



PATIENT

Lola Moreira

SPECIES

Canine

BREED

Pit Bull Terrier

SEX

Spayed Female

AGE

11 Years

WEIGHT

54.4 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Kelly Vazquez

HOSPITAL NAME

Animal General on
Hudson

REFERRING VET

Dr. Stefanie Lang

INVOICE

17593

DATE

10/5/22

PRESENTING CLINICAL SIGNS

History: History of chronic vomiting and regurgitation. No history of toxin exposure or dietary indiscretion. History of high ALT.

Abnormal PE/Chem/CBC/UA Results: ALT - 172.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with primarily anechoic contents and occasional echogenic non-shadowing debris. Apical urinary bladder wall is diffusely thick (0.64 cm). Mucosa is hyperechoic and irregular. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.

Left kidney is normal is size (5.49 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 (5.24 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 (2.8 cm long x 0.5 cm at cranial pole and 0.74 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (3.0 cm long x 0.56 cm at cranial pole and 0.6 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 small 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 moderately distended with echogenic fluid and there is a bright echogenic curvilinear interface that has a "dirty"



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shadow, consistent with gas, but the interface does not move and/or lie adjacent to mucosa, so despite the lack of a strong acoustic shadowing, foreign material, potentially an anchored linear foreign body can't be definitively ruled out.

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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). There is a mildly corrugated loop of bowel medial to the spleen. No plication or obstruction is present, just some mild hyperperistalsis.

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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. There is no apparent lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

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- Subjective microhepatica, rule outs for which include normal patient variant versus end-stage liver disease or vascular anomaly
- Chronic Cystitis - Urinary bladder wall changes are most consistent with chronic cystitis. Infiltrative neoplasia cannot be ruled out but is considered less likely give the location and diffuse nature of the changes.
- The stomach is mildly fluid distended and contains contents that could be consistent with gas and normal ingesta or even granular sand/gravel debris, however, a foreign body, especially an anchored linear foreign body cannot be definitively ruled out. Mild proximal small bowel corrugation is suggestive of some concurrent enteritis. No evidence of small bowel foreign body plication, obstruction, etc.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given this patients combined regurgitation with the vomiting, further evaluation of the esophagus is recommended with a three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

Bile acids are recommended given the subjectively mildly small liver and increased ALT.

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In the meantime, supportive/symptomatic medical management of gastroenteritis and possibly GERD, given the reported regurgitation is recommended in the form of an antiemetic, gastroprotectants (such as 2x per day Omeprazole), a bland easy-to-digest diet and empirical deworming with a 5-day course of Panacur. If clinical signs persist beyond acute management, then 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, as well as recheck abdominal imaging, both abdominal X-rays and recheck abdominal ultrasound are recommended for further evaluation of possible foreign body versus normal gas/ingesta. If the clinical signs are persistent and the GI panel is pursued, a baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation



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test is recommended to rule out hypoadrenocorticism.

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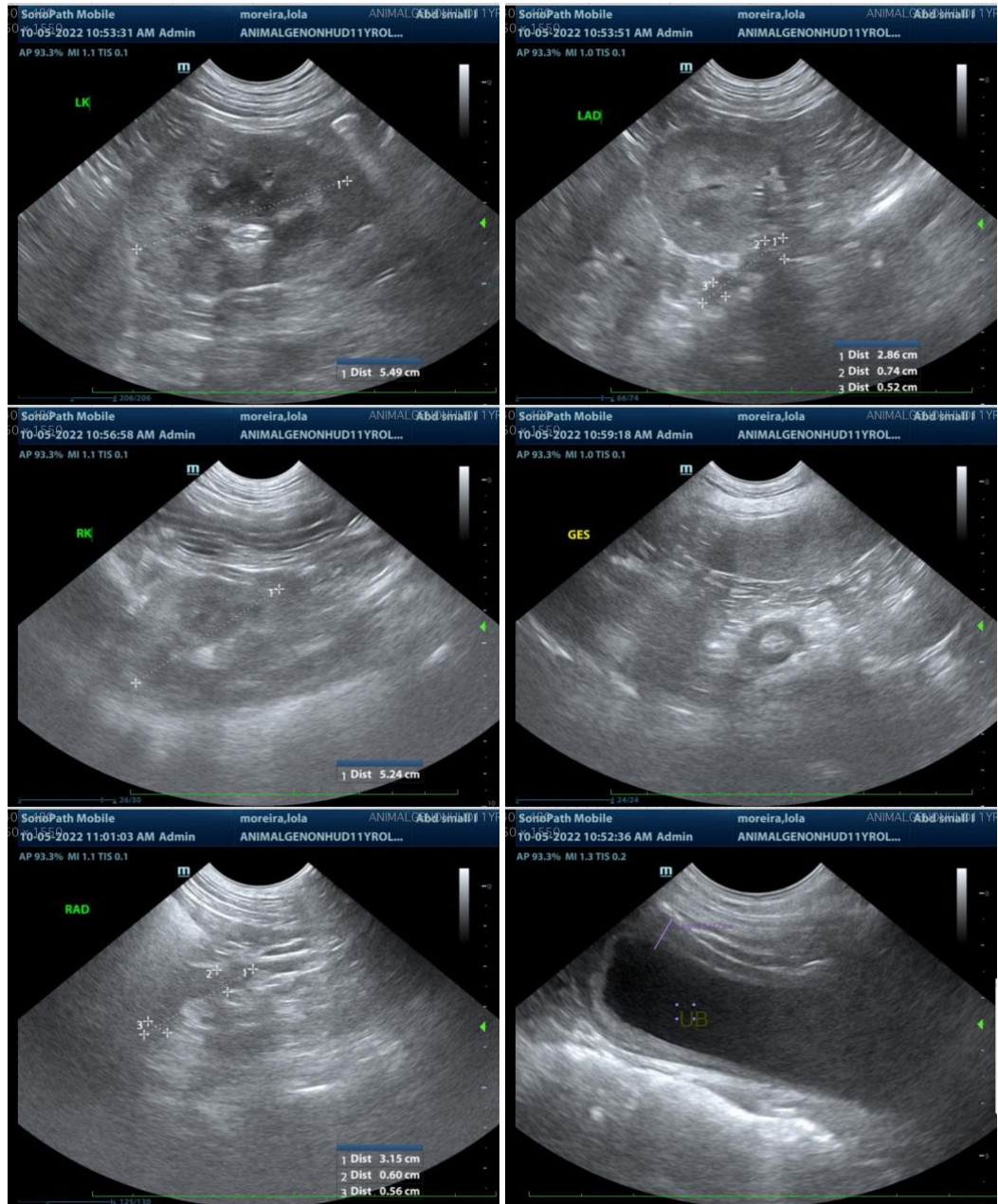
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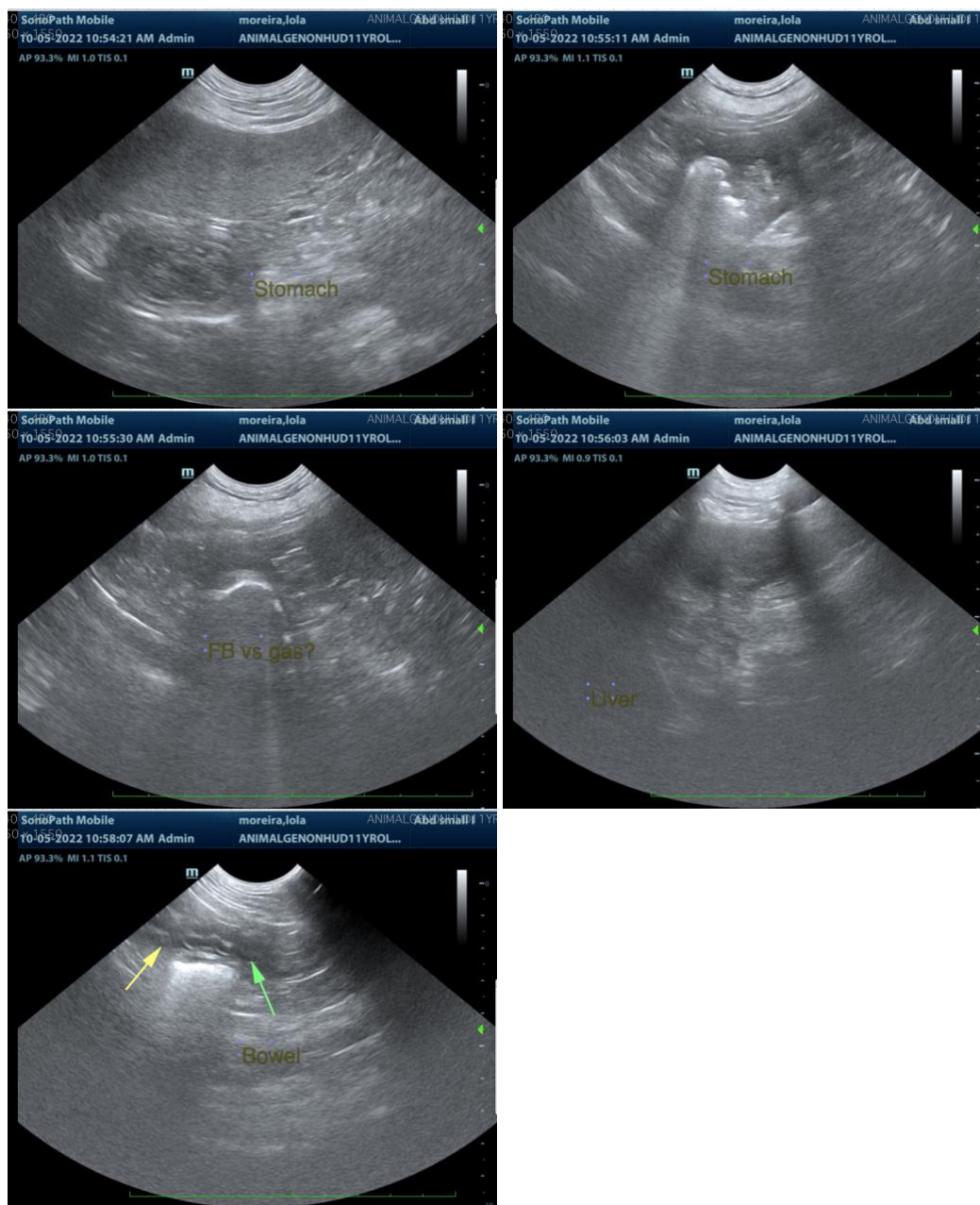
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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Beth.Johnson@SonoPath.com

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