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**DATE PRESENTING CLINICAL SIGNS**

8/31/22 Intermittent, chronic vomiting. Does not seem to respond to a food trial, slowing food down. Radiographs have been normal. Bloodwork performed elsewhere was normal for her age.

**PATIENT**

Daisy Lang  
Current Medications: Famotidine, no clinical response  
Date of Previous IntraPet Ultrasound: No previous.  
Sedation: Not required to complete full diagnostic ultrasound.  
Stat Report: Not requested.

**SPECIES**

Canine

**BREED**

Labradoodle

**SEX**

Intact Female

**AGE**

3/12/22

**WEIGHT**

19.4 Pounds

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**IMAGING PERFORMED BY**

Rachel Brillhart RDMS

**HOSPITAL NAME**

Airpark AH

**REFERRING VET**

Dr. Kennedy

**INVOICE**

40923

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**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.

The right kidney is normal in size (4.88 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 in size (4.97 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 (1.96 cm long x 0.63 cm at the cranial pole and 0.59 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 (1.95 cm long x 0.40 cm at the cranial pole and 0.41 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 stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) 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 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 pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

### ***Free Abdomen***

There is no evidence of free peritoneal effusion noted in these images.

The lymph nodes are prominent in size with swollen capsular contour (appropriate for patient age). Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

The uterus and both ovaries are visualized without evident pathology.

## **ULTRASONOGRAPHIC FINDINGS**

- Normal/unremarkable abdomen without an evident cause for this patient's chronic vomiting visible in these images at this time.

## **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

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.

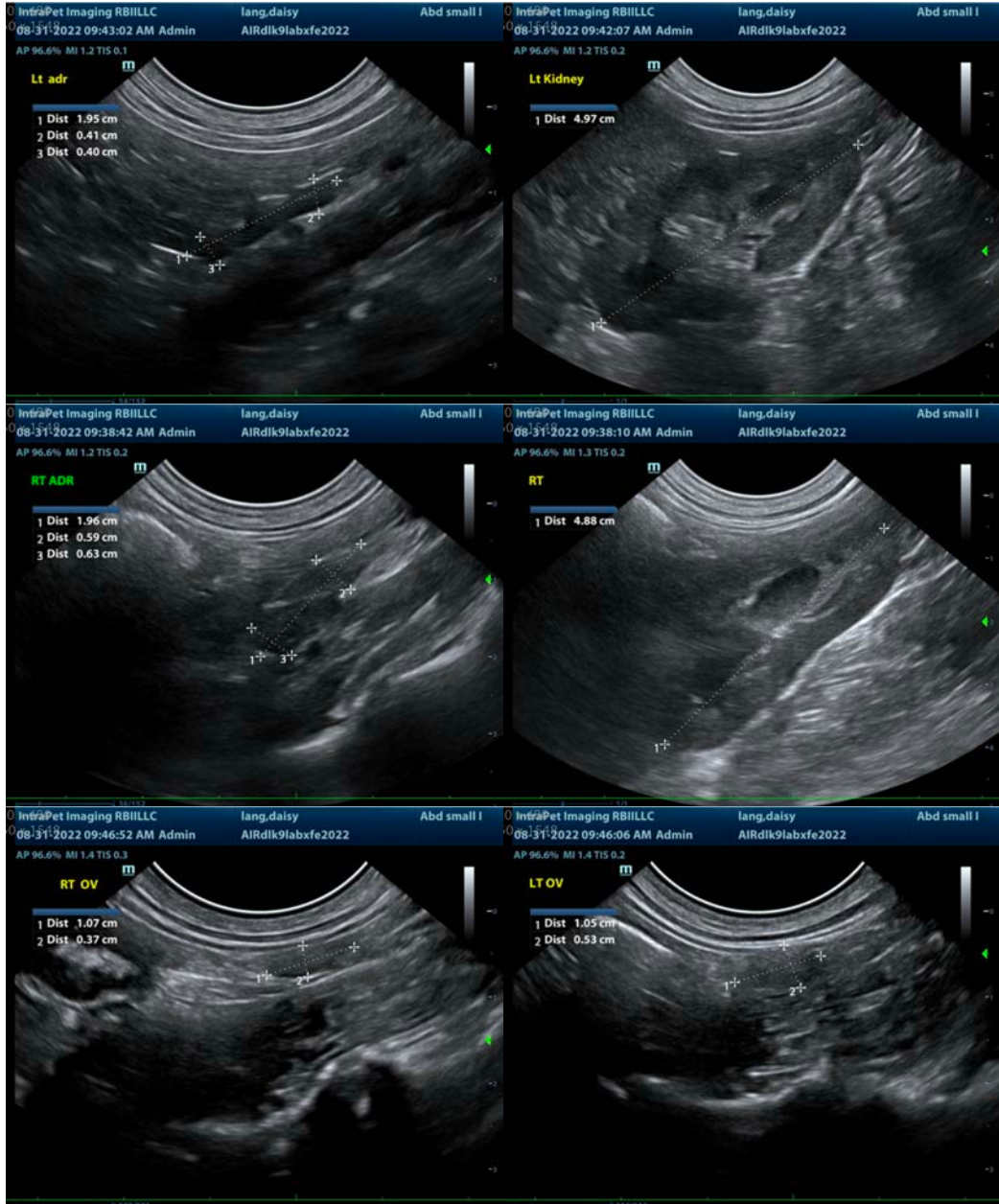
A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

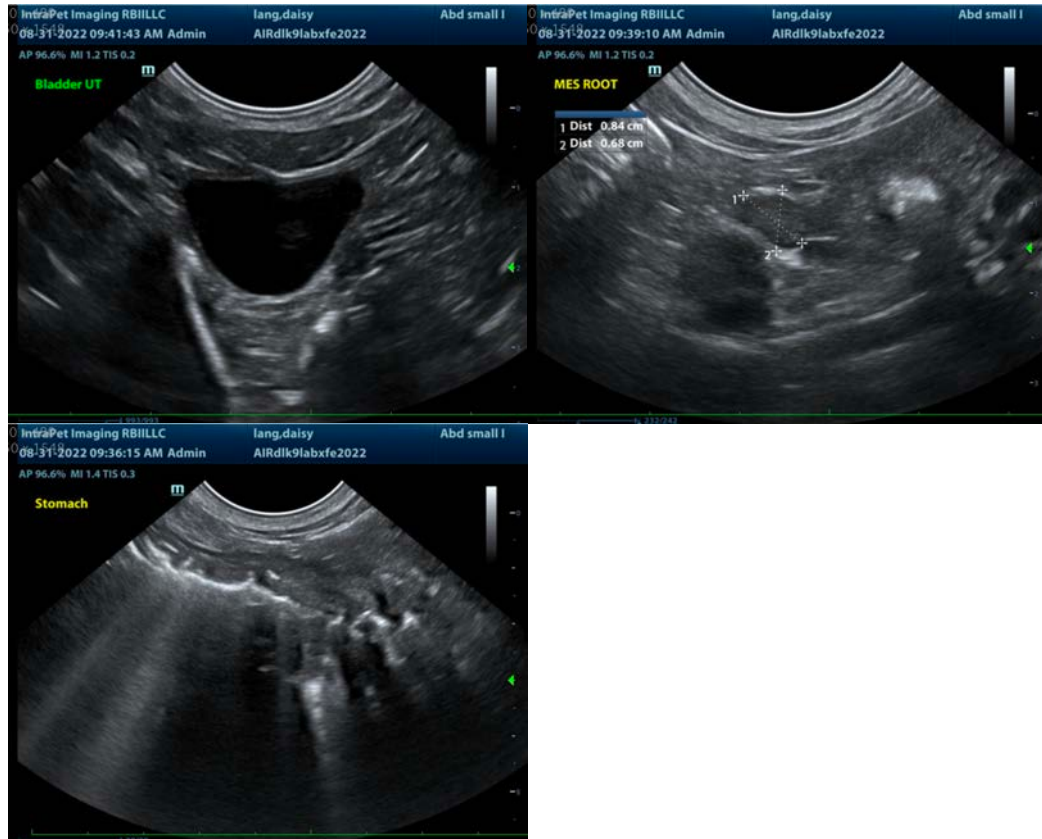
A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease.

In the meantime, empirical deworming with a 5-day course of Panacur is recommended, as well as transition to a new diet. Knowing that one reported diet change has not helped, an alternative diet may, beginning with hydrolyzed or novel protein diet, and even within those groups some diets work in some patients while other do not. If not effective after 3-4 weeks, another option could be a bland, easy to digest diet, using them on a trial-and-error basis and monitoring for improvement.

Additionally, gastritis could be empirically more aggressively managed by switching from Famotidine to Omeprazole on a trial-and-error bases.

Ultimately, if vomiting persists, an upper GI endoscopy may be warranted for further evaluation of the gastrointestinal mucosa and biopsies.





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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