IMAGING PERFORMED BY

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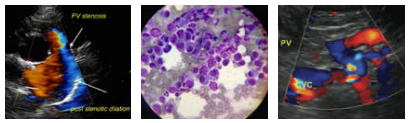

SonoPath
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DATE
1/4/22

PATIENT
Scotty Burchette

SPECIES
Canine

BREED
Rottweiler

SEX
Spayed Female

AGE
7/9/13

WEIGHT
125.5 lbs

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

HOSPITAL NAME
Animal Emergency Hospital

REFERRING VET
Dr. Kalwa

INVOICE
94977

PRESENTING CLINICAL SIGNS

History: Presenting Complaint: Foreign Body; Vomiting with Blood. Date: 01-01-2022. Ate Christmas tree, fake plants, ribbon, bag of cotton balls, plastic. Vomiting blood; foreign material in feces with vomiting- several times from nose/ mouth. ATO- Hx of pica spells recently- few months ago ate screws, spells of eating foreign material overnight. Has been increased drinking, gagging, acid reflex but then asked directly about PU/PD and Os state none. Lizard licking. No walking into corners- did not appear neurologic. Hx of kidney and liver elevations over few years- on Denamarin and k/d diet No mention of Cushing's or hypothyroidism. Brother in household has osteosarcoma This am found P ate multiple things in house. P went outside and started vomiting up the ribbon- O pulled on the ribbon ~10-12 feet long? and O pulled it out of stomach. O states there was no resistance. P started vomiting blood.
Assessment: Scotty 8.5 yr FS Rottweiler - vomiting with blood, dietary indiscretion, tense abdomen, foreign material in feces on rectal. Acute problem- ddx severe esophagitis/ gastritis/ gastroenteritis, risk for FB, risk for pancreatitis, risk for perforation if/when pulled ruptured
intestines- less likely. Chronic pica- ddx brain tumor vs Cushing's vs hypothyroidism vs other. Plan: Hospitalization, IV catheter, fluid therapy, and further treatment as needed. Full bw, repeat x rays.
Current Medications: Amoxicillin, Gabapentin, Ondansetron, Omeprazole, Sucralfate, Pantoprazole, Entyce, Unasyn, Buprenex.
Lab Results: Attached separately.
Radiographs: AFAST: No FF.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: Patient sedated with Torb/Ace.
Stat Report: Not requested.
Imaging Performed By: Andi Parkinson, 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 left kidney has a normal shape and size (6.87 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of 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 (7.35 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of 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 0.63 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 0.74 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. The spleen echotexture is heterogenous and mottled, the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. There is a 0.97 x 1.29 cm hypoechoic nodule visualized within the parenchyma of the spleen.

Liver
The liver is subjectively large in size, and echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. 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 gallbladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal
The stomach is moderately dilated with fluid and irregular shadowing material most consistent with normal ingesta and gas. 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 layering 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. The duodenum measured as normal (0.38 cm) and the jejunum measured as normal (0.36 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 large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. This is consistent with mild pancreatitis, particularly in the right limb.

Free Abdomen
Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS
PRIMARY FINDINGS:

- Large heterogenous liver. The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy.

- Hypoechoic splenic nodule. There is a non-cavitated, hypoechoic splenic nodule visualized. Differentials include lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis

- Small amount of soft shadowing material in the gastric lumen. Correlate with radiographs and feeding history. This can be consistent with a small amount of ingesta or small amount of foreign material.

- Prominent, mottled right limb of the pancreas. The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a small amount of soft shadowing material in the gastric lumen. This could be consistent with ingesta or a small amount of fabric, etc. There is no evidence of obstruction and no obstructive pattern visualized in the small intestine. Additionally the right limb of the pancreas is mildly prominent. Consider a quantitative PLI to further evaluate for possible pancreatitis. I recommend a GI panel to Texas A&M with quantitative PLI, TLI, cobalamin and folate to evaluate for current pancreatitis and small intestinal disease.

The liver is large and heterogenous, but no focal lesions are visualized. Additionally, there is a small, hypoechoic nodule in the spleen. I recommend FNA if an angle can be obtained to reach this lesion or continue to monitor with ultrasound. I recommend three view thoracic radiographs.

With the significant elevation in ALP and recent ingestion of foreign material I would recommend close monitoring of the material in the stomach with supportive care as you have been doing. Additionally, consider these recommendations for the ALP elevation.

- Consider close evaluation of history for possible toxic changes examine medications, diet, dietary indiscretion etc...
- If not already done, consider pre and post prandial bile acids to evaluate liver function
- If the ALP is significantly elevated relative to the ALT and symptoms consistent with Cushing's are present, consider adrenal function testing (ACTH stim)
- Consider Fine needle aspirate if round cell neoplasia is on your differentia list (25 g needle, normal coags)
- If no response to supportive care (fluids, anti-emetics, anti-ulcerative therapy +/- antibiotics, etc) then you may need to consider endoscopy to evaluate the stomach contents or surgery to evaluate for foreign material, obtain GI biopsies and obtain a liver biopsy at that time.
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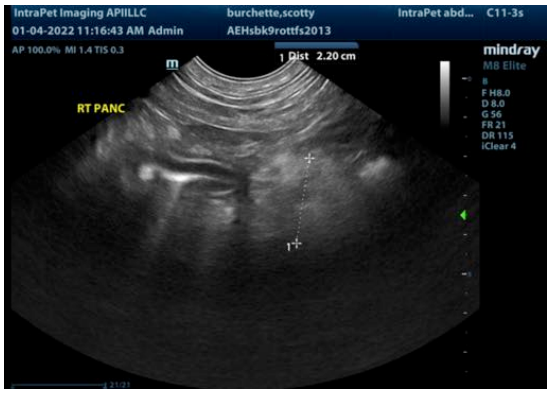

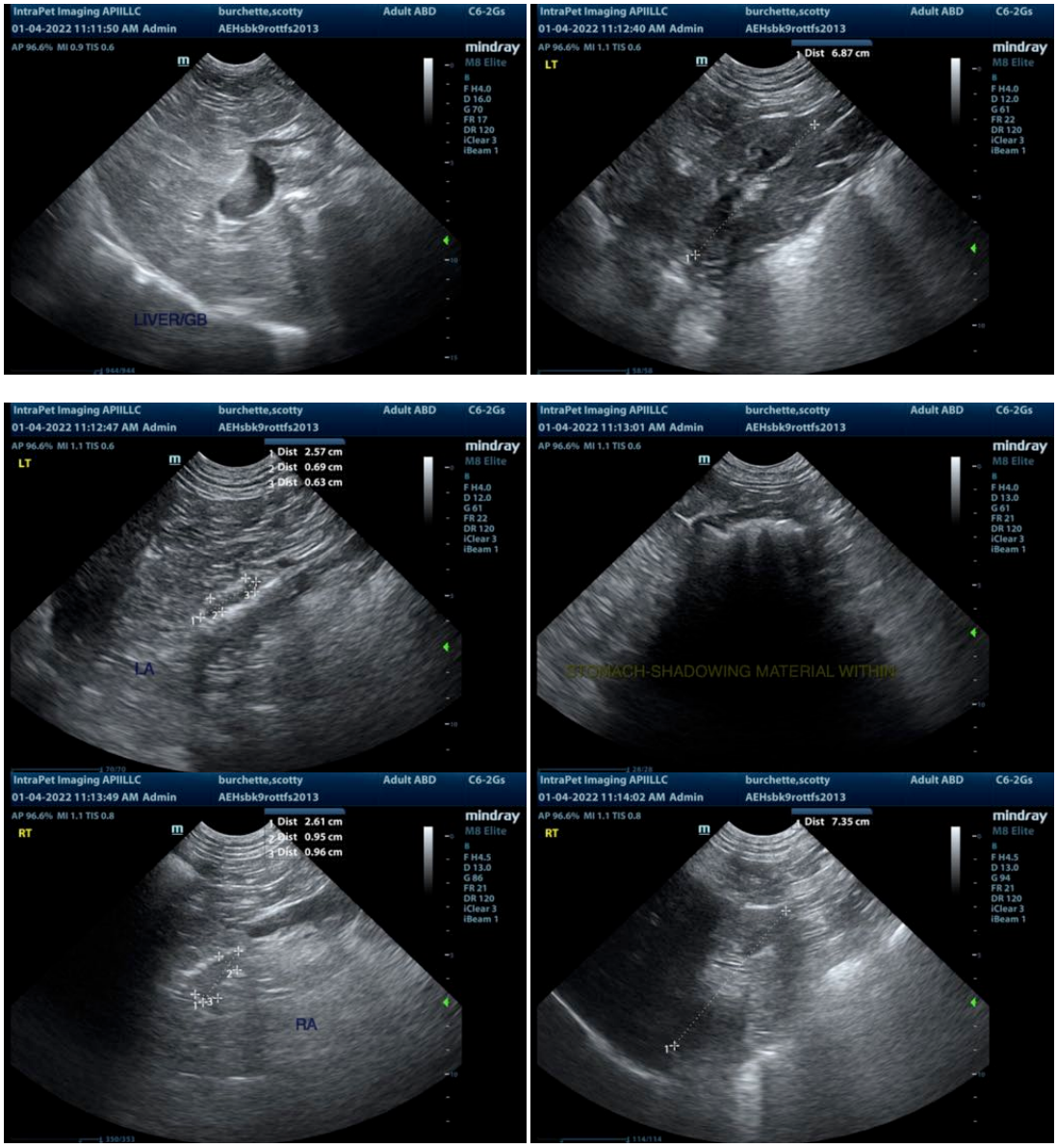

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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