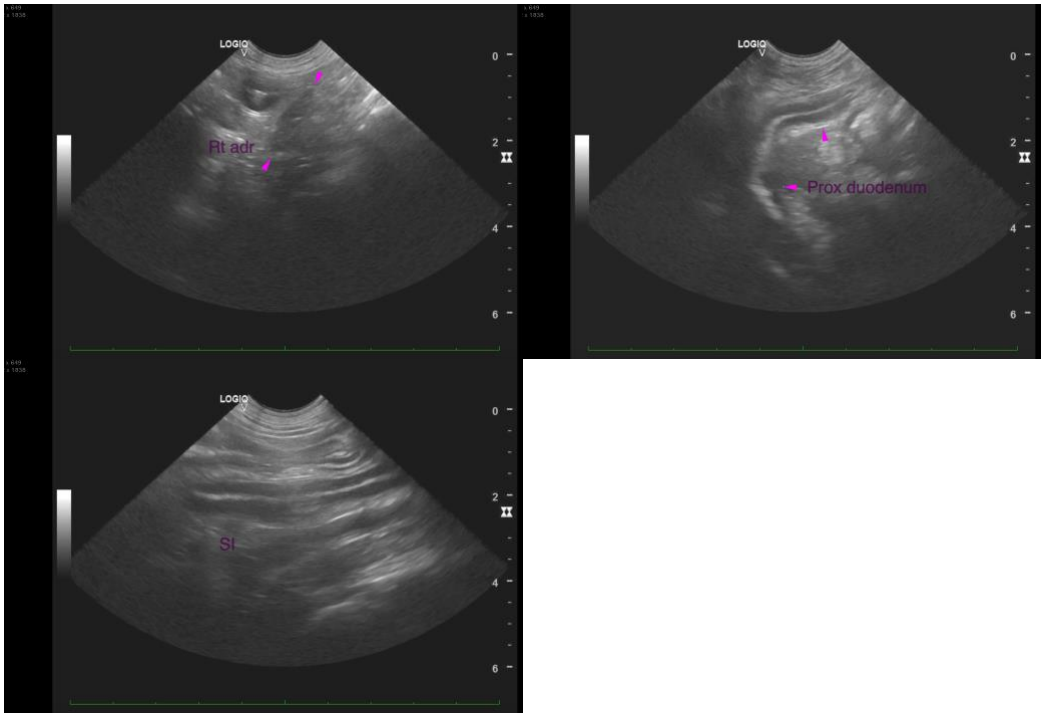

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com