

**DATE PRESENTING CLINICAL SIGNS**

7/5/23

Presenting Complaint: Not Eating. Vomiting.

**PATIENT**

Bear Cook

History: Date: 07-04-2023 Notes: Boarded Thursday-Today 3:30 Upon picking up he had vomit everywhere with blood present in it. Didn't feed him this morning at the boarding Head down, tail down, hunched appearance Zero interest in food. Coffee grounds vomit. Lethargic- normally running around the house, not wanting to do anything. Black diarrhea - nothing present (looked through to make sure no strings present from toy brought with him) Known toy destroyer.

**SPECIES**

Canine

Assessment: Acute vomiting and diarrhea. DDX include foreign material ingestion, stress induced gastroenteritis, viral/ bacterial/ parasitic infection, open.

**BREED**

Pit Bull X

Current Medications: Pantoprazole (Protonix) 40mg/vial Injection (Per mL) 7.2, Ampicillin 125mg/vial Injection (Per mL) 5, and Buprenorphine 0.6mg/mL 1.

**SEX**

Neutered Male

Lab Results: Attached.

Radiographs: Xray Abdomen 2 View: Lat and V/D abdomen- some fluid vs. foreign material vs. blood clot in stomach, no obvious FB/ obstruction in SI, evidence of hyperperistalsis. Otherwise unremarkable abdomen.

**AGE**

2022

Xray: Lateral abdomen - small intestinal gas pattern has improved. Stomach smaller in size but not completely emptied.

**WEIGHT**

63.5 Pounds

Date of Previous IntraPet Ultrasound: No previous.

Sedation: IV: Butorphanol.

Stat Report: Not requested.

**INTERPRETED BY**Beth Johnson, DVM  
DACVIM

Imaging Performed By: Rachel Brillhart, RDMS.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN****HOSPITAL NAME**Animal Emergency  
Hospital**Urinary System**

The urinary bladder is moderately 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.

**REFERRING VET**

Dr. Goessling

Prostate is normal in size, echotexture and echogenicity for a neutered male.

The right kidney is normal in size (6.91 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.

**INVOICE**

43775

The left kidney is normal in size (6.34 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 (0.66 cm at the cranial pole and 0.75 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.66 cm at the cranial pole and 0.72 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. 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 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 luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). 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 (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

### ***Pancreas***

The pancreas is mildly prominent in size with a diffusely mildly coarse echotexture and heterogeneous to mildly hypoechoic echogenicity. The duct is visible but not pathologically dilated and there is no evidence of peripancreatic inflammation visible in these images.

### ***Free Abdomen***

There is no evidence of 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**

- Mildly prominent pancreas – likely normal patient variant, but mild or potentially emerging or resolving acute pancreatitis cannot be ruled out.
- Reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely. This is likely a normal variant, given patient's young age.
- The gastric contents are most consistent with ingesta as described above. However, non-shadowing foreign material cannot be definitively ruled out.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If this is an acute episode, recommendations include an overall general metabolic evaluation (CBC, chemistry panel with electrolytes, coagulation panel, urinalysis and fecal exam if not recently evaluated) followed by supportive/symptomatic medical management of clinical signs (possibly HGE) including anti-emetics, gastroprotectants (including sucralfate), a probiotic (such as visbiome or proviable), empirical deworming with a 5-day course of Panacur, +/- metronidazole or tylosin and if tolerated a short term course of a bland, easy to digest or possibly fiber responsive diet.

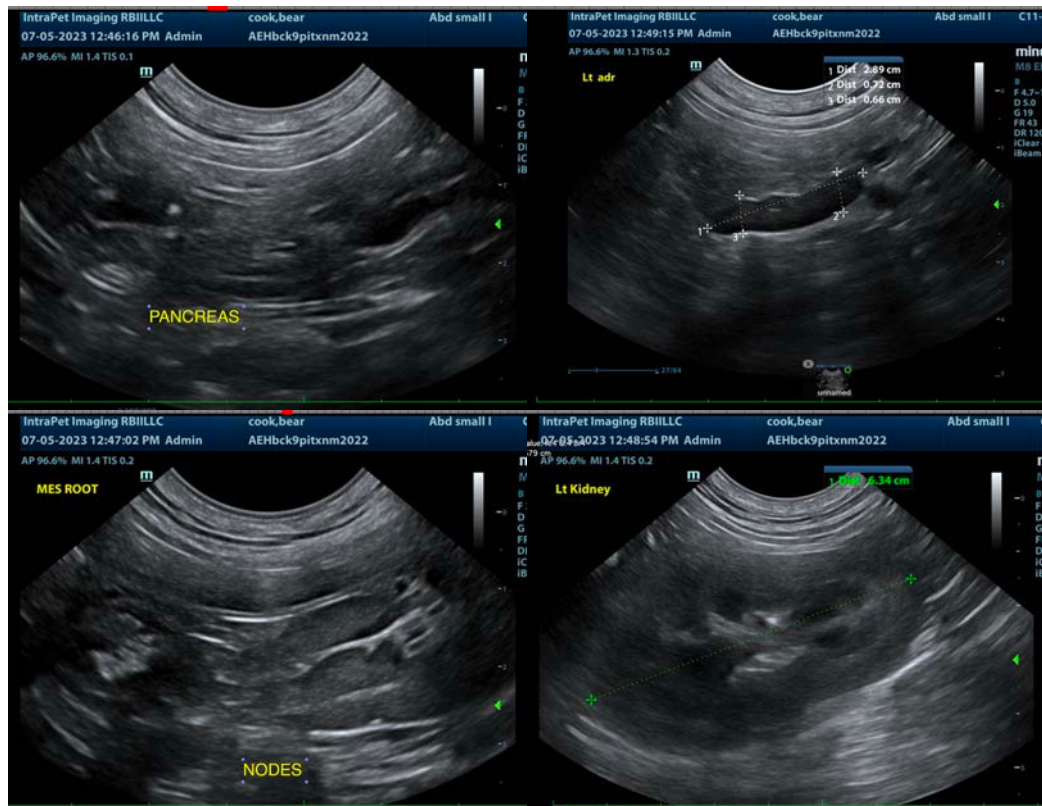
If, however, there is any chronicity, then in addition to the above, further evaluation is warranted beginning with:

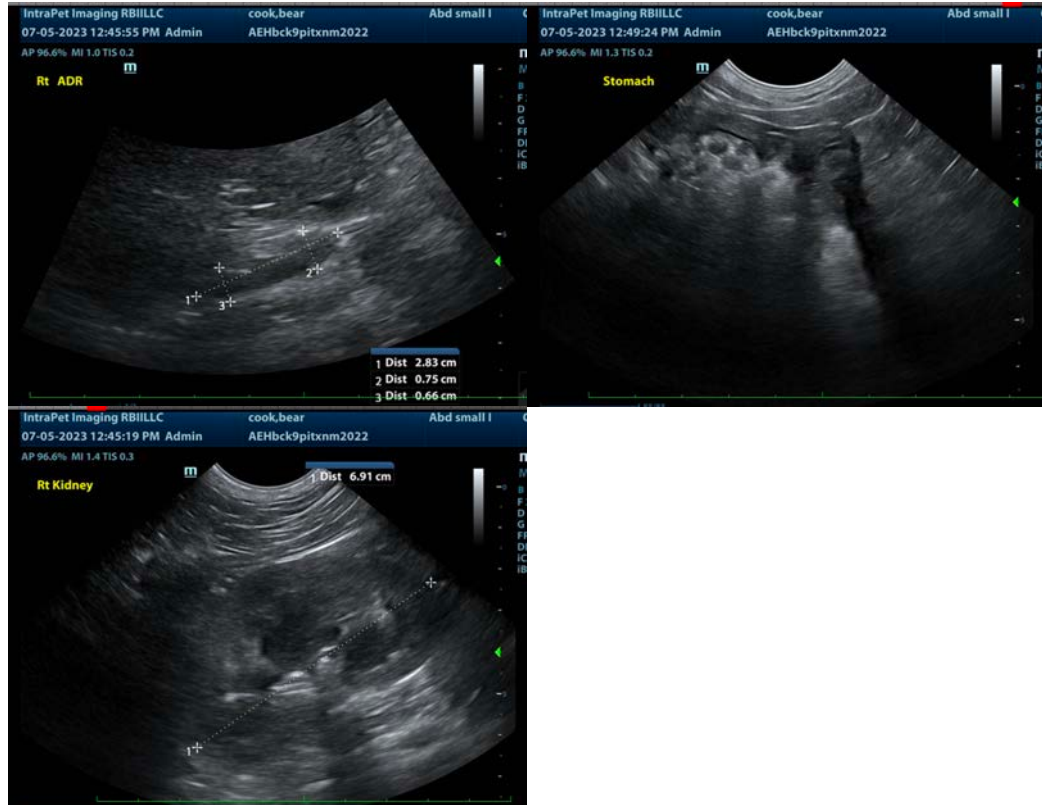
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

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

A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease.

Ultimately, if clinical signs persist, and a diagnosis is not reached, further evaluation of the GI tract via upper and lower endoscopy for visualization and biopsies may be warranted.





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.

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