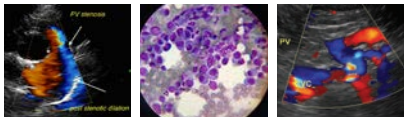
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

DATE

1/19/23

PATIENT

Garbanzo Fairfield

SPECIES

Canine

BREED

Poodle X

SEX

Neutered Male

AGE

1/7/21

WEIGHT

21.6 Pounds

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

HOSPITAL NAME

Jacksonville VH

REFERRING VET

Dr. Burk

INVOICE

44302

PRESENTING CLINICAL SIGNS

History of suspected bilious vomiting diagnosed 8/23/22. Started pepcid 5mg daily and a late meal. Owner reported (8/23/22) at one time pet had vomited plastic pieces. Owner presented patient for exam 1/16/23 with history of vomiting 2-3 times within a week a few times a month. Improved with later feeding. Most recent vomiting (1/7/23 and 1/10/23) contained blood. Initially bile with specks of blood then puddle of bloody liquid vomitus. He had a stool that looked very dark and had mucus. He is eating. No vomiting or diarrhea since. He eats Purina dog chow, chicken based training treats, peanut butter oat treats and occasionally chew sticks. Bar, bcs 5/9, mm/crt wnl, abd-nsf, rectal brown stool, carrot pieces

Current Medications: omeprazole 10 mg once a day, sucralfate 0.5 g as slurry tid
Lab Results: CBC platelet 145K estimate adequate, super nchemistry normal, cortisol, resting 2.7
Radiographs: abdomen ingesta in stomach, decreased detail, lean body condition
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: STAT requested.
Imaging Performed By: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The visualized areas of prostate and surrounding tissue appear normal. Unfortunately, the prostate is not fully visualized likely due to its intrapelvic location. Correlate with rectal exam findings.

The left kidney has a normal shape and size (4.33 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.85 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.59 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.68 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver
The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal
The stomach contains a large amount of ingesta and fluid. It measures at a normal thickness of <0.7cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Duodenum wall measures 0.46 cm. Jejunum wall measures 0.23 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas
The pancreas is prominent and hypoechoic as compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen
Evaluation of the peritoneal cavity did not reveal any evidence of effusion. A mesenteric lymph node is visualized measuring 0.45 cm. The omentum is generally of normal echogenicity.

ULTRASONOGRAPHIC FINDINGS

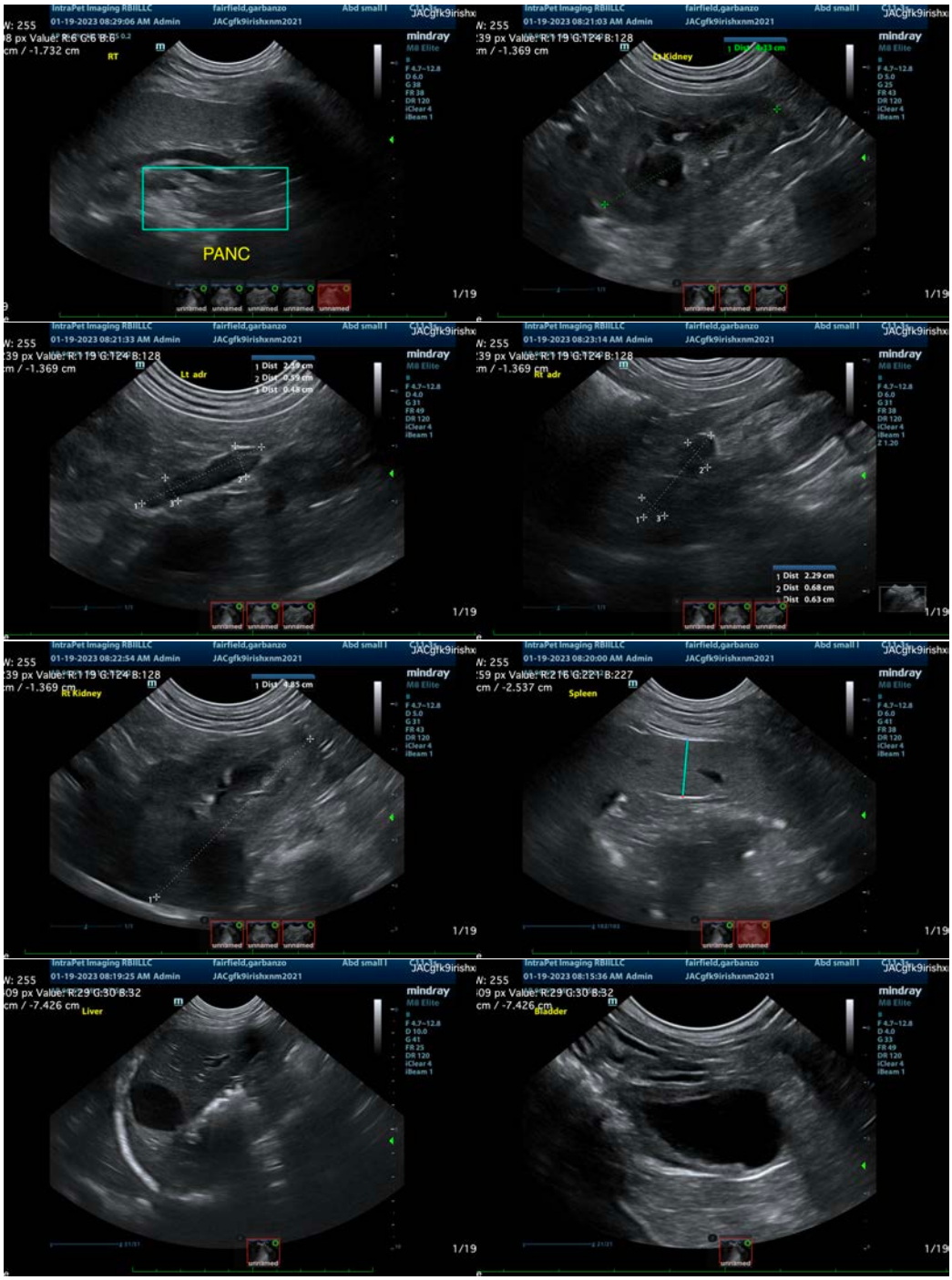
- Hypoechoic, prominent pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

- Fluid/ingesta dilated stomach – Correlate with the feeding history. Per the history, this patient was adequately fasted, which increases concern for delayed gastric emptying, a partial pyloric outflow tract obstruction, etc. (none observed).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The most prominent abnormality noted on today's exam is a large, fluid and ingesta dilated stomach. This material can be seen mobile with peristalsis. No outflow tract obstruction is observed, but this cannot be entirely ruled out. Additionally, consider the possibility of ileus/decreased progressive motility, etc., often secondary to underlying inflammation, irritation. Correlate these findings with abdominal radiographs. Recommend symptomatic treatment for gastroenteritis with close monitoring, with serial radiographs looking for passage of the gastric contents. If this material is not passing or the patient is deteriorating, consider either reimaging or endoscopy/surgery to further evaluate the stomach and small bowel.

- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Consider chronic probiotic therapy.



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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)
kathleen.sennello@sonopath.com