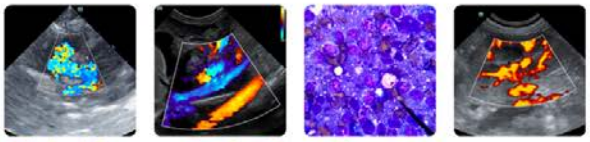


PATIENT

Lincoln McCann

SPECIES

Canine

BREED

Doodle

SEX

Neutered Male

AGE

10.5 Years

WEIGHT

27.2 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Melissa Randolph

HOSPITAL NAME

Shores Veterinary Emergency Center

REFERRING VET

Dr. Logan Law

INVOICE

73070

DATE

2/19/26

PRESENTING CLINICAL SIGNS

Presented 2/18 for abdominal distension, lethargy. Patient was outside for most of today. When he returned inside, owner noted his abdomen was distended. Reports of him grunting when laying around multiple times. prior history of elevated liver values, corneal endothelial degeneration, corneal edema, and anaplasmosis. Fed a raw diet beef with ground bones.

Admitted for supportive care and gastric lavage. approximately 4 cups of blood-red-brown material, bone, and beef were removed. NG tube placed after lavage; resistance was met past the lower esophageal sphincter, with the tube being deviated by what appeared to be a soft tissue structure. treatments iv fluids w/ KCl, methadone, cerenia, ondansetron.

Abdominal Distension: Gastric Dilation no overt volvulus; Pyloric Outflow Obstruction (foreign material vs. other vs. mass) vs. Ileus (pancreatitis) vs. Other

Abnormal PE/Chem/CBC/UA Results: E: pain 3/4; abd tense/hard to palpate, reactive CBC: HCT 44.1%, Plt 117,000 slow draw Chem: Glob 3.8 H, GGT 19 H, Tbili 1.2, Amylase 1502 H Lytes: K+ 3.9, lact 4.5 H CPL: < 50 normal rads: Abdominal Serosal Detail is appropriate. The gastric fundus is significantly distended w/ a large quant of gas, fluid, mineral opaque material. No overt GDV. gas throughout SI, no overt foreign material in SI or colon. rad after lavage: significantly less gas and fluid in the stomach, reduction in amount of bone material present. persistence of some fluid, gas, and mineral opaque material. repeat rad 2nd lavage: persistence of mineral opaque material in the fundus rad w/ NG tube: Noted tip of tube even w/ stylette in deviates ventrally. Concern for Gastric wall mass. Afast: no effusion

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with a mild amount of echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

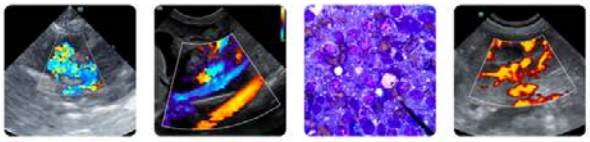
The prostate is unable to be well visualized in these images.

The right kidney is normal is size (5.85 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. A hyperechoic band parallel to the corticomedullary border is present.

The left kidney is normal is size (6.35 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. A hyperechoic band parallel to the corticomedullary border is present.

Adrenal Glands

The areas of the adrenal glands are examined without evident adrenal gland pathology, but they are unable to well visualized/fully isolated for measurement.



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Spleen

The 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). An approximately 2.0 cm in diameter hypo- to anechoic, non-capsule disrupting density is noted near the caudal aspect of the spleen. A potentially similar sized 1.7 cm x 2.2 cm density may be present additionally in the cranial aspect of the spleen, but I'm suspicious that I'm seeing the same nodule in two different imaging positions. Splenic vasculature appears normal.

Liver

The 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.

The 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 overdistended primarily with fluid as well as some echogenic non-shadowing luminal contents and gas, consistent with remaining ingesta. Pyloric outflow tract appears empty/patent.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen 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.

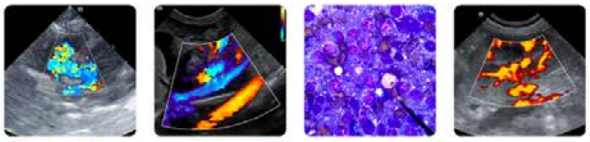
Free Abdomen

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

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- There is not a definitively visible reason for the remaining mild gastric distention. Partial or intermittent obstruction can't be ruled out, but an underlying metabolic or other functional ileus cause is suspected.



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- Hypo to anechoic splenic nodule(s) – likely represents a benign lesion such as a cyst, hematoma, nodular hyperplasia, extramedullary hematopoiesis, etc., however while considered less likely, infiltrative neoplasia can mimic benign lesions, and cannot be ruled out.

- Bilateral medullary rim sign - This finding is of unknown clinical significance and can be a normal variant, often idiopathic. Medullary rim sign can be present with renal disease including lymphoma, hypercalcemic nephropathy, Leptospirosis, tubular disease, other and should be interpreted in combination with other more specific indications of kidney disease such as isosthenuria, proteinuria, azotemia, etc. This is a common incidental finding in patients with diabetes mellitus.

- Mild amount of echogenic urinary bladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If clinical signs persist beyond the reported alleviation of most of the gastric distention and supportive/symptomatic medical management of clinical signs, further gastrointestinal workup recommendations include:

A routine fecal/giardia exam.

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.

Especially given patient's history of raw diet, 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.

In the meantime, 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 as is a full course of empirical Helicobacter triple therapy.

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 raw diet is of unknown if any contribution to patient's reported clinical signs. However, regardless of constipation, raw diets are typically not recommended in dogs.

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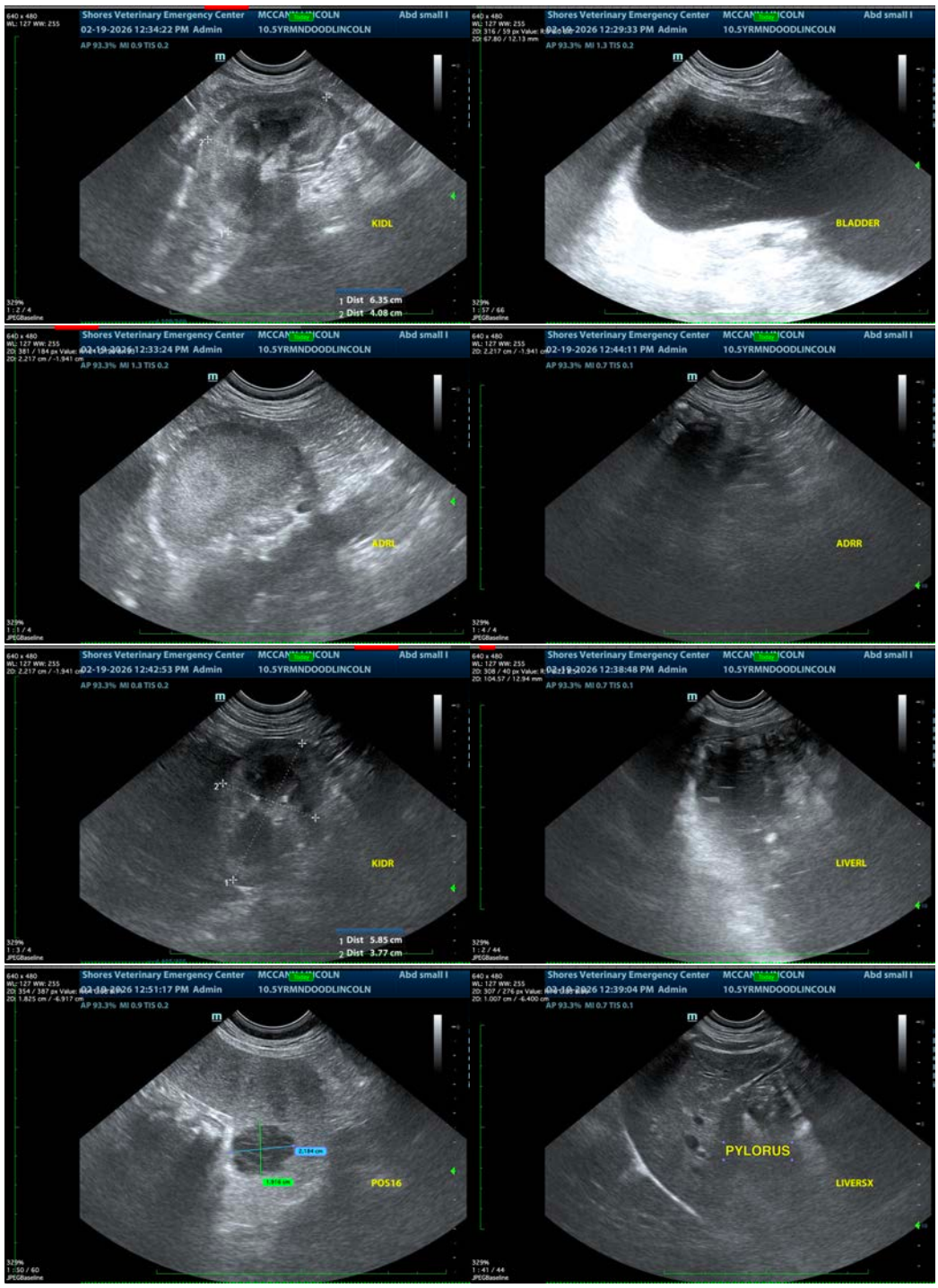

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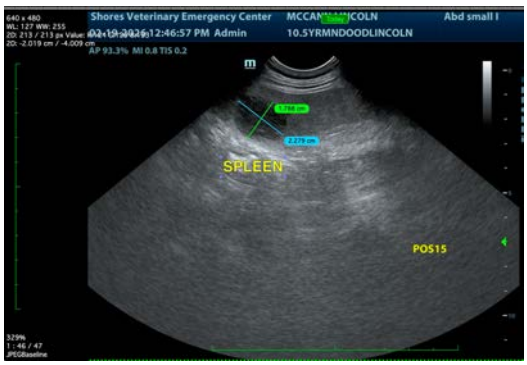

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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