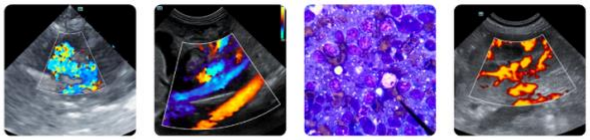



**PATIENT**

Sadie Fetch

**SPECIES**

Canine

**BREED**

American Eskimo

**SEX**

Spayed Female

**AGE**

25 Pounds

**WEIGHT**

25 Pounds

**INTERPRETED BY**

Beth Johnson, DVM DACVIM

**IMAGING PERFORMED BY**

Dr. Jessie Evoniuk

**HOSPITAL NAME**

State Avenue VC

**REFERRING VET**

Dr. Jessie Evoniuk

**INVOICE**

35373

**DATE**

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## PRESENTING CLINICAL SIGNS

History: Sadie Fetch presents for vomiting episodes of undigested food. Patient History: Vomiting since Tuesday/Wednesday last week; ~10 episodes, always undigested food First episode: vomited entire dinner 7 hours post-ingestion Appetite remains good; no weight loss (stable at 24–25 kg) No abdominal sensitivity reported No coughing, sneezing, diarrhea, or abnormal urination/defecation Diet: Fromm kibble with dehydrated food topper No recent medication changes or toxin exposure Last blood work: June 2024 History of major surgery and rehabilitation (details not specified) No recent travel outside backyard since May.

Abnormal PE/Chem/CBC/UA Results: Abnormal PE: Demeanor: anxious, vocal, dislikes restraint and car rides; Abdomen: tense Abnormal BW: Albumin 4.7, Potassium 3.3, Total Protein 6.3, Globulin 1.6, Glucose 148, Phosphorus 1.7, Chloride 106, ALT 783, ALP 998, GGT 16, MCH 26.4, PLT 727

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

Urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia or infarcts observed. The left kidney measures 3.8 cm. The kidney is not well visualized in a fully sagittal view, so I suspect the measurement is falsely smaller than what is truly accurate. The right kidney measures 4.6 cm. Pinpoint nonobstructive mineral densities are noted bilaterally.

### *Adrenal Glands*

The adrenal glands are unable to be visualized in these images.

### *Spleen*

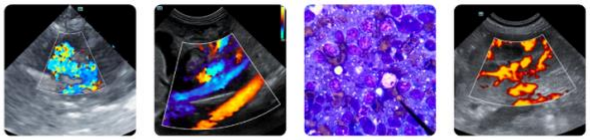
Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

### *Liver*

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is moderately heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

### *Gastrointestinal*





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The visible stomach wall is normal in thickness and layering. The stomach is mildly to moderately distended and contains an echogenic interface with distal progressively shadowing material, consistent with possible hairball density or other similar fluid absorbing material. Normal ingesta and gas can't be definitively ruled out and should be considered, especially if patient was not adequately fasted prior to the ultrasound.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta/chyme. There is no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

### *Pancreas*

The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

### *Free Abdomen*

There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

## ULTRASONOGRAPHIC FINDINGS

### Primary Findings

- Gastric foreign material, given the shadowing, can't be ruled out. Having said that, normal ingesta and gas can mimic this appearance. Reassessment following an additional 12-24 hours of fasting may be helpful.
- Moderately heterogenous liver- These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.
- Moderate gallbladder debris- Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

### Secondary Findings

- Age-related kidney changes with punctate nonobstructive mineral densities bilaterally.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- If lab work has not been done since June of 2024, reassessment of a full general metabolic

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health screen is recommended, beginning with CBC/chemistry panel, electrolytes, and urinalysis.

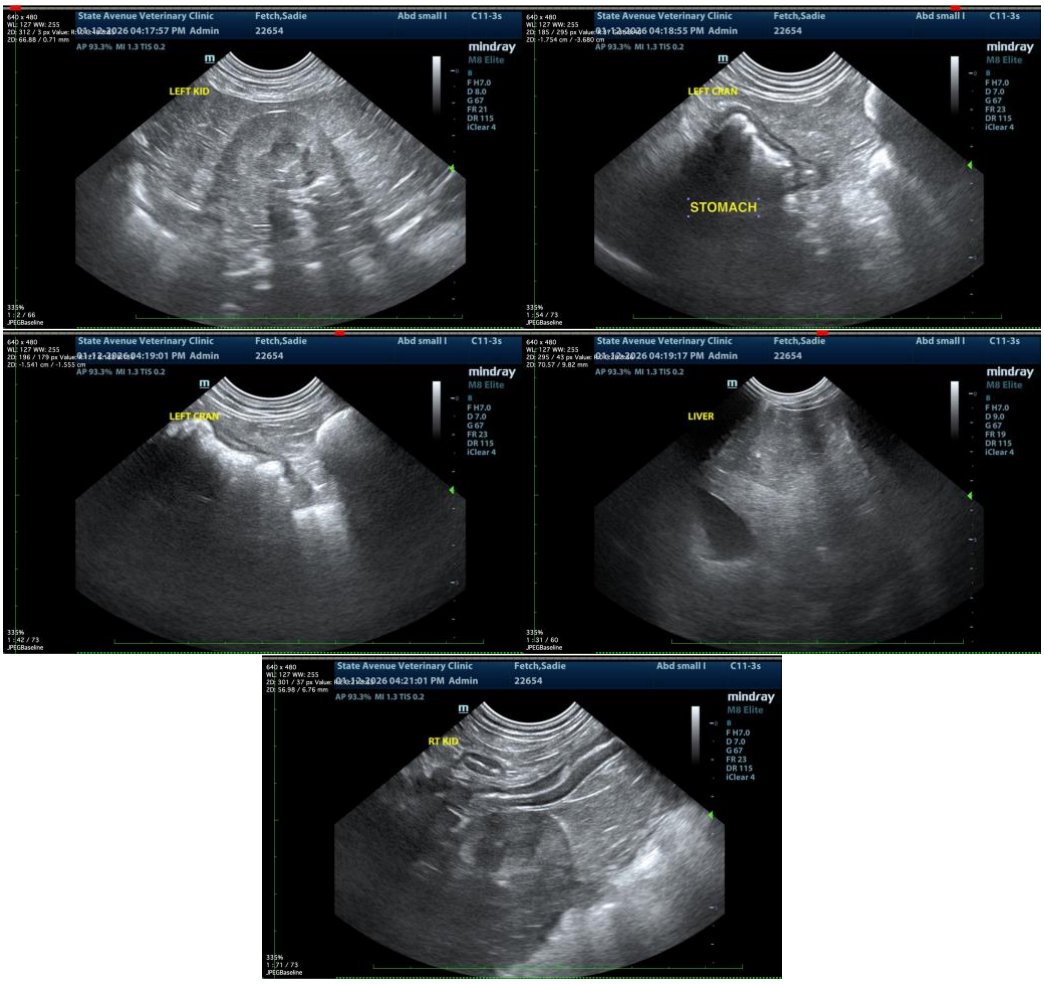
- As described above, an additional 12-24 hours of fasting, followed by recheck imaging of the stomach, could be considered. Alternatively, alternative imaging, such as contrast radiography or even upper GI gastroscopy, could be considered.

Especially if gastric foreign material is ruled out, further work up of the reported vomiting could also include:

- A baseline cortisol. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

- A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory, for further evaluation of GI and pancreatic function.

Otherwise, given the reported liver enzyme changes on the most recent labwork, especially if they are the same or progressive on recheck labs, the vomiting could be secondary to an ongoing hepatopathy, which would change work up recommendations.



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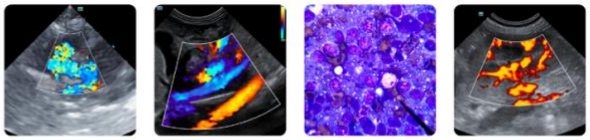

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**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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.

**Beth Johnson, DVM DACVIM**

info@sonopath.com