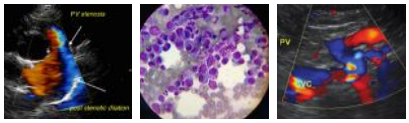
IMAGING PERFORMED BY

IntraPet.com



SonoPath
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DATE

3/6/2022

PATIENT

Milo Hyman

SPECIES

Canine

BREED

Yorkshire Terrier Mix

SEX

Neutered Male

AGE

2020

WEIGHT

17.2 lbs

INTERPRETED BY

Andrea Nicastro, DMV, Diplomate DACVIM (Small Animal Internal Medicine)

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Dr. King

INVOICE

10508

PRESENTING CLINICAL SIGNS

Presenting Complaint: Vomiting. Not Eating. Tremors/Shaking/Trembling. Panting.
History: Date: 03-05-2022 Notes: about 1 week ago, v/d saw RDVM on Monday - had labwork with CPL- all ok treated as outpatient continues to vomiting frequently (not cough, bringing up food and bile-- checked again with owner) usually right after tries to eat no changes in diet or new treats.
No obvious fb obstruction on films-- repeat -- stomach remains small
ate well twice, then regurgitated fluid--even after, stomach still remains small
PE: Fever on presentation, resolved. Abdomen is soft. No diarrhea in hospital, on IVF.

Current Medications: Amoxicillin (Biomox) Tablets 100mg 1.5, Gabapentin Tablets 50mg 1, Ondansetron Tablets 4mg 0.5, Fenbendazole Suspension 100mg/mL 3.7, Gabapentin Tablets 50mg 1, Amoxicillin (Biomox) Tablets 100mg 1.5, Buprenorphine 0.6mg/mL 0.23, Ondansetron 2mg/mL Injection (Per mL) 1, Ampicillin 125mg/vial Injection (Per mL) 1.3, and Maropitant Citrate (Cerenia) 10mg/mL Solution Injection (Per mL) 0.7364.

Lab Results: Attached. Leukocytosis with a neutrophilia and monocytosis. Normal chemistry panel.

Increase in WBC
need fecal still, start prophylatic deworm.

Radiographs: Xray Abdomen 2 View: no overt fb obstruction, appears to have formed stool , stomach is very small. good detail chest -- has density over the chest on lateral only

TFAST US: no free fluid and not see on VD=- suspect pericardial fat no dilation of esophagus

Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

Imaging Performed By: Rachel Brilhart, RDMS.

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 2 cm, are normal.

The prostate is normal in size (0.89 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney presented normal size (5.51 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.

The right kidney is normal size (4.79 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. The

cortex is hyperechoic. Mild pyelectasia is present (0.22 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.57 cm at cranial pole) (0.51 cm at caudal pole) (1.91 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 (0.68 cm at cranial pole) (0.52 cm at caudal pole) (2.05 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 (1.48 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.

Gastrointestinal

The gastric lumen is minimally fluid-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 to mildly thickened (up to 0.49 cm), with a normal layering pattern. There is evidence of mucosal speckling and striations in some segments. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

Pancreas

The left limb of the pancreas is 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 peritoneal cavity is normal. There is no evidence of inflammation or effusion. On prominent mesenteric lymph node is visualized, measuring 1.03 cm in length.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Small intestinal wall pattern suggestive of inflammation +/- lymphangiectasia.

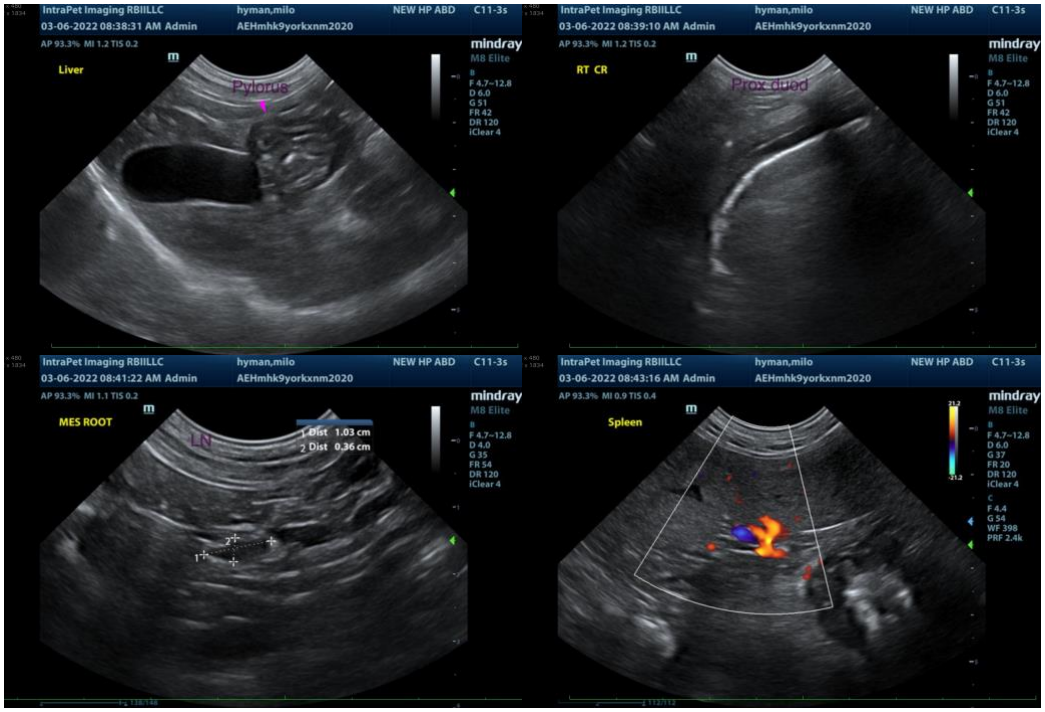
- The pancreatic changes may be a normal variant for this patient or could be suggestive of remodeling +/- fibrosis.

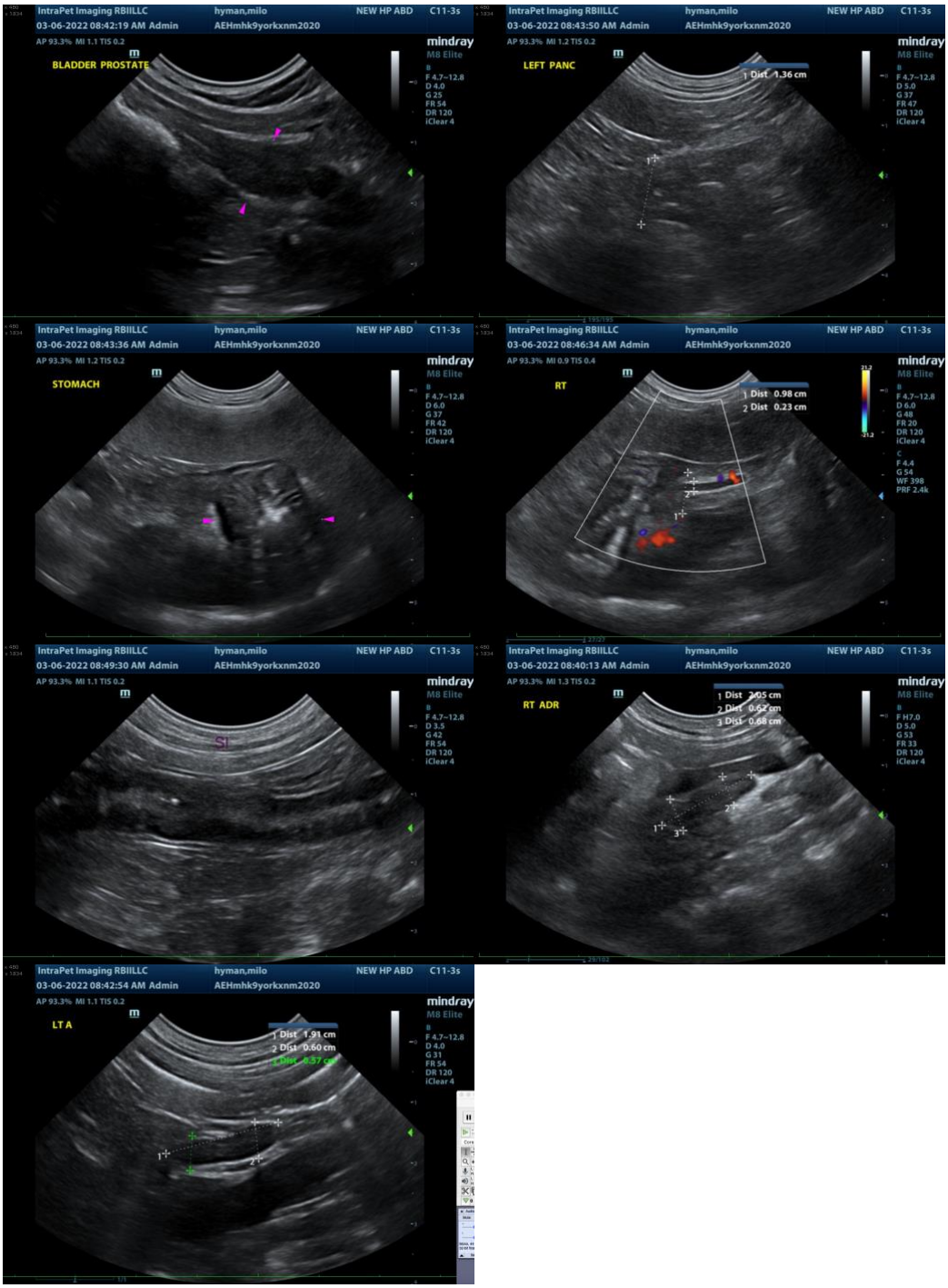
Secondary Findings

- Minor chronic renal changes. The bilateral pyelectasia may be secondary to IV fluid therapy, pyelonephritis, and/or remodeling.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Fecal evaluation for ova and Giardia. Prophylactic deworming with Fenbendazole is also recommended.
- Malabsorption panel including serum cobalamin, folate, TLI and PLI
- A resting cortisol level to screen for hypoadrenocorticism.
- Consider transitioning to a low-fat, hypoallergenic diet, when the patient has stabilized.
- Given the history of regurgitation, empirical treatment for reflux esophagitis (i.e., sucralfate, proton pump inhibitor), is recommended.
- Ultimately endoscopic or surgical gastrointestinal biopsies 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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