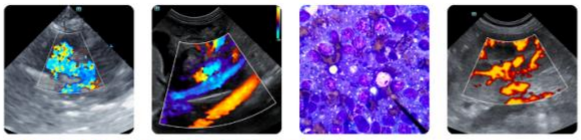


DATE

01/27/26

PATIENT

Hamilton Senior

SPECIES

Canine

BREED

Lab

SEX

Neutered Male

AGE

08/27/23

WEIGHT

39 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Eastern Animal Hospital

REFERRING VET

Dr. Wensil-Strow

INVOICE

13415

PRESENTING CLINICAL SIGNS

Patient History: Vomiting, not eating, diarrhea.
Current Medications: Dexmed and torb IV, Cerenia IV
Labwork Results: Labwork not submitted. Radiographic Findings--Three-view abdominal study provided for interpretation. There is vertebral endplate sclerosis and spondylosis with intervertebral disc space narrowing at the lumbosacral junction. Caudal thorax is normal. Serosal detail is adequate throughout the peritoneal space. Liver, spleen, kidneys, and bladder are normal. The stomach and small bowel demonstrate mild uniform luminal fluid and gas distention. There is no evidence of radiopaque GI luminal content present. Formed stool and gas are noted within the colon. Otherwise, normal study. Radiographic Conclusions/Recommendations:
1. The appearance of the GI tract is suggestive of paralytic ileus that could be related to gastroenteritis, pancreatitis, or infiltrative pathology including IBD or round cell neoplasia. Partial or intermittent obstruction associated with radiolucent foreign material considered less likely at this time though cannot be entirely excluded radiographically. 2. Intervertebral disc disease at the lumbosacral junction. Abdominal ultrasound could be considered for further assessment the GI tract, pancreas, and remaining abdominal organs as clinically indicated. CBC CHEM UNREMARKABLE. CPLI NORMAL
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Patient sedated with Dexdomitor.
Stat Report: Not requested.
Imaging Performed by: Andi Parkinson, BS, RDMS.

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.

The prostate is unable to be well visualized in these images.

Left kidney is normal in size (7.4 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Right kidney is normal in size (7.13 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

Left adrenal gland is normal in size (0.70 cm at cranial pole and 0.67 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.76 cm at cranial pole and 0.69 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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 normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with primarily fluid as well as some echogenic non-shadowing luminal contents and gas consistent with normal chyme. There is no evidence of obstruction, foreign material, or infiltrative disease. Pyloric outflow tract appears patent.

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 primarily fluid as well as some echogenic non-shadowing luminal contents and gas consistent with normal 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. The lumen is diffusely midlly fluid distended.

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

Mesenteric lymphadenopathy are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

ULTRASONOGRAPHIC FINDINGS

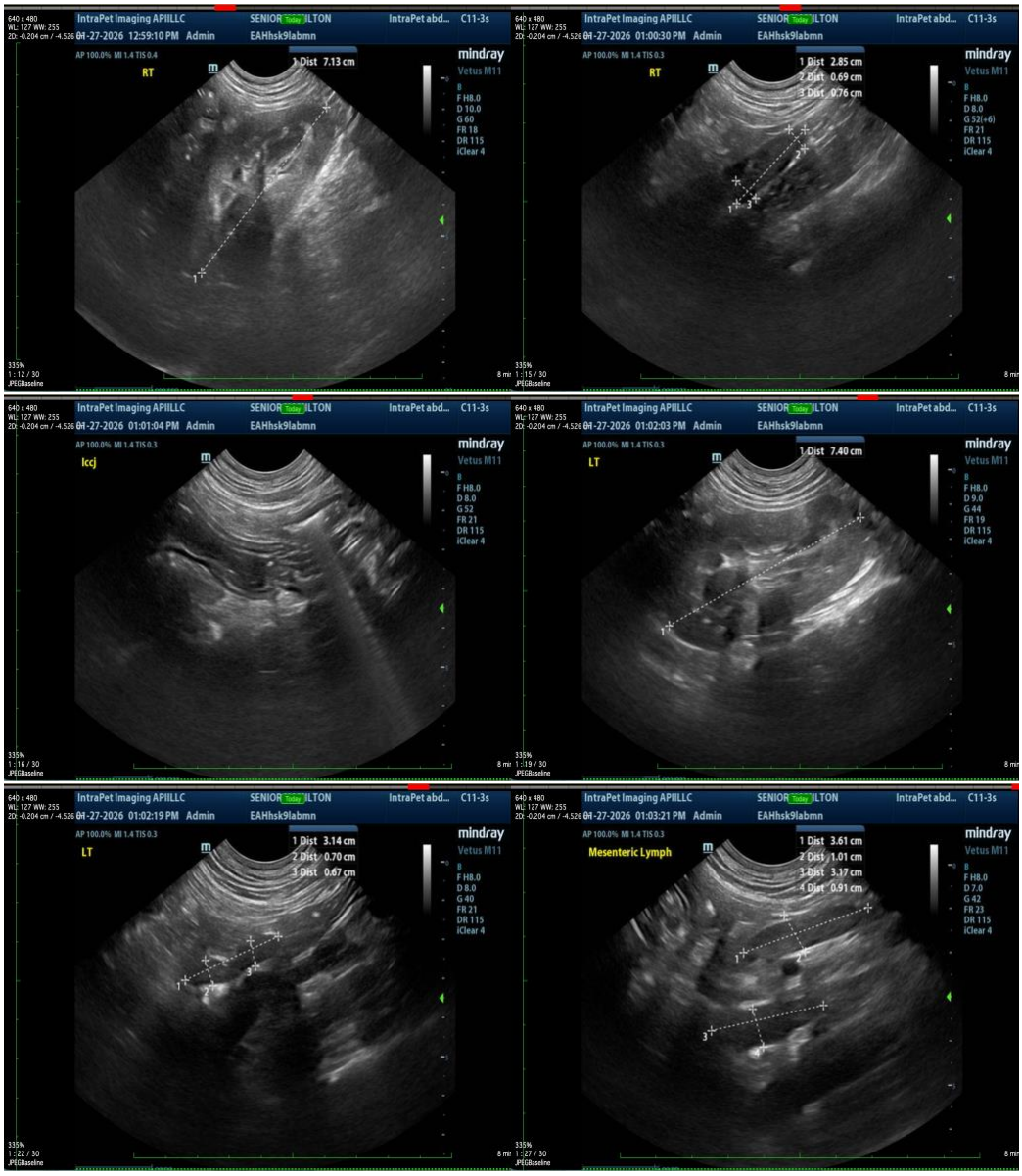
- Gastroenteritis- Consistent with irritation secondary to dietary indiscretion or intolerance, infection (bacterial, viral, other), parasitic or protozoal disease, toxin, other metabolic disease such as pancreatitis, other.
- Moderately mesenteric lymphadenopathy- infiltrative neoplastic disease cannot be ruled out but is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- The appearance of the gastrointestinal tract is more consistent with gastroenteritis as described

above versus an obstruction. There's no visible evidence of foreign material, obstructive pattern, placation, etc. in these images at this time.

- Therefore, recommendations include, if not recently evaluated, a general metabolic health screen (CBC, chemistry panel with electrolytes and urinalysis) is recommended.
- A routine fecal/Giardia exam is recommended if not recently evaluated.
- In the meantime, a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.
- A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.
- A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.
- Supportive/symptomatic medical management of clinical signs is recommended, including anti-emetics, gastroprotectants (+/- sucralfate, especially with any history of hematemesis), an appetite stimulant and fluid therapy if indicated, etc.
- Additionally, empirical deworming with a 5-day course of Panacur is recommended.
- A full course of empirical Helicobacter triple therapy could be considered.
- A probiotic, such a visbiome or proviable, may be helpful.
- Finally, if tolerated, a transition in diet could be considered, based on trial-and-error response with some options to consider including a gastrointestinal biome diet vs a hydrolyzed protein diet (sometimes several trials with different brands are necessary) vs an easy to digest, bland or low-fat diet vs other.



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

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