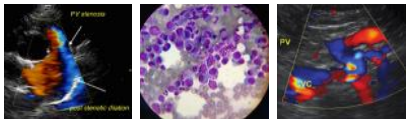
IMAGING PERFORMED BY

IntraPet.com



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**DATE**

4/10/23

**PATIENT**

Auggie Reeves

**SPECIES**

Canine

**BREED**

Labrador

**SEX**

Neutered Male

**AGE**

95.3 Pounds

**WEIGHT**

5/20/20

**INTERPRETED BY**

Beth Johnson, DVM DACVIM

**HOSPITAL NAME**

Animal Emergency Hospital

**REFERRING VET**

Dr. Hicks

**INVOICE**

21930

## PRESENTING CLINICAL SIGNS

History: ATO P vomited at 3 a.m. what looked like his dinner P was given a sweet potato chew that he also threw up; is now constantly vomiting water, last vomit was 1 hour prior to arrival Had normal BM around 5:30 a.m P has hx of sensitive stomach, eats Fresh Pet with quinoa and sweet potato added Was at Doggy Day care on Friday, may have gotten something Known chewer/eater of stick

Current Medications: Famotidine, Gabapentin, Ondansetron.
Lab Results: NSF.
Radiographs: No obvious foreign material, poor detail in abdomen.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: IV: Domitor.
Stat Report: Not requested.
Imaging Performed By: Rachel Brilhart, 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.

Prostate is mildly enlarged (1.43 cm wide). Parenchyma is diffusely homogenous and relatively hyperechoic. Normal distinct margins and symmetrical bilobed shape are maintained. This finding is likely normal patient variant, especially if patient was neutered as an adult; however, if patient was neutered as a puppy, prostatitis or, less likely, infiltrative neoplasia cannot be ruled out. This finding should be interpreted in combination with clinical signs, urinalysis results, etc. and either further investigated or monitored, as indicated.

Left kidney is normal is size (6.73 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 (6.4 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.

### *Adrenal Glands*

Left adrenal gland is normal in size (3.14 cm long x 0.65 cm at cranial pole and 0.75 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (2.66 cm long x 0.83 cm at cranial pole and 0.92 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 very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material or infiltrative disease; however, complete visualization of far wall is partially inhibited by gas. 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 empty with no evidence of obstruction, foreign material or infiltrative disease.

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

### *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*
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

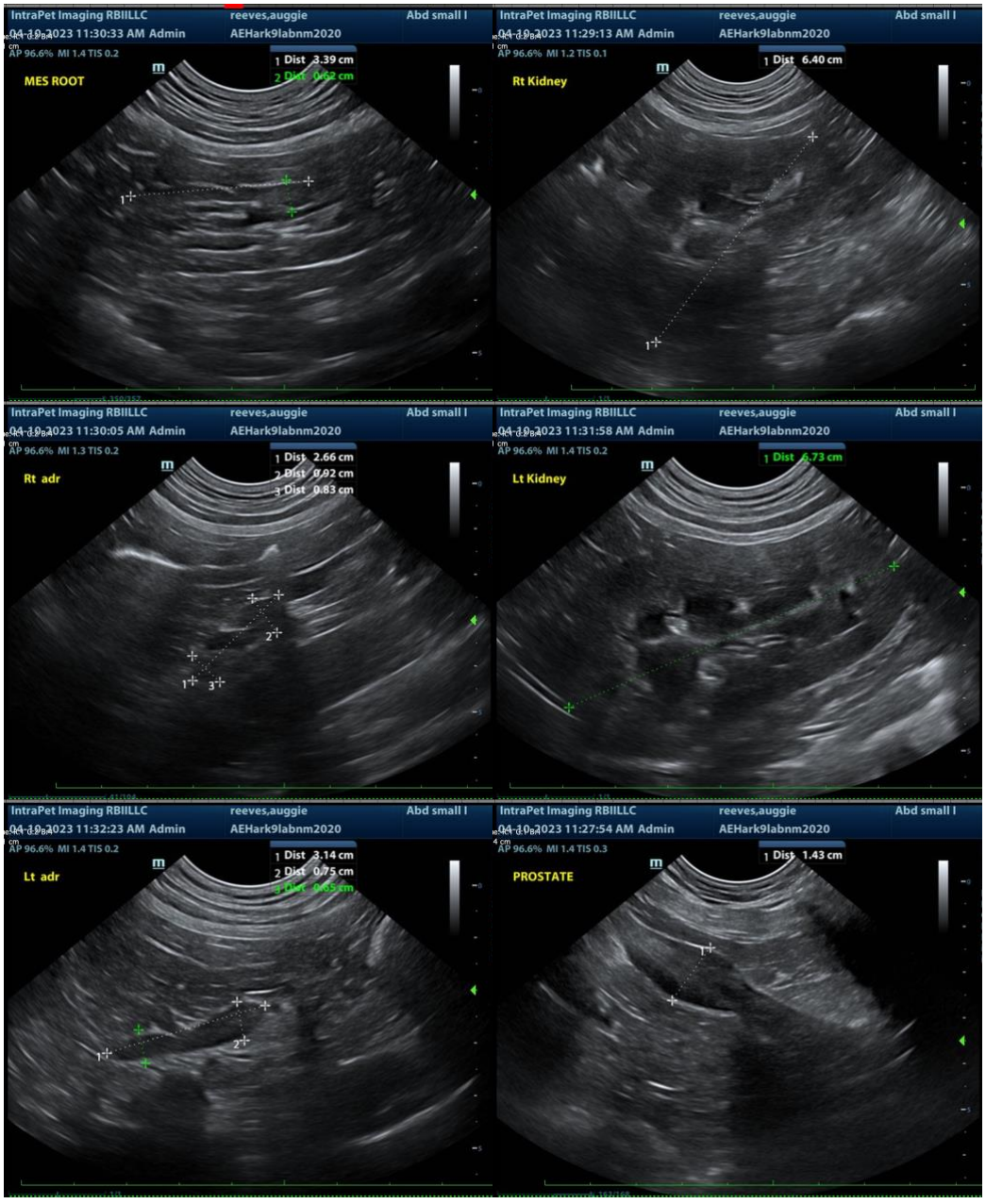
- Reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Otherwise, this is a relatively unremarkable/normal abdomen without an evident cause for the patients reported vomiting.

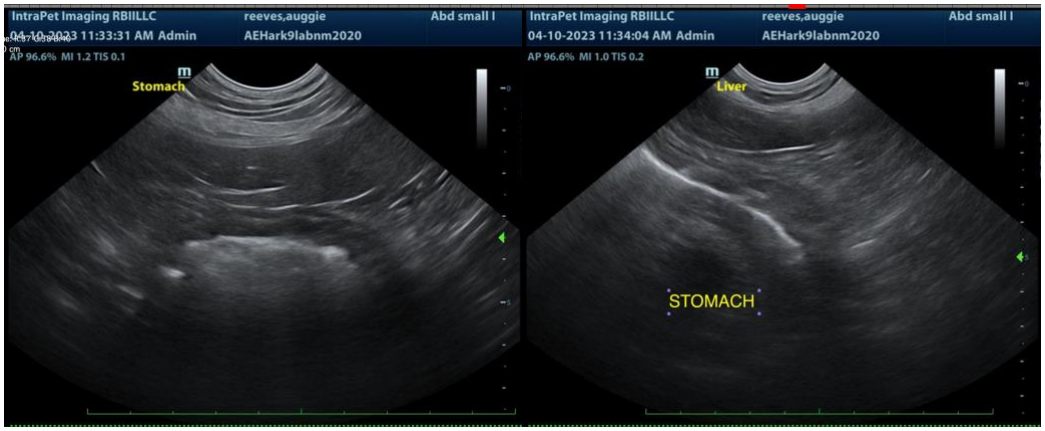
## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Occult or mild pancreatitis or gastroenteritis, potentially secondary to dietary indiscretion, etc., cannot be ruled out based on a relatively unremarkable ultrasound. Therefore, next diagnostic steps could include a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory, for further evaluation of GI and pancreatic function. Additionally, 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 is recommended in the form of antiemetics, gastroprotectants, as well as empirical deworming with a 5-day course of Panacur.

Additionally, an empirical course of therapy for helicobacter could be considered. If clinical signs persist, recheck imaging and/or proceeding to upper GI gastroscopy/endoscopy for further visualization and biopsies may be necessary.






**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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