

PATIENT PRESENTING CLINICAL SIGNS

Gus MacDonald History: TTO with DDX, rec starting with rads and EPOC, further rec pending results. EPOC - HCT 36%, BUN 6, rest WNL

SPECIES

Canine

BREED

Labrador Retr

SEX

Neutered Male

AGE

4 years

WEIGHT

44.5 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Harmon

HOSPITAL NAME

Wilvet South

REFERRING VET

Harmon

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8.28.23

2-view abdominal rads findings: Abdominal serosal detail is good. The stomach is slightly distended, shows prominent rugal folds, and is filled with gas and a small amount of heterogeneous fluid. Gas appears to fill the pyloric antral region normally on the left lateral image and extends into the proximal descending duodenum. A definitive gastric outflow obstruction is not identified. Small intestinal structures are gas and fluid filled without evidence of pathologic bowel dilation or plication. The colon contains gas and amorphous feces and is normal in diameter and position. There is no evidence of radiopaque foreign material associated with the gastrointestinal tract. The liver, spleen, kidneys, and urinary bladder exhibit no gross abnormalities such as severe organomegaly, large mass lesions, or opaque calculi. The visible caudal thoracic and skeletal structures are unremarkable.

CONCLUSIONS: The mild heterogenous gastric soft tissue content is nonspecific. Given the patient's history of vomiting and foreign body ingestion, some component of foreign material is of increased likelihood but the presence of normal ingesta retained secondary to a functional cause of ileus (e.g. gastroenterocolitis, pancreatitis, exacerbation of chronic enteropathy, organ dysfunction) is also possible if the patient has had a recent meal (i.e. within the last 24 hours). There is no evidence of mechanical obstruction but it is undetermined based on this single study whether or not the gastric content will be passable/digestible.

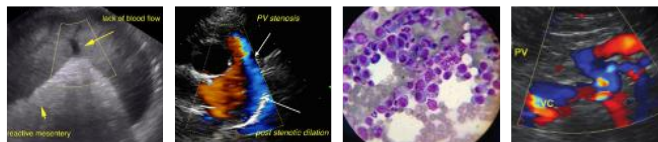
RECOMMENDATIONS: A therapeutic trial of medical management for a presumed self-limiting functional cause of ileus (e.g. gastroenterocolitis) could be reasonable if the clinical signs respond to therapy but follow-up on the gastric content is recommended to inform/refute the need for more invasive intervention. This could be pursued by fasting, treating medically, and rechecking abdominal radiographs in 12-18 hours. Upper GI series could also be used for this purpose. Though abdominal ultrasound could be used for investigation of the gastrointestinal tract and remainder of the abdomen, gastric luminal visualization can be limited with this modality (if that is the intent of the study). The decision to pursue continued monitoring and medical management or eventual removal of the gastric content could be based on additional imaging findings and patient's clinical status. If not already performed CBC, cPI, serum chemistry and urinalysis is recommended. Additional ancillary testing if indicated (e.g. enteric pathogen testing, GI panel) could also be pursued if deemed beneficial for correlation and/or rule out purposes.

A FAST- area in central abdomen where mesentery appears bright/reactive, and prominent to enlarged mesenteric lns present. TTO with findings, rec additional labs, rec hosp, fluids and supportive care +/- complete abdominal u/s
O agreed to plan

Abnormal lab-work values: CBC-RBC 4.97, HCT 33.1%, retic 17.7, neuts 13.28, Eos 0.01 (Non regenerative anemia and mild neutrophilia). CHEM 17 - WNL. Fecal direct-negative for salmon fluke eggs, full fecal to idexx pending. IV cath. LRS @ 150ml/hr

Medications: Cerenia 1mg/kg IV q 24 hours
Ampicillin/sulbactam 30mg/kg IV q 8 hours
Butorphanol 10mg IV and Dexdomitor 0.22mg IV to facilitate complete abdominal ultrasound
Antisedan 2.25mg IM reversal

U/S history: 24-hour-history of vomiting, still interested in eating but unable to keep food down, no diarrhea, abdomen tense on palpation of mid/cranial region. Poss ingestion of stuffing from toy 2 days ago, presented with fever of 104 on A FAST region of bright/reactive mesentery and prominent mesenteric lns noted



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Rad conclusion: The mild heterogenous gastric soft tissue content is nonspecific. Given the patient's history of vomiting and foreign body ingestion, some component of foreign material is of increased likelihood but the presence of normal ingesta retained secondary to a functional cause of ileus (e.g. gastroenterocolitis, pancreatitis, exacerbation of chronic enteropathy, organ dysfunction) is also possible if the patient has had a recent meal (i.e. within the last 24 hours). There is no evidence of mechanical obstruction but it is undetermined based on this single study whether or not the gastric content will be passable/digestible.

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ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

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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 is normal.

WEIGHT

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The region of the prostate is not visualized due to its pelvic location.

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The left kidney is normal in size (7.66 cm in length) with a normal shape, architecture and 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.

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The right kidney is normal in size (7.49 cm in length) with a normal shape, architecture and 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.

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Adrenal Glands

The region of the adrenal glands is evaluated. No obvious abnormalities are observed in this region.

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Spleen

The spleen is normal in size (2.65 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.

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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.

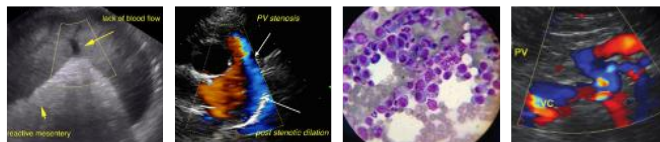
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The gall bladder lumen is moderately distended. The wall is thin and smooth. A moderate amount of aggregated, echogenic, gas-distended debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The 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 a normal



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layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

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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.

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Free Abdomen

There is no obvious evidence of free fluid. A few prominent mesenteric lymph nodes are visualized (the largest measuring 0.42 x 0.24 cm). Surrounding mesentery is slightly hyperechoic.

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ULTRASONOGRAPHIC FINDINGS

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

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*An obvious cause for the patient's clinical signs is not definitively identified in this study. Considerations include microscopic gastrointestinal disease (i.e., dietary indiscretion, infectious/parasitic disease, food allergy/intolerance, inflammatory bowel disease), underlying metabolic issue (i.e., hypoadrenocorticism), other.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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Internal Medicine)

- Consider prophylactic deworming with Fenbendazole, along with symptomatic care for acute gastroenteritis. A probiotic may also prove beneficial.
- Consider a resting cortisol level to screen for hypoadrenocorticism.
- If the above diagnostics are inconclusive and the patient's clinical signs persist, a more comprehensive GI work-up (i.e., Texas GI panel, GI biopsies) may be warranted.

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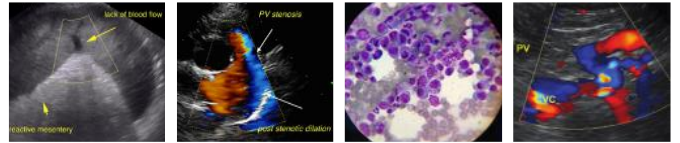
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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