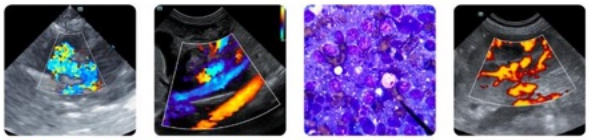



**PATIENT**

Venom Cook

**SPECIES**

Canine

**BREED**

Pitbull

**SEX**

Male, neutered

**AGE**

6 Yrs. 11 months

**WEIGHT**

27.8 kgs.

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Dr. Trionfetti

**HOSPITAL NAME**

Blue Pearl Wyomissing

**REFERRING VET**

Dr. Trionfetti

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13515

**DATE**

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## PRESENTING CLINICAL SIGNS

History:

- AUS to further evaluate vomiting. Presented to the ER for eating a glove over a week ago. V+ 2x in cage this morning with parts of the glove in it. The glove was entirely cloth material. Not wanting to eat today. V+ 5x more after being let out. No current diarrhea but has a history of intermittent diarrhea. Per O, more lethargic and slow. HX of FBO. PE shows ~ 7% dehydrated and tachycardic, HR 200 bpm.
- PMH: 4 yrs ago fbo after eating cat toys, gastritis, food allergies, allergies
- Medications: apoquel, proviable, B12 prn
- Hosp mgmt: IV Fluids , Pantoprazole IV - D/C as no evidence of GI bleed, Methadone IV Q6, Cerenia IV Q24

Abnormal PE/Chem/CBC/UA Results: PCV/TP: 59/6.8 CBC: WCB 11.42, neut 10, lymph 0.85, plt 342k Chem 15: ALT 166 (H), ALP 136, alb 3.6, glob 2.5, Na 144, Cl 113, K 4.1, chol 373 (H) rads: concern for gastric FB/O and plicated SI in cranial abd, mild constipation Repeat AXR 10 hrs (DACVR): Stom mild gas distention. V/D -ST radiopaque material left side of the body of the stomach. r/o fluid & rugal folds vs ingesta. Gastric foreign material cannot be r/o. Jejunum gas & fluid-filled, WNL luminal dimensions. Cecum/Colon contain ST radiopaque stool & gas & a piece of mineral opaque ingesta which measures up to 3 to 4 mm in size. Con: The origin of the vomiting is uncertain. The possibility of a small amount of ST radiopaque gastric foreign material cannot be r/o.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder wall is normal in thickness and 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 4 cm, are normal.

The prostate is normal in size (0.93 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

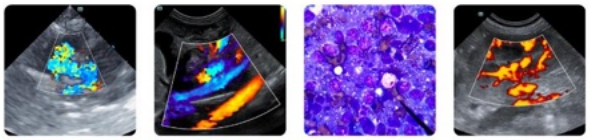
The left kidney is normal in size (7.06 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (6.96 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal 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 mildly enlarged (0.69 cm at cranial pole) (0.81 cm at caudal pole) with slightly swollen peripheral contours. The glandular echogenicity and detail are unremarkable. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.85 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.





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### *Spleen*

The spleen is normal in size (2.39 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.

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.

### *Gastrointestinal*

The gastric lumen is not distended. The gastric wall is normal in thickness with a normal layering pattern. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal with slight disruption in the normal 1:3 muscularis: mucosal ratio in several segments. Discreet masses are not identified. The colonic wall is 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*

A t least one prominent mesenteric lymph node is visualized measuring 2.24 x 0.85 cm.

### *Free Abdomen*

There is no obvious evidence of free fluid.

## ULTRASONOGRAPHIC FINDINGS

**Primary Findings:**

- The small intestinal wall changes could be consistent with inflammatory bowel disease or less likely, emerging lymphoma.

**Secondary Findings:**

- Mild left adrenomegaly
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Continued supportive care for dietary indiscretion is recommended. If clinical signs persist despite medical management, further GI workup may be warranted and could include the following:

1. Fecal evaluation for ova and Giardia
2. GI panel including serum cobalamin, folate, TLI, PLI and resting cortisol level
3. 3-4 week limited antigen or hydrolyzed protein diet trial

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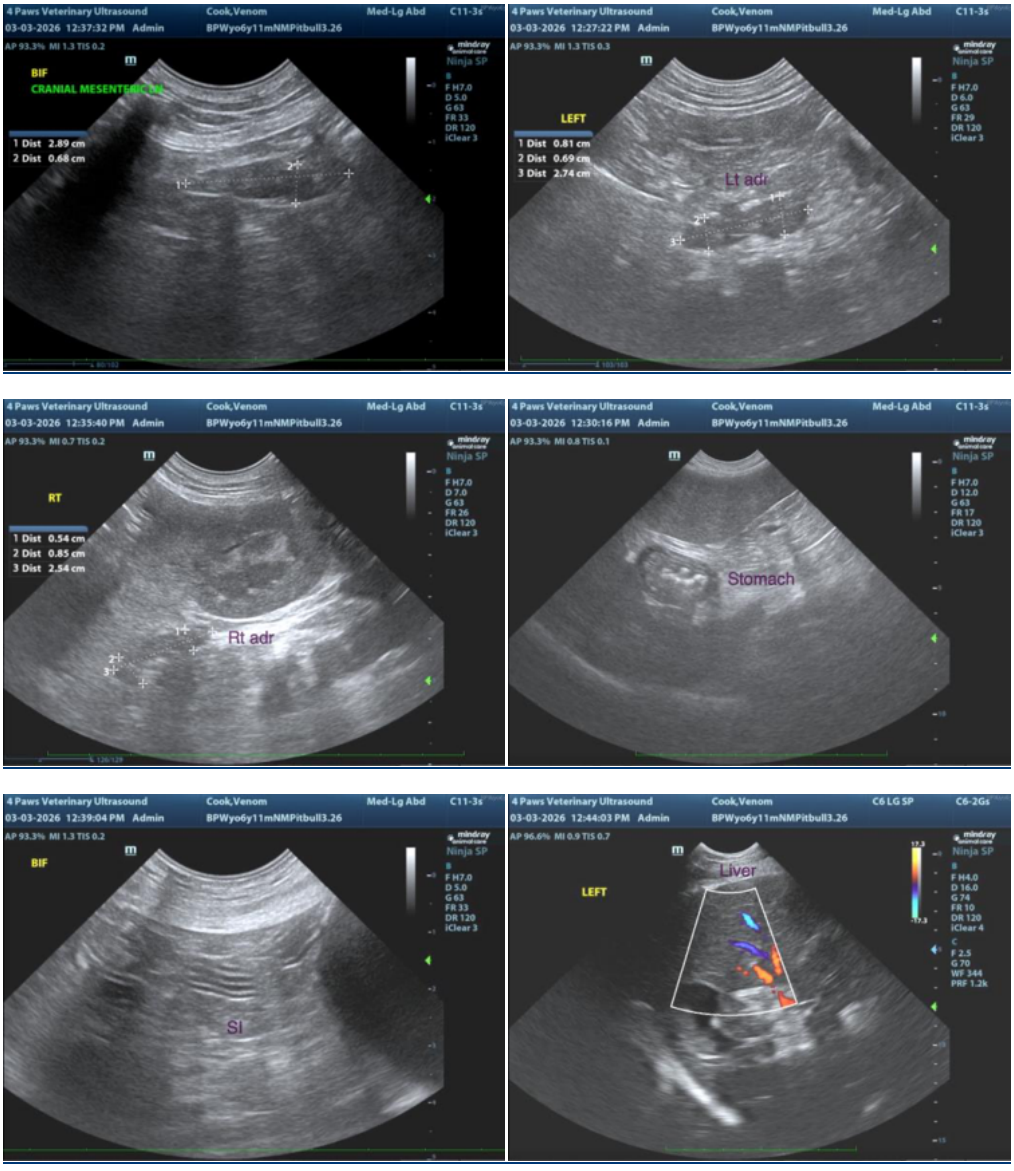
4. +/- endoscopic or surgical GI biopsies




**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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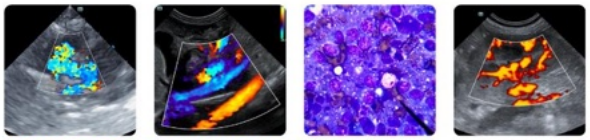

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