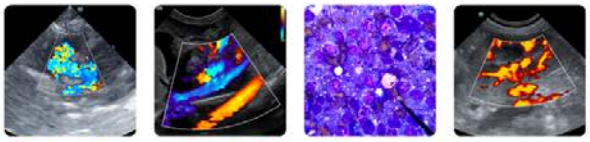

PATIENT

Roxie Capps

SPECIES

Canine

BREED

Rottweiler x

SEX

Spayed Female

AGE

12 Years

WEIGHT

24.6 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Blue Pearl Wyomissing

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INVOICE

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PRESENTING CLINICAL SIGNS

AUS to further evaluate nausea, abdominal pain, elevated liver enzymes (mild). Abdnormal cPLI. Rads show amorphous gastric material. Currently hospitalized. Between 4pm-7pm owner noticed patient's abdomen was distended. Patient gagging like she's trying to vomit, and flatulence. Circling and panting at home. Normal appetite. Has a history of central vestibular disease (sees Neuro at Eastern) and suspected to have a brain tumor but no imaging has been done. Patient is on Prednisone and amantadine. Physical exam revealed mild cranial abdominal pain, 5% dehydration, vestibular ataxia, and circling to the right. Hosp tx: P-lyte @ 110 ml/hr IV, Cerenia 1 mg/kg IV q24h , Buprenorphine 0.02 mg/kg IV q8h PRN, Dexamethasone SP 0.06 mg/kg IV AM and 0.03 mg/kg IV PM

Abnormal PE/Chem/CBC/UA Results: CBC: HCT 38.3%, otherwise unremarkable - PCV/TS: 36/6.6 - Chem: BUN 33.8 H, Cr 0.7, Phos 5.4 H, TP 5.3 L, Glob 1.8 L, ALT 189 H, ALP 78 H - EPOC: BUN 27 H, otherwise wnl - cPLI: abnormal - 3V AXR (DACVR): Amorphous gastric material. Although the exact nature of the gastric contents is unknown, the possibility of foreign/indigestible material might be considered, given the history provided. An abdominal ultrasound or an upper gastrointestinal contrast study should be considered. If the patient is stable, rechecking radiographs after a 12-18 hour fast in the hospital might be considered to assist in differentiating food from foreign indigestible gastric contents.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The 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 right kidney is normal is size (6.9 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.

The left kidney is normal is size (6.16 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

The right adrenal gland is normal in size (0.79 cm at cranial pole and 0.59 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

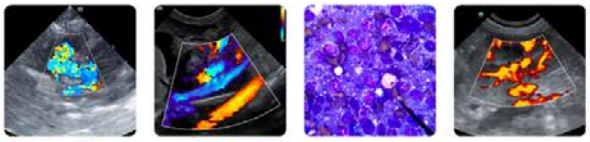
The left adrenal gland is normal in size (0.57 cm at cranial pole and 0.57 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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). No focal nodules or masses are observed. 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



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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 mildly distended with echogenic non-shadowing contents consistent with normal ingesta with some fluid and some gas as well as some very subtle progressively shadowing contents that could similarly represent ingesta, but non-obstructive or partially obstructive foreign material cannot be definitively ruled out.

The visible small intestine demonstrates areas of moderately thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. The duct appears subjectively mildly tortuous, at the upper end of normal limit for dilation in some views. 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

- Moderate inflammatory bowel disease (IBD) pattern – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No loss of layering or distinct characteristics of malignancy are present. Therefore, differentials cannot be further ranked without tissue sampling.

- Pancreatic age-related remodeling/Chronic pancreatitis – Mild irregularities are consistent with benign age-related change. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.

- The gastric contents could represent normal ingesta, although given the subtle shadowing combined with patient's history, non-obstructive foreign material cannot be definitively ruled out. Reassessment following an additional 12-24 hours of fasting could be considered.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated, a urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

Given patient's history, bile acids could be considered if total bilirubin is not increased.

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 routine fecal/giardia exam is recommended.

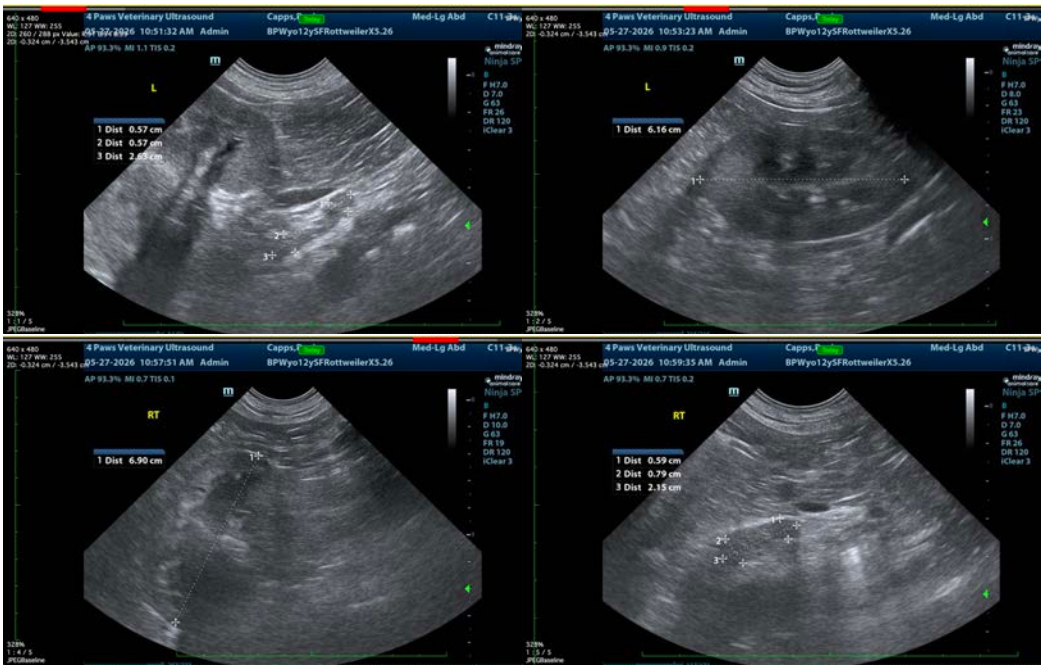
If a diagnosis is not made, a baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

As mentioned above, in the meantime, an additional 12-24 hours of fasting followed by recheck imaging of the stomach could be considered, or alternative imaging such as contrast radiography or even gastroscopy could be considered.

While continuing workup, 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.



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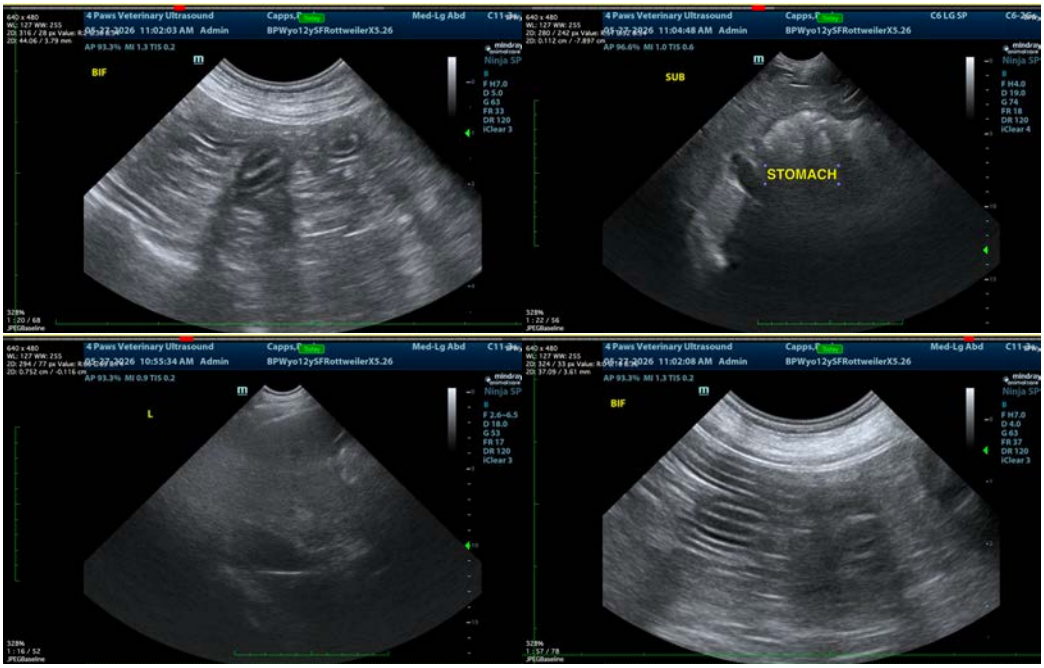

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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