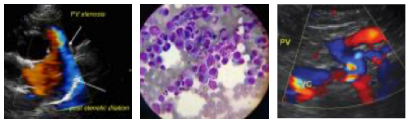
IMAGING PERFORMED BY

IntraPet.com



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**DATE**

7.10.2023

**PATIENT**

Ricky Jarvis

**SPECIES**

Canine

**BREED**

Catahoula Mix

**SEX**

Neutered Male

**AGE**

4/10/2015

**WEIGHT**

73 lbs

**INTERPRETED BY**

Beth Johnson, DVM DACVIM

**HOSPITAL NAME**

Eastern Animal Hospital

**REFERRING VET**

Dr. Sole

**INVOICE**

13639

## PRESENTING CLINICAL SIGNS

Two- to three-day history of soft stool. One-day history of melena and liquid diarrhea. Hyporexia, progressing to anorexia. One episode of vomiting.

Current Medications: Long term Fluoxetine. Started 7/7- Cerenia, Pantoprazole, Sucralfate, Diagel, Visbiome.
Lab Results: Mild anemia.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: IV: Domitor 0.5/torb 0.5.
Stat Report: Not requested.
Imaging Performed By: Rachel Brilhart, RDMS.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

Urinary bladder is very mildly 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 normal in size, echotexture and echogenicity for a neutered male.

Left kidney is normal in size (6.59 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 (6.58 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 (0.57 cm at cranial pole / 0.63 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.95 cm at cranial pole / 0.80 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 echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

Diffusely, 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 proximal duodenum is mildly thick in one view (ranging between 0.50 and 0.57 cm thick, depending on the view).

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. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. 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 sublumbar 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

- Mildly thick duodenum – Differentials for which include benign inflammatory disease associated with possibly parasitic, infectious (such as bacterial for viral), benign inflammatory, and less likely, infiltrative neoplastic disease. Infiltrative malignancy cannot be ruled out, but there are no criteria of malignancy (i.e., loss of layering, etc.) to make it a high differential.

- Reactive sublumbar lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

### Secondary Findings

- Pancreatic age-related remodeling – 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.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated, full evaluation of this patient's coagulation status is recommended.

If not recently evaluated, a fecal exam is recommended.

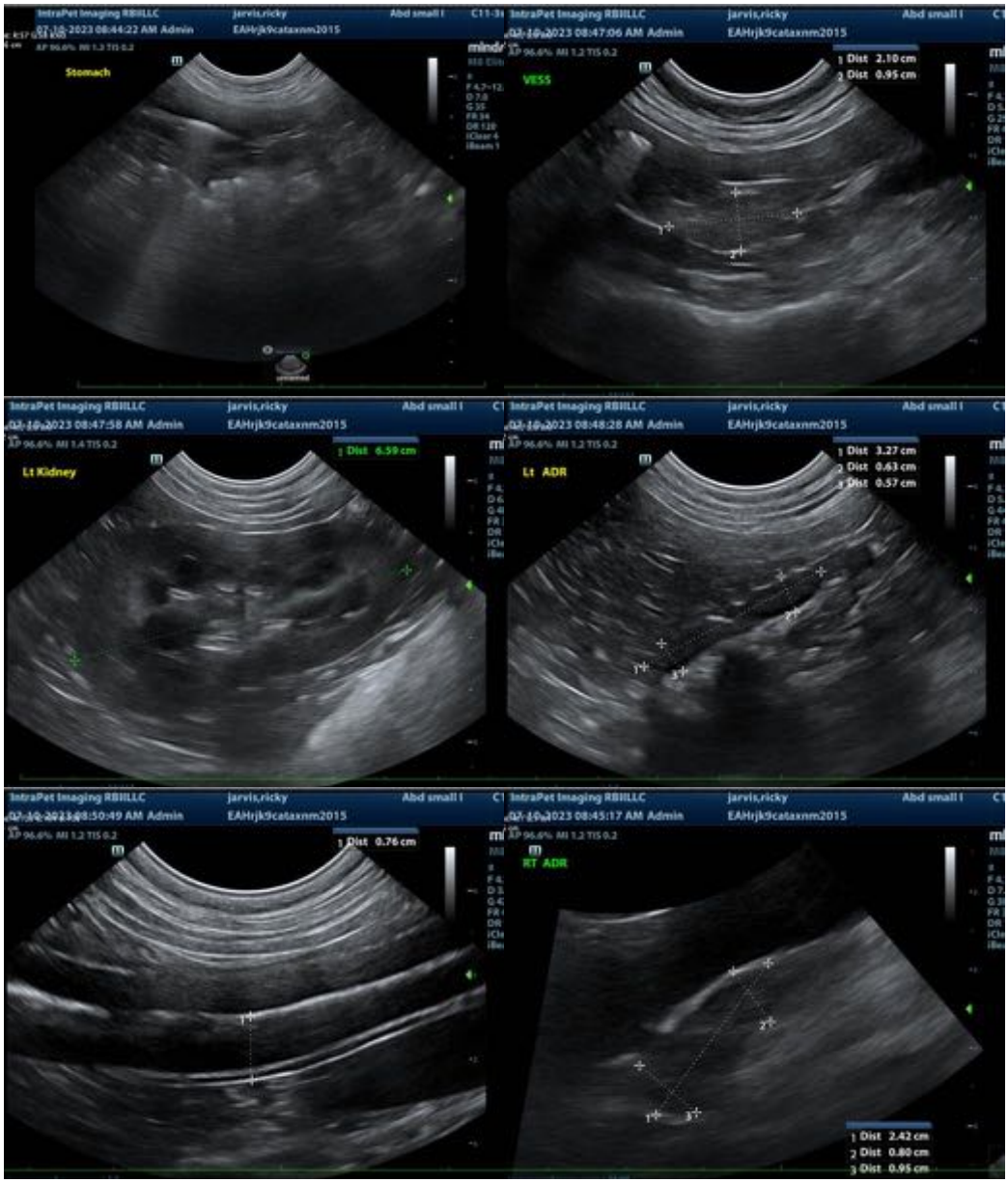
A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

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.

Ultimately, tissue sampling may be necessary for a definitive diagnosis and could be attempted via a fine-needle aspirate of the enlarged sublumbar lymph node (if coagulation status of the patient is appropriate) or may need to be obtained via upper GI gastroscopy/endoscopy, that would allow both further visualization of the stomach and duodenum as well as biopsies.

In the meantime, empirical deworming with a 5-day course of Panacur is recommended. In addition, supportive/symptomatic medical management of clinical signs (possibly HGE, including antiemetics, gastric protectants (including sucralfate), a probiotic (i.e., Visbiome or Proviable), +/- an antibiotic such as Tylosin.

Additionally, given this patient's reported anemia, close monitoring of the red blood cell count is recommended to help determine if/when a transfusion is needed, secondary to GI blood loss.




**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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