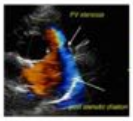
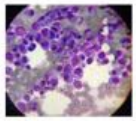
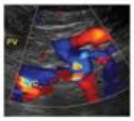






**PATIENT**

Marysol Razo 277418

**SPECIES**

Canine

**BREED**

Mixed

**SEX**

Spayed Female

**AGE**

4 mos

**WEIGHT**

18.4 kg

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Tom McNeill

**HOSPITAL NAME**

SVS Imaging CT

**REFERRING VET**

WVRC Dr. Jochman

**INVOICE**

11442

**DATE**

8.18.22

## PRESENTING CLINICAL SIGNS

History: Diarrhea, vomiting, not eating today. Had vaccines last week at rDVM and appeared healthy then. She developed diarrhea after that time and has progressed since. Started to vomit Tuesday PM. Has had negative fecal test in past. Adopted from HAWS mid-June and did have diarrhea then, but with puppy GI diet, this improved. Did tear up parts of a couch (arm rest) on 08/11/2022 and then tore up dog bed on 08/12/2022. Wednesday saw rDVM for signs. ABXR done and unremarkable. Transferred here for cont'd supportive care.
Abnormal PE/Chem/CBC/UA Results: Hemoconcentration, mild hyponatremia, otherwise NSF

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The **urinary bladder** wall is 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. The region of the trigone and the visible portion of the proximal urethra are normal.

The **left kidney** is normal size (6.07 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** is normal size (6.67 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 (0.48 cm at cranial pole) (0.46 cm at caudal pole) (2.48 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 (0.66 cm at cranial pole) (0.55 cm at caudal pole); 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 (1.62 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.

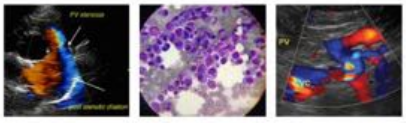
### *Liver*

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/not seen.

### *Gastrointestinal*

The **stomach and intestine** are free of stasis and exhibit normal peristaltic activity. 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 segmentally fluid-distended (mild). The small intestinal wall thickness is normal with a normal layering pattern and appropriate





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mural detail. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. The lumen of the descending colon contains liquid-appearing fecal material. 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.

***Free Abdomen***

Trace ascites is seen. The medial iliac **lymph nodes** are visualized, the largest measuring 2.60 cm in length. In addition, a few prominent mesenteric lymph nodes are seen, the largest measuring 2.91 cm in length.

## ULTRASONOGRAPHIC FINDINGS

### Primary Findings

- The intestinal changes are most consistent with enteritis with possible ileus, the etiology of which is unclear.
- Trace ascites - this is often seen in normal puppies, but may be secondary to increased vascular permeability, low oncotic pressure, or increased hydrostatic pressure

### Secondary Findings

- The abdominal lymphadenopathy could be consistent with immunologic immaturity, reactive lymphadenitis or lymphoid hyperplasia. Infiltrative neoplasia is possible but considered unlikely.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A fecal evaluation for ova and Giardia is recommended, if not already performed.
- Also consider parvovirus testing.
- Prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.
- Consider initiation of a probiotic with a high colony count (i.e., Proviable Forte or Visbiome).
- If the patient's clinical signs do not improve with medical management, a more advanced GI work-up (i.e., malabsorption panel including serum cobalamin and folate, TLI and PLI), resting cortisol level, pre-and postprandial serum bile acids, 6-week novel protein diet trial, +/- GI biopsies) may be warranted.

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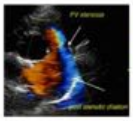
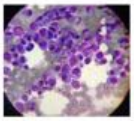
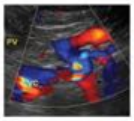

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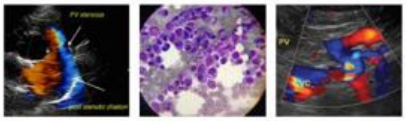

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**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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