



## PATIENT

Luna Collins 49440A

## SPECIES

Canine

## BREED

Goldendoodle

## SEX

Spayed Female

## AGE

3 years, 11 mos

## WEIGHT

13.7 kg

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Tom McNeill

## HOSPITAL NAME

SVS Imaging CT

## REFERRING VET

Madison Vet Spec Dr  
Keller

## INVOICE

11471

## DATE

8.22.22

## PRESENTING CLINICAL SIGNS

History: Luna first started vomiting last week Friday and Sunday. She then went a few days without vomiting. She then started to have diarrhea on 8/19. The diarrhea got progressively more loose until Sunday when it became bloody as well. The dog also started vomiting again Saturday and Sunday. The dog only vomits bile in between meals and keeps all kibble and water down just fine. The owner thought her dog was having bile acid nausea and was feeding her dog extra meals to try to prevent the buildup of bile and subsequent vomiting. Luna is otherwise acting normal. She had worms about a year ago that were treated with antiparasitics and is on a sensitive stomach diet (and occasionally a bland diet).

Abnormal PE/Chem/CBC/UA Results: PCV - 57% (35-55)

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The **urinary bladder** 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 cystourethral junction and the visible portion of the proximal urethra are normal.

The **left kidney** is normal size (5.28 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 hydronephrosis.

The **right kidney** is normal size (5.47 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 hydronephrosis.

### Adrenal Glands

The **left adrenal gland** is normal size (0.46 cm at cranial pole) (0.46 cm at caudal pole) (2.08 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 (0.67 cm at cranial pole) (0.44 cm at caudal pole) (2.73 cm in length); with a 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 (1.63 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 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.

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pattern. The pyloric outflow tract is 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 ileocecolic junction and colonic wall are normal. The lumen of the descending colon is mildly distended with liquid-appearing fecal material. There is no 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 free fluid is observed. The medial iliac **lymph nodes** are visualized (the left measuring 1.43 x 0.45 cm; the right 1.62 x 0.41 cm). The nodes are normal in size and echogenicity. In addition, a few prominent mesenteric lymph nodes are visualized (the largest measuring 2.01 cm in length). A few prominent colic lymph nodes are also seen (the largest measuring 0.62 cm in length).

**ULTRASONOGRAPHIC FINDINGS****Primary Findings**

- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.
- Liquid-appearing fecal material, consistent with diarrhea
- The trace ascites may be secondary to mild bowel inflammation, or other causes of increased vascular permeability or low oncotic pressure (if applicable).

\*An obvious cause for the patient's clinical signs is not identified in this study. Acute gastroenteritis (i.e., secondary to dietary indiscretion, infectious/parasitic disease, other) is possible. Alternatively, given the patient's history of a "sensitive" stomach, a chronic enteropathy (i.e., food allergy/intolerance, or inflammatory bowel disease) is also possible. Underlying metabolic conditions (i.e., hypoadrenocorticism) should also be considered.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The following diagnostics/treatment recommendations can be considered:

1. Baseline lab work, (i.e., CBC, Chemistry panel, urinalysis and T4) is recommended, if not already performed.
2. Serum cobalamin, folate, PLI and TLI
3. A fecal evaluation for ova/Giardia
4. Prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.
5. A 6-week limited antigen diet trial to assess for food allergies.
6. Consider a 4-week course of Tylosin at 15-20 mg/kg by mouth every 12 hours as empirical treatment for small intestinal bacterial overgrowth.
7. A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended.



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- 8. Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be warranted.
- 9. Three-view thoracic radiographs should be performed prior to any anesthetic event.



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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)**  
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