

**DATE**

1/28/22

PRESENTING CLINICAL SIGNS**PATIENT**

Brody Lind

SPECIES

Canine

BREED

Pitbull Terrier Mix

SEX

Neutered Male

AGE

1/26/10

WEIGHT

75 Lbs.

INTERPRETED BYEric Lindquist, DMV
DABVP, Cert. IVUSS**HOSPITAL NAME**

Animal Emergency H

REFERRING VET

Dr. King

INVOICE

13681

History: Presenting Complaint: Vomiting; Lethargic. Date: 01-26-2022 Notes: Jacksonville staff called stating that Brody came to them yesterday due to vomiting all day, eating grass, and not eating dinner. Blood work and x-rays were performed, and the Doctor on hand believes they saw a mass in the x-rays but is unsure. O contacted Jacksonville again today and is concerned due to Brody moping all day and not eating. 01-27-2022 Notes: Had episode of Evan syndrome when 3, has been on meds long term Had relapse last year, currently stable and on 10 mg of pred twice weekly Acutely had vomiting, after discussing with owner, also started coughing the day after vomiting started vomit was large, liquidy. No change in diet or ingestions known. Saw RDVM yesterday-- labwork-- slight increase in ALKP abdomen films-- possible mass effect in abdomen, no obvious fb continues to be lethargic and not eating, vomiting thin fluid. Assessment: discussed with owner numerous causes of vomiting--pancreatitis, fb, metabolic, or related to the possible mass. I also discussed concern about the cough-- it is new- so do recommend chest films-- ensure nothing else; we will monitor hct/ts to ensure not relapse, but currently do not think so given RDVM labs from yesterday. Owner would like to pursue ab US to evaluate the possible mass but would not likely perform surgery on her. After I got the chest films-- did discuss pneumonia, possible aspiration- given the vomiting have started IV abs and nebs.

Current Medications: Famotidine, Baytril, metocloperamide, maropitant, ondansetron, trazadone, gentamicin nebulization, buprenorphine.

Lab Results: Elevated ALP- 341, Globuins- 5.1.

Radiographs: patchy alveolar pattern.

Date of Previous IntraPet Ultrasound: No previous IntraPet scans.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

Imaging Performed By: Rachel Brillhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized, and anechoic urine was present. No evidence of inflammatory or neoplastic changes were noted. Ureteral papillae were normal.

The **kidneys** revealed normal size and structure, corticomedullary definition and ratio for this age. The cortices presented largely uniform texture with normal echogenic relationship to liver and spleen. Medullary structure differed distinctly from the cortex and no evidence of pelvic dilation was present. The capsules were acceptably uniform without significant irregularities. The left kidney measured 6.92 cm. The right kidney measured 6.92 cm.

Adrenal Glands

Both **adrenal glands** were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measured 2.9 cm x 0.71 cm at the caudal pole and 0.72 cm at the cranial pole. The right adrenal gland measured 3.22 cm x 0.75 cm at the caudal pole and 0.75 cm at the cranial pole.

Spleen

The **spleen** was slightly enlarged with subtle micronodular changes.

Liver

The **liver** images submitted revealed subjectively normal liver size, contour, and structure. Parenchymal echogenicity was naturally coarse and hypoechoic to the spleen. Vascular and biliary tracts were of normal volume with no evidence of congestion. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal. No pathological hepatic lymphadenopathy was evident. No overt structural evidence of inflammatory, infiltrative or regenerative pathology was evident.

Gastrointestinal

The **stomach** revealed excessive gas accumulation. A minor amount of stasis was present. The jejunum in this patient revealed a 3.0 cm shadowing foreign structure. The small intestinal foreign body was followed by empty small intestine.

Pancreas

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

Other

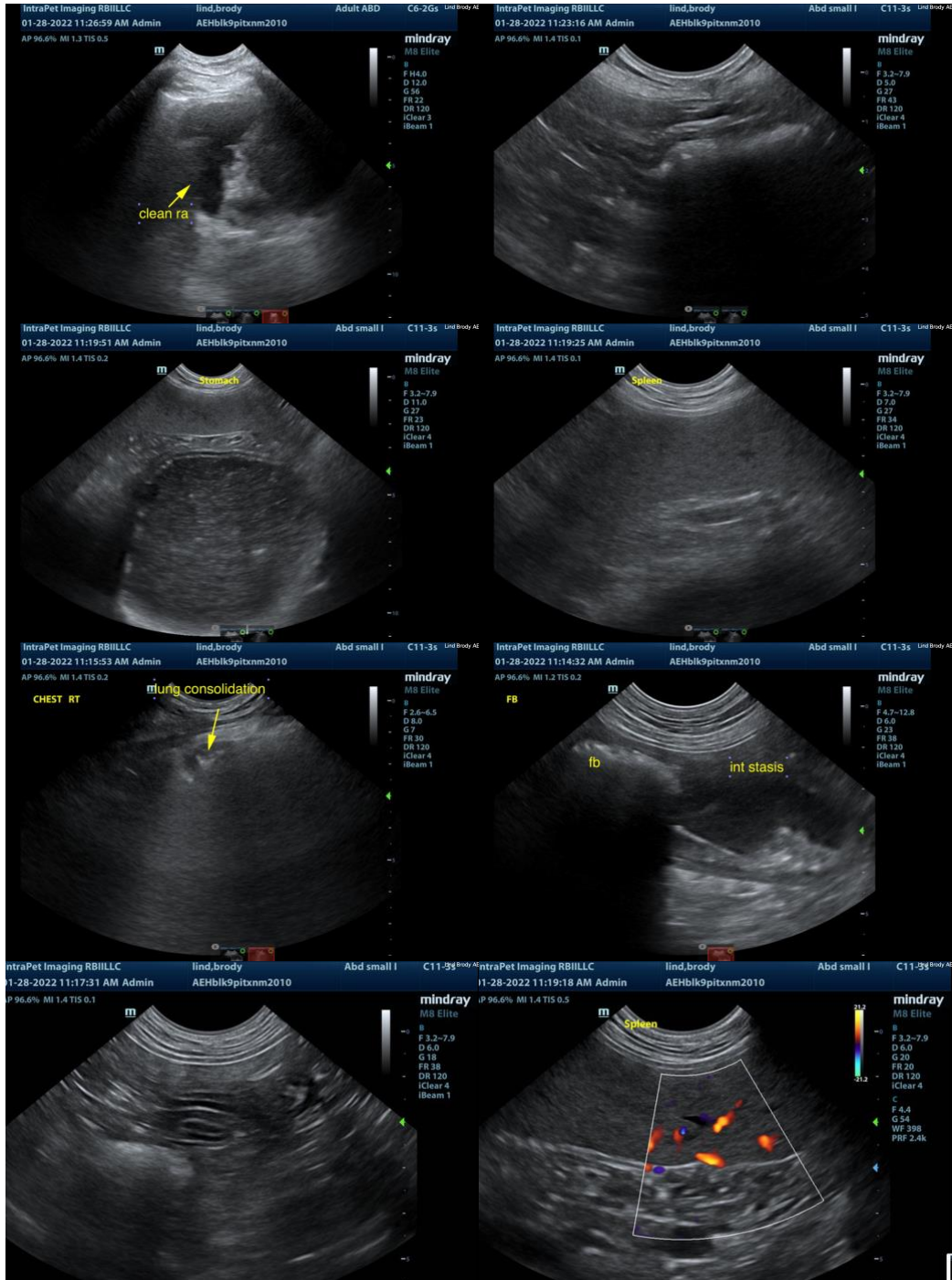
A comet tail lung pattern was noted through the diaphragm, indicative of multifocal alveolar process- chest radiographs warranted. The **thorax** revealed areas of lung consolidation. A rapid view of the heart revealed no evident pathology.

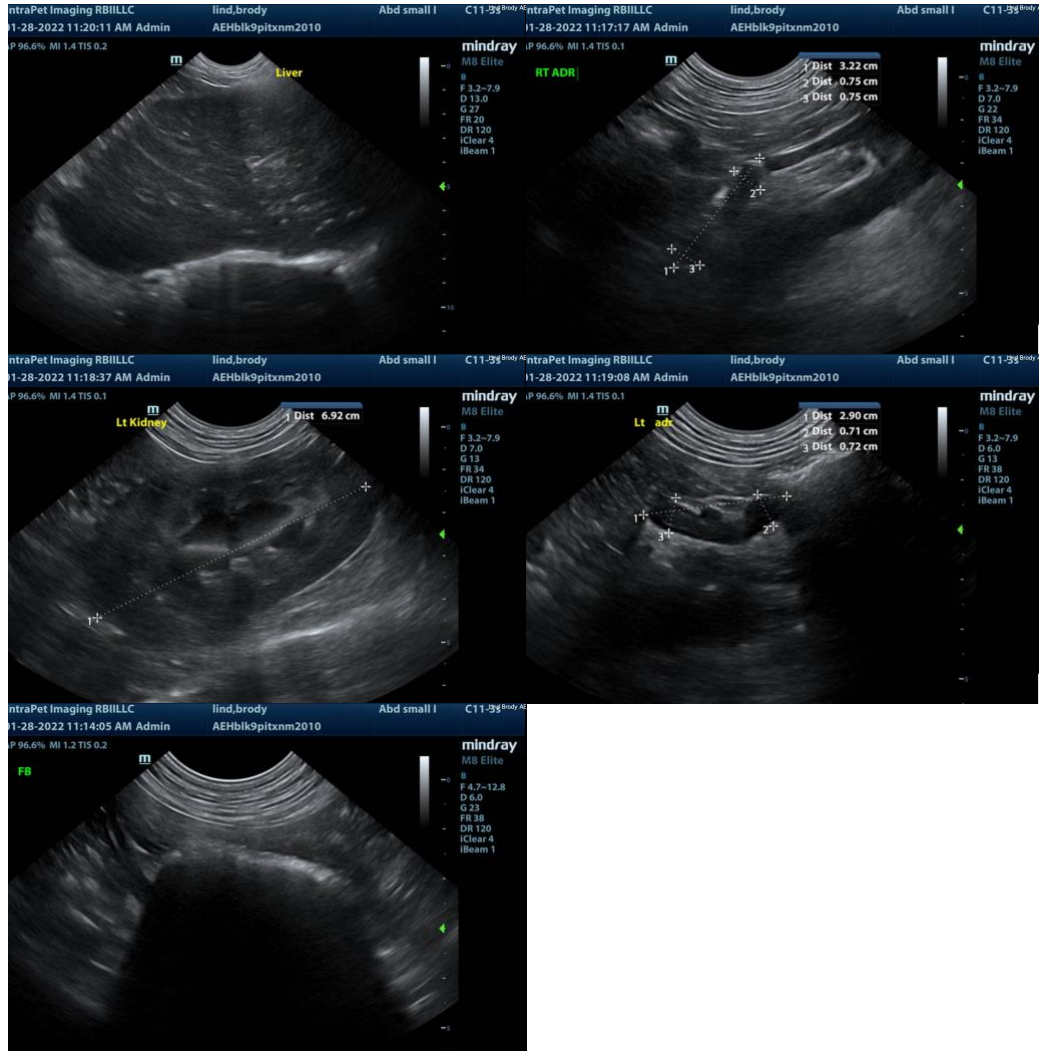
ULTRASONOGRAPHIC FINDINGS

- Obstructive small intestinal foreign body with undefined multifocal lung lesions
- Splenic nodular changes, consistent with hyperplasia or possible emerging round cell neoplasia.
- Comet tail lung pattern
- Areas of lung consolidations

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Chest radiographs and stabilization warranted. Direct enterotomy (if the patient is stable) may be necessary in this patient given that the patient is overtly obstructed. Splenic FNA or biopsy and FNA of the lung lesions could be taken at the time of surgery. Treatment for pneumonitis warranted in the meantime, however, cannot rule out a neoplastic process in the lungs.





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.

Eric Lindquist, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com
 Eric.Lindquist@SonoPath.com