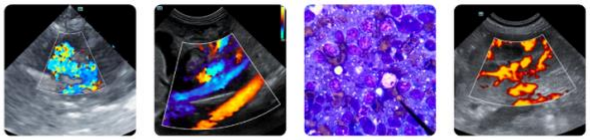


PATIENT

Anakin Economos

SPECIES

Canine

BREED

Golden Retriever

SEX

Intact Male

AGE

1 Year 11 Months

WEIGHT

25.2 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Sookhoo

HOSPITAL NAME

Calusa VC

REFERRING VET

Dr. Turkell

INVOICE

37302

DATE

6/3/26

PRESENTING CLINICAL SIGNS

History: Vomiting foam/bile (acute), not eating, very dehydrated, began last night, barely defected. Was at training facility/daycare. Unknown if ate anything should not have. On ultrasound - painful when pressing on upper right quadrant.

Abnormal PE/Chem/CBC/UA Results: Lymph 0.63 K/uL, Normal chemistry, rest of CBC normal, CPL normal - Radiographs (abdominal) - no radio-opaque foreign material, no evidence of GI obstruction at this time.

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 symmetrically enlarged (3.4 cm sagittal view) with smooth margins that are well differentiated from surrounding tissue. Normal bilobed shape is maintained. Parenchyma is heterogenous with scattered hyperechoic foci present. No mineral or cysts are noted.

Left kidney is normal in 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.

Right kidney is normal in size (6.0 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 (0.43 cm at cranial pole and 0.45 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

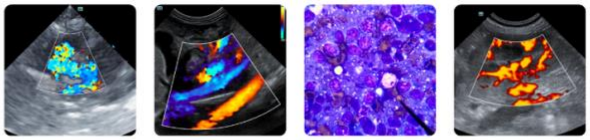
Right adrenal gland is normal in size (0.68 cm at cranial pole and 0.5 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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.



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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 empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are largely primarily 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. However, some loops of small bowel, primarily what I believe is the very proximal duodenum, are mildly fluid distended and hyperperistaltic, but no evidence of shadowing plication or other indication of foreign material.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. The lumen is diffusely markedly distended with fluid.

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.

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.

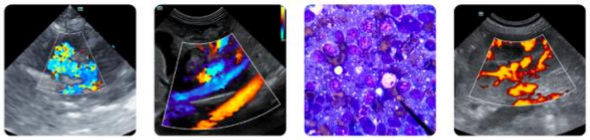
ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Moderately reactive mesenteric lymphadenopathy- This finding may be in part normal patient variant/juvenile lymphadenopathy given patient's young age.
- The markedly fluid distended colon is consistent with diarrhea and could be secondary to a parasitic, infectious, dietary related, other benign inflammatory colitis.
- There is no definitively visible evidence of shadowing plication, etc., to indicate foreign material or a small bowel obstruction. Having said that, there is a lot of fluid distended bowel, and I believe most of it is colon, but if some of it is small bowel, that is more concerning for at least a partial obstructive pattern.

Secondary Findings

- Benign prostatic hyperplasia- Prostatic findings are most consistent with Benign Prostatic Hyperplasia (BPH) and hyperechoic foci consistent with increased vascularity and fibrosis



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often associated with BPH. Active prostatitis cannot be ruled out. Infiltrative neoplasia cannot be ruled out but is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Further gastrointestinal workup is recommended, beginning with a routine fecal/Giardia exam, if not recently evaluated.
- 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. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

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.
- A full course of empirical Helicobacter triple therapy could be considered
- A probiotic, such a visbiome or proviable, may be helpful.
- 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.
- Having said that, however, as described above, given the suspect colon distention, it is difficult to definitively rule out an obstruction, therefore, especially if patient does not respond and/or continues to vomit through supportive symptomatic medical management, recheck/follow-up imaging or potentially alternative imaging, such as contrast radiography versus other, is recommended.

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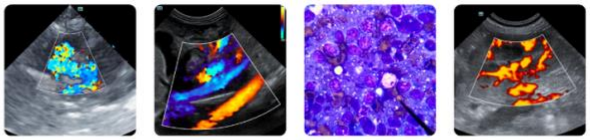

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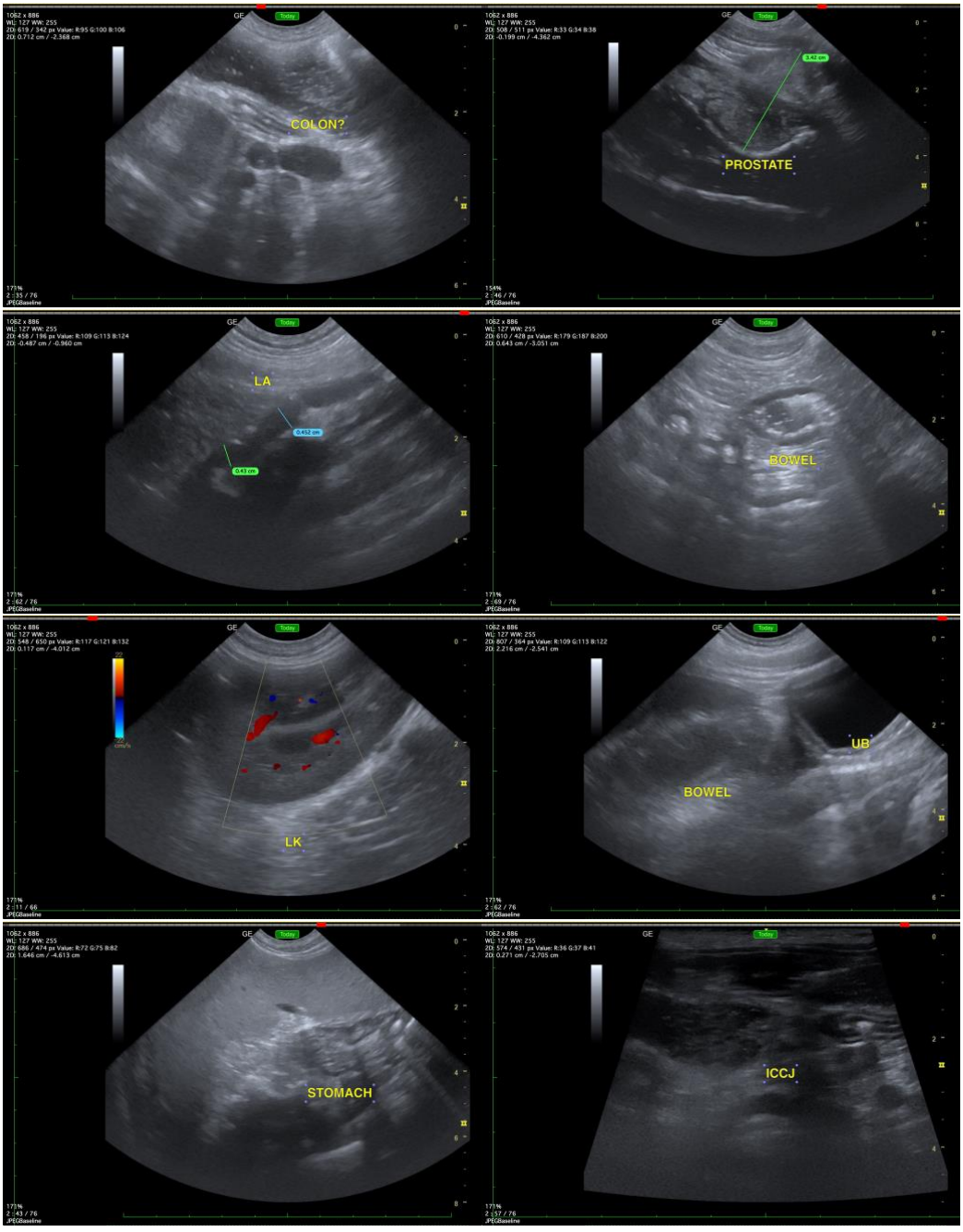

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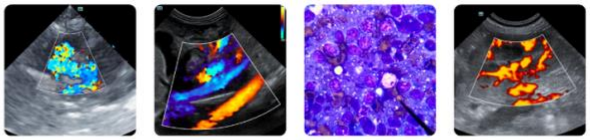

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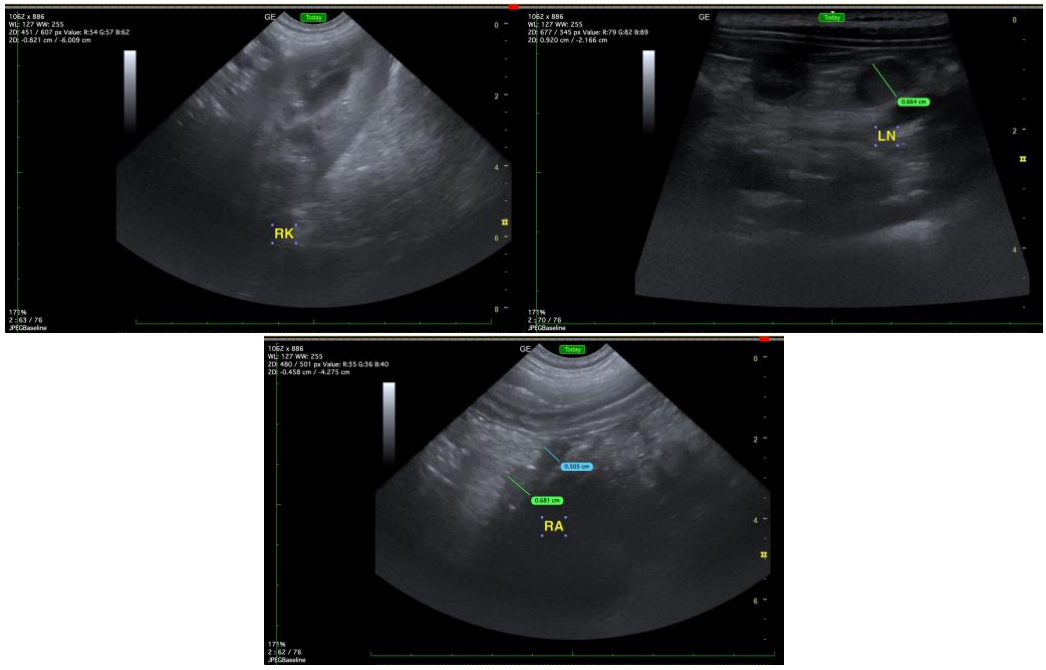

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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