



**PATIENT**

Maui Prescott

**SPECIES**

Canine

**BREED**

Goldendoodle

**SEX**

Intact Female

**AGE**

6 Months

**WEIGHT**

14 Pounds

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**IMAGING PERFORMED BY**

Brian Klug

**HOSPITAL NAME**

Sondel Family VC

**REFERRING VET**

Elana Frankenthal

**INVOICE**

20523

**DATE**

1/9/23

**PRESENTING CLINICAL SIGNS**

History: History of chronic intermittent vomiting. Currently on Royal Canin HP canned. Will vomit more if fed HP kibble. Getting spayed later this week and can take GI biopsies/explore if necessary.

Abnormal PE/Chem/CBC/UA Results: CBC/Chem wnl Cortisol wnl Abd radiograph review: "The appearance of the bowel is most consistent with enteritis/gastroenteritis. Differentials to consider include gastritis/esophagitis, pancreatitis, enteritis (which could be viral, bacterial, dietary, toxic or parasitic), or due to the path of irritating or partially obstructive foreign body. Definitive evidence of a gastric foreign body is not identified." Fecal: nps

**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.

Left kidney is normal is size (4.03 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 is size (4.57 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 (0.29 cm at cranial pole and 0.26 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.39 cm at cranial pole and 0.38 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**



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Marked fundic mucosal hypertrophy with hyperechoic mucosa and some mucosal remodeling is noted. There is no loss of mural detail. Layering is normal. There is mild luminal fluid accumulation. No evidence of masses/nodules or foreign material present.

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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 empty with no evidence of obstruction, foreign material or infiltrative disease.

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The visible colon is normal in wall thickness and layering. Contents are consistent with normal formed feces and gas.

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**Pancreas**

The observed pancreas 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**

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There is no evidence of peritoneal effusion. The mesenteric lymph nodes 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**

**WEIGHT**

14 Pounds

- Gastritis – 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. Microulceration cannot be ruled out.

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- Reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely. This is likely a normal puppy variant.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

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Given this patient's young age, if not recently evaluated, a fecal exam is recommended, as is 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.

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In the meantime, empirical supportive/symptomatic medical management of gastritis, with antiemetics and gastroprotectants, as well as empirical deworming with a 5-day course of Panacur is recommended.

**REFERRING VET**

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Additionally, empirical medical management of helicobacter, given the marked gastric wall changes, could be considered. Pending results, and especially if clinical signs don't improve with medical management, an abdominal exploratory at the time of the planned spay with at least gastric, if not gastric and bowel biopsies is a reasonable next step.

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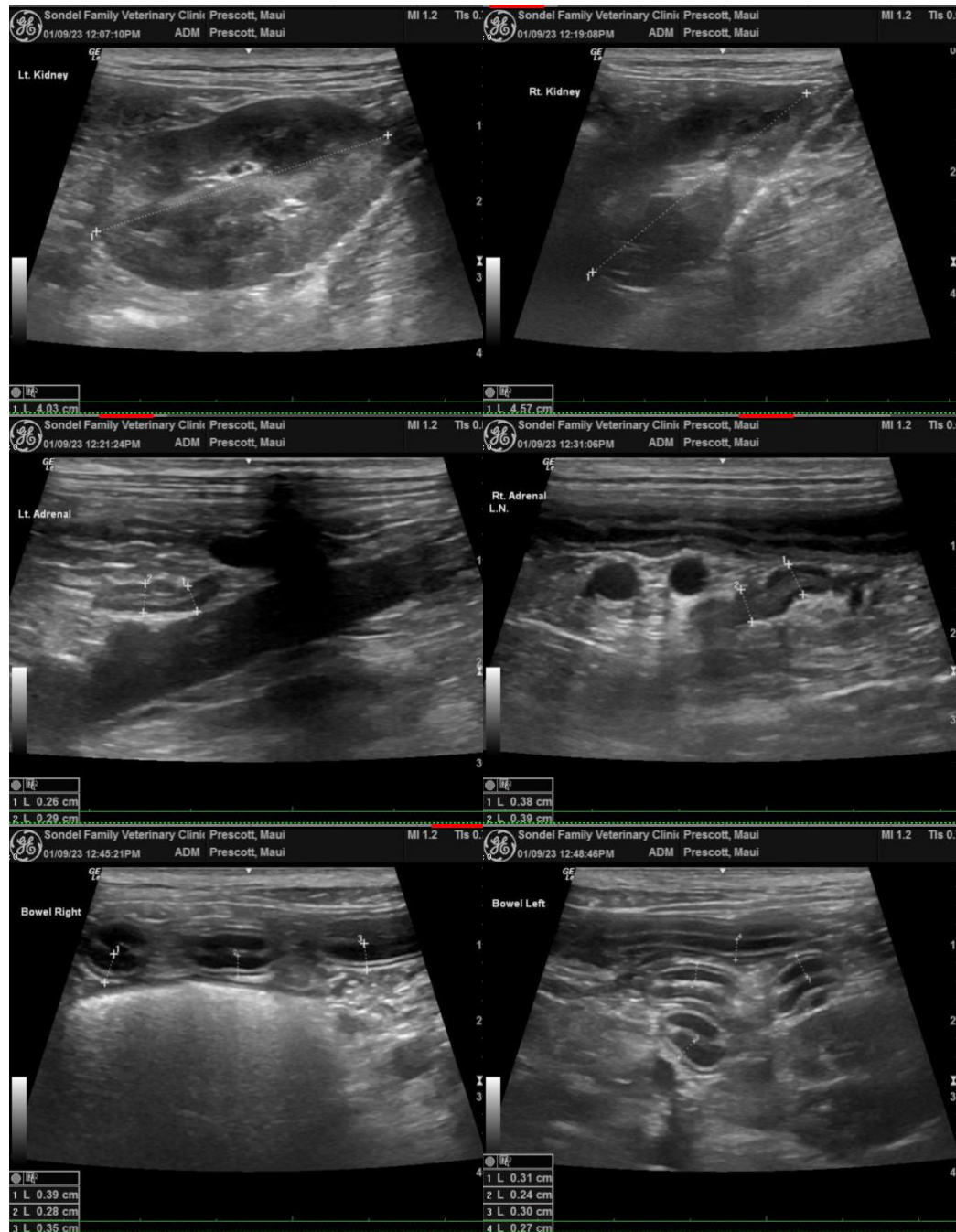
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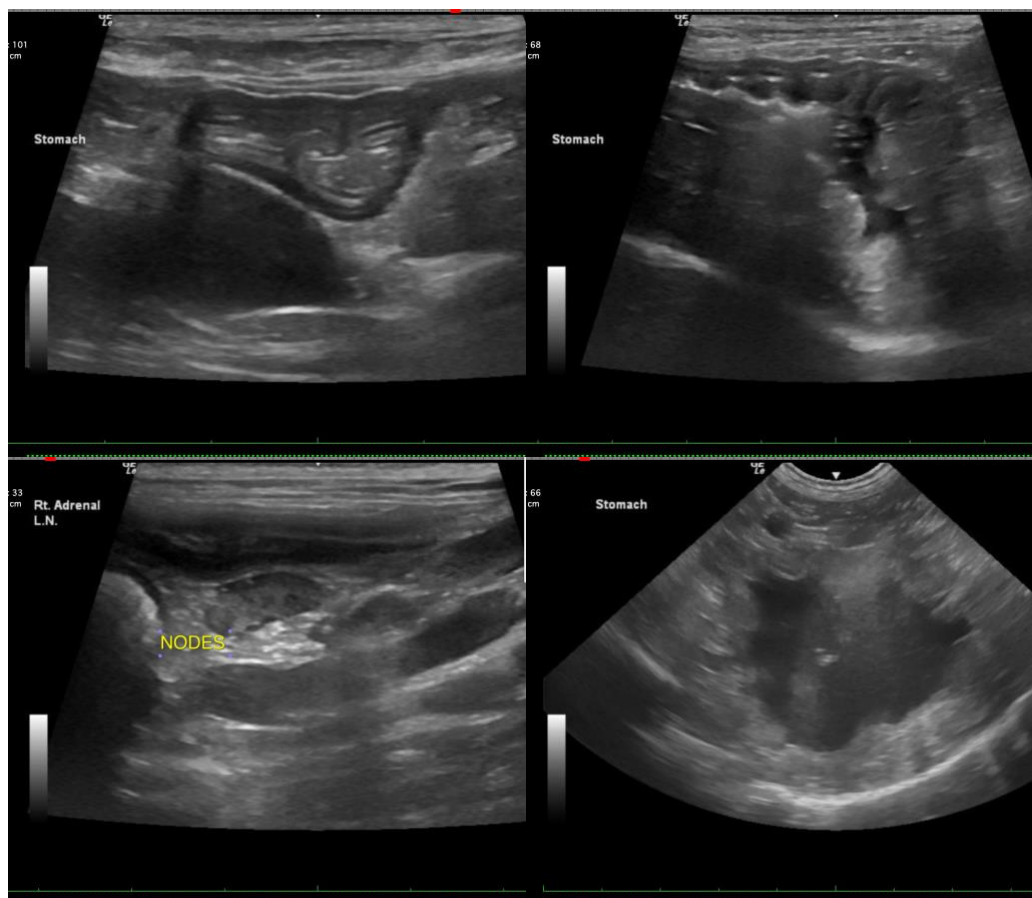
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**The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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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