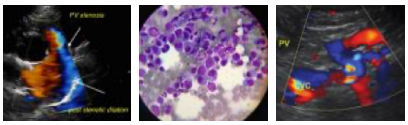
IMAGING PERFORMED BY

IntraPet.com



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DATE

8/29/22

PATIENT

Buddy Feiler

SPECIES

Canine

BREED

Labrador Retriever

SEX

Male, neutered

AGE

3/21/2020

WEIGHT

56.3 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Dr. Willer

INVOICE

13887

PRESENTING CLINICAL SIGNS

Presenting Complaint:
Vomiting With Blood. Not Eating. Diarrhea. Diarrhea with blood. HX-- in sept of 2021-- here for several days with severe HGE, protein loss. Fecal neg, prophylactic deworm, US-- NSF(intrapet 9/2021). Ultimately resolved and protein improved

Since intermittent GI signs, when has issues does chick/rice with a slow wean. Initial films bunchy, repeat- gas in colon, but no obvious fb
Had vomited small bile a few times, none since ondansetron given
Then started with very watery, mucoid, and blood fleck diarrhea
Lytes- wnl, Albumin wnl, Fecal out

Current Médications: Ampicillin, Ondansetron, Protonix.
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 wall is normal in thickness and the mucosal surface is smooth. The bladder lumen is mildly 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 (1.28 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal size (5.36 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 (5.59 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 (0.54 cm at cranial pole) (0.67 cm at caudal pole) (2.72 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 (0.91 cm at cranial pole) (0.72 cm at caudal pole) (2.67 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 (1.86 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 curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and homogeneous in appearance. There is an increase in portal markings. Vascular is of normal volume with no evidence of congestion. 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. The duodenal papilla is normal in size (0.56 cm in width).

Gastrointestinal
The gastric lumen is mildly fluid distended. The gastric wall in the region of the fundus is normal in thickness with a normal layering pattern. In the region of the pyloric antrum, the wall is thickened (up to 1.69 cm) and irregular with apparent retention of the normal layering pattern. The mesentery effacing the serosal surface in this region is hyperechoic. 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. The colonic wall is normal. No obstructive disease is noted.

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
The mesentery in the cranial abdomen is hyperechoic. There is no obvious evidence of free fluid. A 1.53 cm medial iliac lymph node is visualized.

ULTRASONOGRAPHIC FINDINGS
Primary Findings:

- The pyloric antral wall changes could be consistent with inflammation, hypertrophy or less likely, emerging neoplasia. Adjacent peritonitis is present.

Secondary Findings:

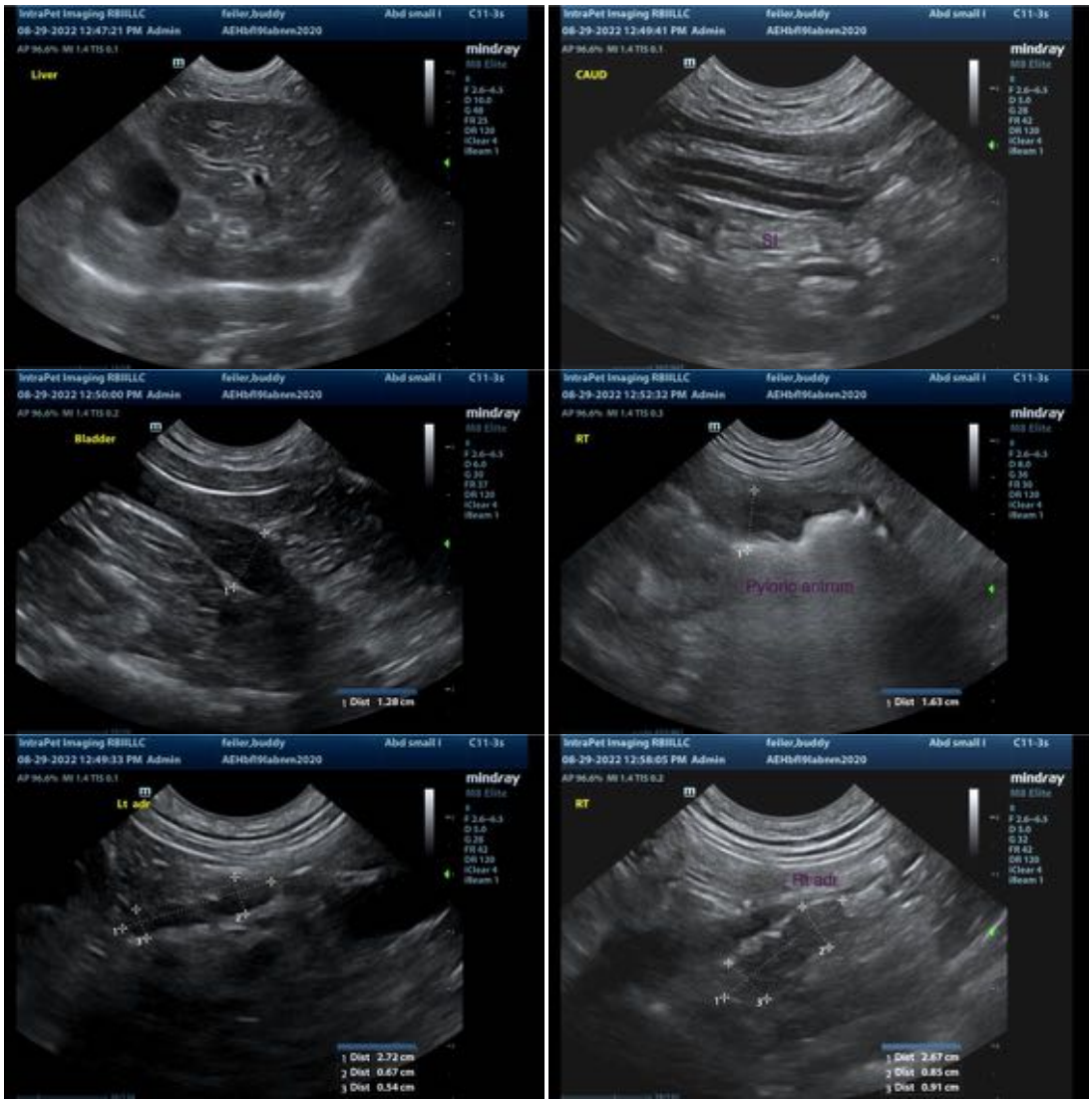
- The increase in hepatic portal markings is suggestive of an inflammatory hepatopathy. However, normal variation cannot be completely excluded. Correlation with the patient's liver values is recommended.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the chronic intermittent nature of the patient's GI signs, an advanced workup is warranted and could include the following:

    1. Prophylactic deworming with Fenbendazole despite the negative fecal evaluation.
    2. Resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended
    3. GI panel (send to Texas A&M); serum cobalamin, folate, TLI and PLI.
    4. 6-week novel protein diet trial.

5. Fecal GI PCR panel for infectious diseases can also be considered.
6. Ultimately, GI biopsies (i.e., endoscopic or surgical) may be necessary to get a definitive diagnosis. If biopsies are pursued, particular attention to the pyloric antrum is recommended.
7. While awaiting test results, consider initiation of a probiotic with a high colony count (i.e., Visbiome or Proviable Forte) along with empirical treatment for small intestinal bacterial overgrowth (i.e., Tylosin).



The information and recommendations provided are based on the images presented by the referring veterinarian. 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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