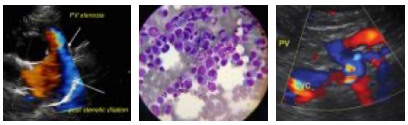
IMAGING PERFORMED BY

IntraPet.com



SonoPath
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DATE

9/21/2021

PATIENT

Cooper Baker

SPECIES

Canine

BREED

Rottweiler mix

SEX

Male, intact

AGE

12/15/2020

WEIGHT

91.4 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Dr. Kalwa

INVOICE

12233

PRESENTING CLINICAL SIGNS

History: Presenting Complaint: Vomiting. Date: 09-20-2021. Notes: Decreased eating for 1.5 weeks. Continuous vomiting - every meal + in car, no blood no feces. 9/19/21 AEH VISIT: Patient has decreased appetite this week. He usually eats 6 cups of food per day and now won't even eat 3 cups daily. He was having normal/ formed stools until 10:30 last night, then started having liquid diarrhea. He vomited up his dog food last night. Ate chicken and rice this morning but then vomited it up around 1pm. Continued vomiting yellow bile and then white foamy material. He started having facial swelling today at 11 am. Does like to stick his head in bushes and stuff outside. Had recently stayed with owner's mom and chewed up a toy, so may have eaten toy stuffing/ parts. Discussed in patient vs outpatient: Lat and V/D abdomen- stomach empty, some mild gas distension in one loop of small intestine, moderate gas distension and small pieces of stool in colon. No obvious foreign material or obstructive pattern. Administered SQ fluids, Benadryl + steroid; Benadryl TGH. Since left AEH has continued to vomit.
Assessment: vomiting- continuous; diarrhea; dietary indiscretion; facial swelling- resolved (occurred yesterday); dehydration - gums tacky
AFAST: no FF. DX: Dietary indiscretion leading to FB vs anaphylaxis - risk for liver elevations, GI upset vs gastroenteritis vs pancreatitis vs viral vs bacterial vs GI parasites vs other. Plan: Recommend to owner hospitalization, IV catheter, fluid therapy, and further treatment as needed HCT/CHEM10/Lytes, +- Fecal, +- X rays and repeat, +- US. Risk of Sx if true obstruction. Discussed limitations of X rays- O frustrated with x rays would like US. Will check lab work risk for anaphylaxis. O feels that the vomiting and not eating are separate. O declines repeat rads.

Current Medications: Unasyn, Pantoprazole.
Lab Results: Attached separately.
Radiographs: Lat and V/D abdomen- stomach empty, some mild gas distension in one loop of small intestine, moderate gas distension and small pieces of stool in colon. No obvious foreign material or obstructive pattern. AFAST: no FF.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: Sedation not required for scan.
Stat Report: STAT report not requested by the veterinarian.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are 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 enlarged (3.19 cm in width) with a normal shape and smooth peripheral contours. The parenchyma is hyperechoic and subtly mottled in appearance. No distinct focal lesions are observed. The prostatic urethra is not overtly dilated.

The left kidney is normal size (8.20 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 (7.82 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 (0.59 cm at cranial pole) (0.63 cm at caudal pole) (2.97 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 (0.61 cm at cranial pole) (0.63 cm at caudal pole) (2.42 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 (2.04 cm in width at the level of the hilus) with a normal capsular contour. The parenchyma is subtly mottled in appearance. 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. A scant amount of echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is minimally fluid distended. The gastric wall is subjectively mildly thickened although the wall thickness is difficult to definitively determine due to rugal folds. There is a normal layering pattern with appropriate mural detail. 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. No obvious 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

A small amount of anechoic free fluid is present. Several prominent to enlarged mesenteric lymph nodes are visualized, the largest measuring 2.75 cm in length.

Other

The testicles are subjectively normal in size and symmetrical with a normal shape and homogeneous parenchyma. No focal lesions are observed.

ULTRASONOGRAPHIC FINDINGS

- The splenic parenchyma changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis or splenitis with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).
- The abdominal lymphadenopathy is likely secondary to immunologic immaturity and/or reactive changes with low potential for emerging neoplasia.
- The trace ascites may be secondary to increased vascular permeability (i.e., due to recent anaphylactic reaction), increased hydrostatic pressure or low oncotic pressure (less likely).

- The prostate changes are most consistent with benign prostatic hyperplasia. Bacterial prostatitis is also a differential but considered unlikely in the absence of lower urinary tract signs.

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

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider three-view thoracic radiographs to assess for aspiration pneumonia and occult esophageal disease.

- Other diagnostic considerations include the following:

    1. A fecal evaluation for ova/Giardia

    2. Prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.

    3. Serum cobalamin, folate, PLI and TLI

    4. A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended.

    5. A hypoallergenic diet trial can be considered if the patient will tolerate it.

    6. Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be warranted.


IntraPet Imaging RBIILLC
baker,cooper
Adult ABD
C6-2Gs
09-21-2021 02:16:08 PM Admin
AEHcbk9rottxma2020
mindray
PROSTATE
Dist 3.19 cm
BLADDER


IntraPet Imaging RBIILLC
baker,cooper
Adult ABD
C6-2Gs
09-21-2021 02:17:55 PM Admin
AEHcbk9rottxma2020
mindray
Spleen


IntraPet Imaging RBIILLC
baker,cooper
Adult ABD
C6-2Gs
09-21-2021 02:18:27 PM Admin
AEHcbk9rottxma2020
mindray
Stomach


IntraPet Imaging RBIILLC
baker,cooper
Abd small I
C11-3s
09-21-2021 02:21:38 PM Admin
AEHcbk9rottxma2020
mindray


IntraPet Imaging RBIILLC
baker,cooper
Adult ABD
C6-2Gs
09-21-2021 02:17:12 PM Admin
AEHcbk9rottxma2020
mindray
LT ADR
Dist 2.97 cm
Dist 0.63 cm
Dist 0.59 cm


IntraPet Imaging RBIILLC
baker,cooper
Abd small I
C11-3s
09-21-2021 02:22:03 PM Admin
AEHcbk9rottxma2020
mindray
RT ADR
Dist 2.42 cm
Dist 0.63 cm
Dist 0.61 cm

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