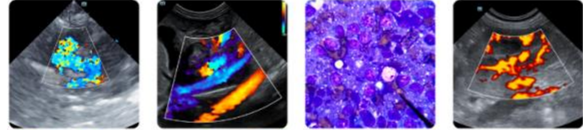
Charleston Mobile Veterinary Services
IN PARTNERSHIP WITH SONOPATH VETERINARY ULTRASOUND



Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath
FOSTERING THE ART OF VETERINARY MEDICINE™
www.charlestonmobile.net
info@charlestonmobile.net 800.403.5408

PATIENT
Bentley Shaw

SPECIES
Canine

BREED
Cavachon

SEX
Male Neutered

AGE
4/9/19

WEIGHT
8.4kg

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
BluePearl MP ER

REFERRING VET
Dr Danielle Fraser

INVOICE
22956

DATE
5-1-26

PRESENTING CLINICAL SIGNS

History/Clinical Exam Findings: Monday after noon P stopped eating and o reported P vomited Monday evening by Tuesday morning P had no interest in food at all and throughout the day anorexia persisted. on Wednesday P was taken into pDVM who diagnosed him with a GI infection and prescribed flagyl and Entyce. O was able to give the Entyce which helped with appetite and P was subsequently able to be medicated with flagyl. o reports lab work at that appointment was normal. On Thursday P got worse and had a massive fluid-like BM a couple of times and represented to pDVM who added Cerenia and recommended continuing all other meds. Vomited after Thursday's Entyce. pDVM gave inj. Cerenia but o gave a 1/2 tab Thursday evening as P appeared to still be nauseous.
He still appears to be irritated, pacing and scratching a lot. O notes he didn't get into anything, he is with the, at all times and is leashed for walks.

Abnormal lab-work values: Chem8: AnGap 24 (H). PCV/TS: 55/4.2. Lactate: 1.5.
Current Medications: IVF, Cerenia, ondansetron

Radiographic Assessment:
The appearance of the large intestine is consistent with the diarrhea described clinically. Differential diagnoses for the clinical signs described include acute gastroenteritis, enterocolitis and pancreatitis. If the clinical signs persist despite appropriate medical therapy an abdominal ultrasound is recommended.

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 mostly anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (0.74 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 (4.45 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 (4.31 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 normal in size (0.38 cm at cranial pole) (0.49 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 (0.70 cm at cranial pole) (0.40 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.

Spleen
The spleen is normal in size (1.13 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

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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 lumen is moderately distended. The wall is thin and smooth. Luminal contents are mostly anechoic. 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. The colonic lumen contains a small amount of unformed fecal material. There is no obvious evidence of an obstructive pattern.

Pancreas
The base and right limb of the pancreas are visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and slightly heterogenous in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Lymph Nodes
One- to two prominent medial iliac lymph nodes are visualized (one measuring 1.79 x 0.90 cm). A few prominent mesenteric lymph nodes are also seen (one measuring 2.19 x 0.37 cm). The mesentery surrounding the mesenteric lymph nodes is hyperechoic.

Free Abdomen
A focal area of mesentery adjacent to the ileocecocolic junction is hyperechoic. There is no obvious evidence of free fluid.

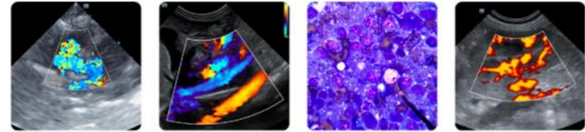
Other
A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.

ULTRASONOGRAPHIC FINDINGS

- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Mild midabdominal peritonitis adjacent to the ileocecocolic junction. This likely represents sterile peritonitis, the cause of which is unclear.
- 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 signs is not definitively identified in this study. Considerations include dietary indiscretion, toxicity, food allergy/intolerance, inflammatory bowel disease, infectious/parasitic disease, underlying metabolic issue, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS



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- Supportive care for gastroenteritis is recommended along with a fecal evaluation for ova and Giardia.
- If clinical signs persist despite medical management, further GI work-up may be indicated.

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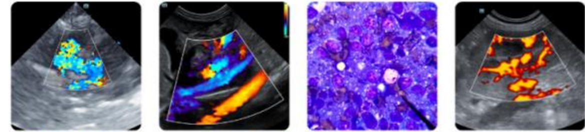

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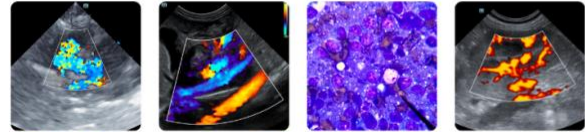

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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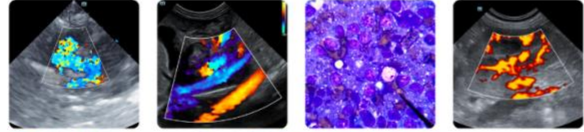

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