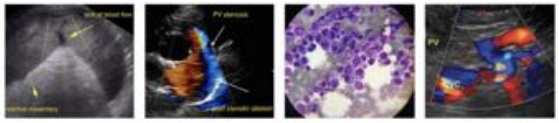

PATIENT

Cooper Huffstetler

SPECIES

Canine

BREED

Labrador

SEX

Neutered Male

AGE

7.19.2011

WEIGHT

28.3 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

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

HOSPITAL NAME

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REFERRING VET

Dr Shannon Graham

INVOICE

11326

DATE

8.4.22

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: presented for gagging/retching and abdominal pain, history of eating things, PE showed abdominal pain otherwise BAR

Abnormal lab-work values: PLT 121 (on machine, manual count was: ALT 146
Current Medications: IVF, cerenia, pantoprazole
Radiographic Findings -Three radiographs included:
There are small, mineral opacity several bone-like pieces in the colon and in the SI, those have sharp ends. The cecum is gas distended and with some soft tissue material. Fecal material is dehydrated. The SI loops have gas and have normal volume.
No liver, spleen and renal abnormalities noted, normal urinary bladder. The pancreatic region is effaced by the cecum, transverse colon and feces within it. Normal serosal detail but cranial right abdomen slightly increased opacity which may be caused by pancreatitis or by inflammation in the cecum.

Assessment: Dietary indiscretion signs - bony structures.
In the cranial right abdomen slightly increased opacity which may be caused by pancreatitis or by inflammation in the cecum, small amount of free fluid. Please do ultrasound of the region and if FF present then tap it since sharp bony material in GI tract detected (maybe chicken bones?).
May be chemical peritonitis caused by pancreatitis or ICCJ disease, unlikely perforation by bones.
Ultrasound recommended and please check blood GLU.

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. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The **prostate** is normal in size (0.88 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 (6.14 cm in length); normal shape and architecture with 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** normal size (6.59 cm in length); shape and architecture with 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.

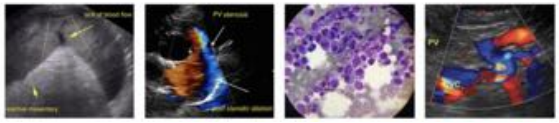
Adrenal Glands

The **left adrenal gland** is enlarged (1.22 cm at cranial pole) (1.03 cm at caudal pole); with a slightly irregular shape. The parenchyma is heterogenous with loss glandular echogenicity detail. The phrenicoabdominal vein and surrounding vasculature are normal.

The **right adrenal gland** is normal size (1.31 cm at cranial pole) (0.66 cm at caudal pole) (2.58 cm in length); with a slightly irregular shape. The parenchyma is mildly heterogenous with some loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature appear normal.

Spleen

The **spleen** is normal in size (2.03 cm in width at the level of the hilus) with a normal capsular



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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** is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. 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 not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. The colonic lumen contains shadowing 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

The **peritoneal cavity** is normal. There is no evidence of inflammation or effusion. The abdominal **lymph nodes** are normal/not visible.

Other

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- There is no obvious evidence of gastrointestinal obstruction.

Secondary Findings

- Bilateral adrenomegaly. This may represent early hyperplastic change, emerging tumors, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Supportive care for acute gastroenteritis is recommended, including fluid therapy, gastric protectants, antiemetics and pain medication as needed.

Consider a recheck ultrasound in 4-8 weeks to reevaluate the adrenal glands. If clinical signs of Cushing's disease develop, further testing (i.e., low-dose dexamethasone suppression test) may be warranted.

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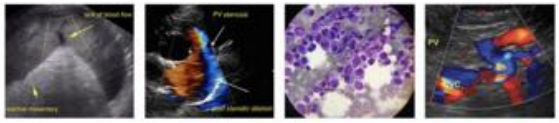

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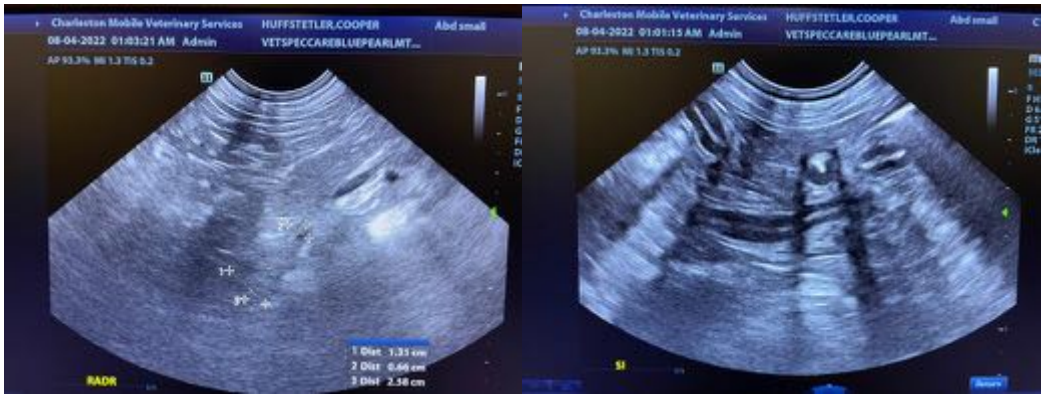

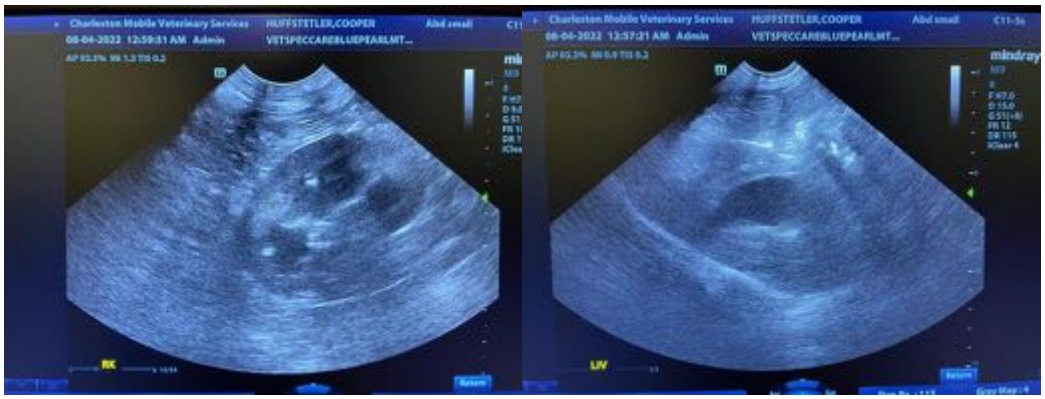

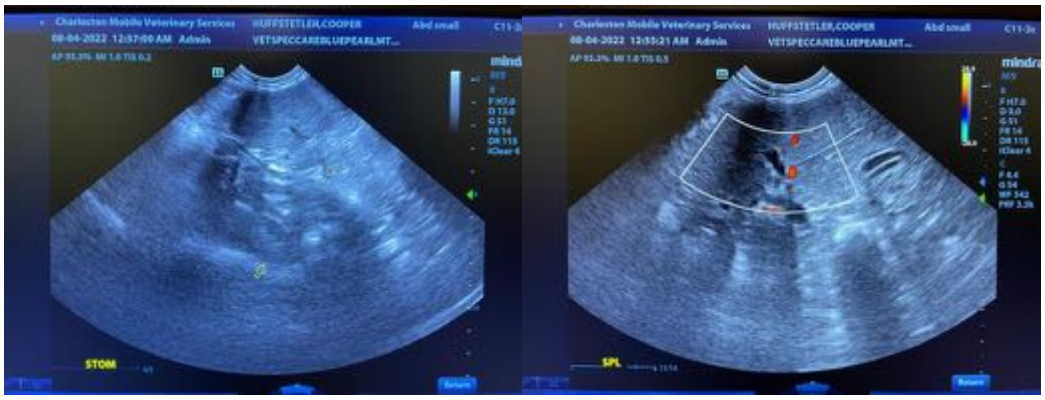

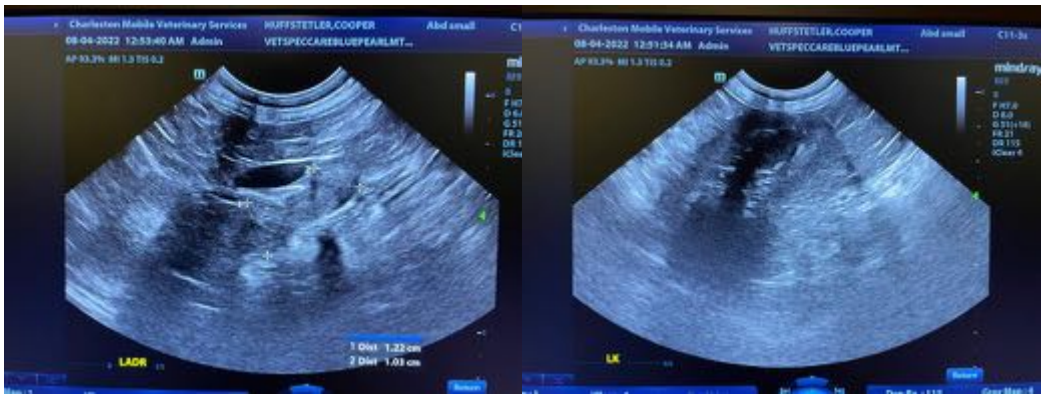

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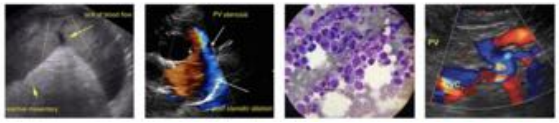

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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