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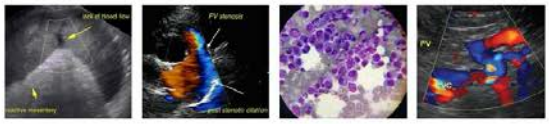

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Frank Dunn

SPECIES

Feline

BREED

DSH

SEX

Neutered Male

AGE

3 Years 6 Months

WEIGHT

10.5 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

Sierra Oaks VS

REFERRING VET

Dr. Josh Ettlin

INVOICE

34012

DATE

1/5/22

PRESENTING CLINICAL SIGNS

General findings Client comment - Richard and Sherry here with patient. Brought in for: vomited blood Adopted from Sammy's Friends Nov 11 2019 pDVM: Sierra Oaks -- CURRENT HISTORY -- Doing well at home. Good appetite and energy level. No C/S/D No PU/PD Vomiting - Started in the spring (~8m ago). Occurs once every 10-21d or so. 10d ago vomited large wad of grass, dirt, and undigested kibble. Usually unwitnessed, but saw this and noted abdominal contractions. This morning found puddle of blood tinged saliva and grass. Daughter gave them elevated/angled feeder 3-5 months ago, around this time they also started feeding P on bathroom counter to prevent dog from getting food. P has to stand in sink to get to food bowl; Mrs wonders if stretched out neck while eating is affecting mechanical function of esophagus. Switched back to feeding on floor but unsure if this has helped. -- ENVIRONMENT -- Standard Poodle (~10yo) at home. Owned for a long time and good friends w cat. -- VACCINES -- UTD on vaccines Medication history None currently - Tried to give Gabapentin pre-visit but were unsuccessful Diet history Diamond kibble; Nulo canned food.Chronic intermittent vomiting R/o motility disorder vs IBD vs dietary indiscretion vs other
Abnormal PE/Chem/CBC/UA Results: Abdominal palpation Palpation non-diagnostic, tense patient

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 (3.5 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 (4.08 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 0.40 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 0.34 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.

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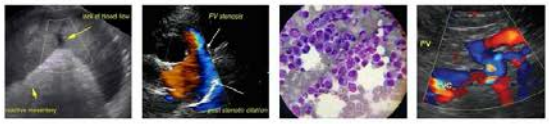

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Liver

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 primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.36cm 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 uniform diameter with minimal fluid distension. Wall thickness is normal to slightly increased. Bowel loops follow a typical curvilinear path with distinct wall layering, but some areas display a prominent muscularis layer which does not display the typical 1:3 muscularis:mucosa layer ratio. Jejunum wall measured 0.24 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 normal and isoechoic to surrounding 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. One prominent mesenteric lymph node was visualized at 0.29 cm. The omentum is of normal echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Mildly prominent muscularis layer to the small intestine – The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Today's scan appears largely normal. Subjectively, the muscularis layer of the small bowel appears slightly promineint, but this is very marginal. I suspect the hemorrhage is due to acute vomiting and mechanical irritation/superficial ulceration. If this persists, consider upper GI endoscopy to further evaluate.

If chronic vomiting persists, then consider such differentials as dietary insensitivity, GI parasites, mild pancreatitis, etc., and consider starting with a hydrolyzed protein and novel protein diet.

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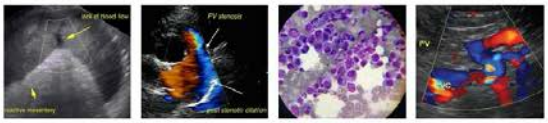

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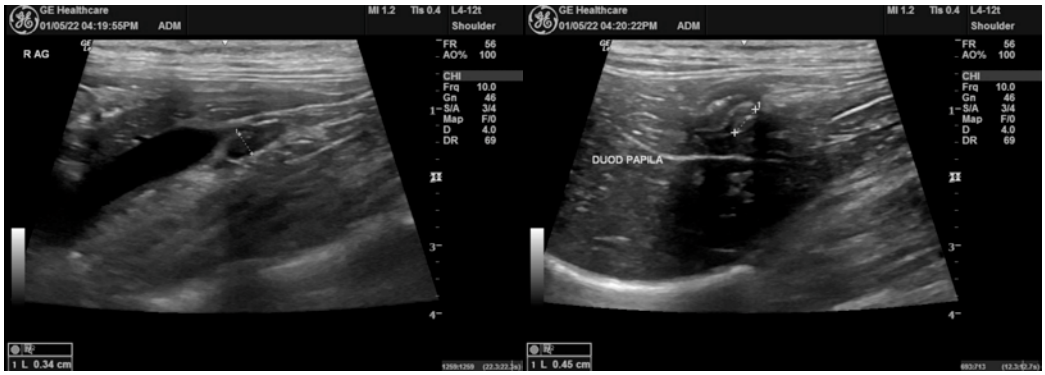

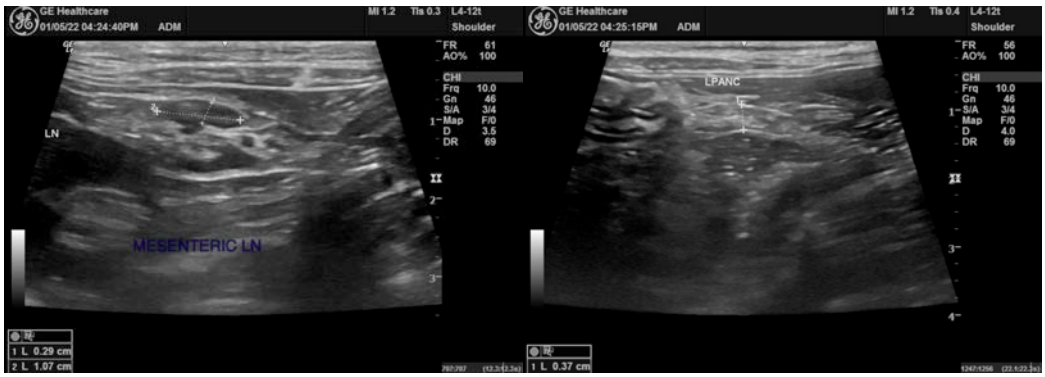

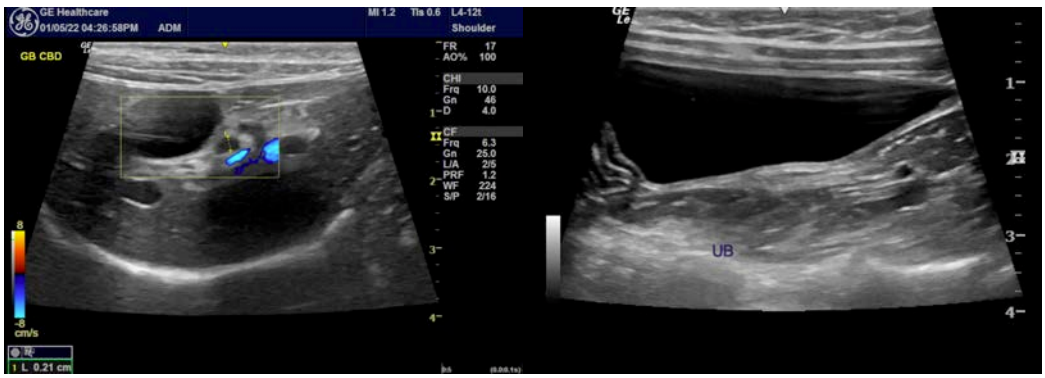

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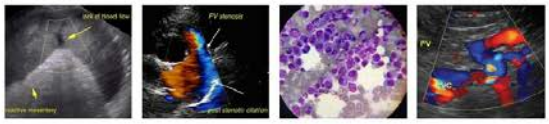

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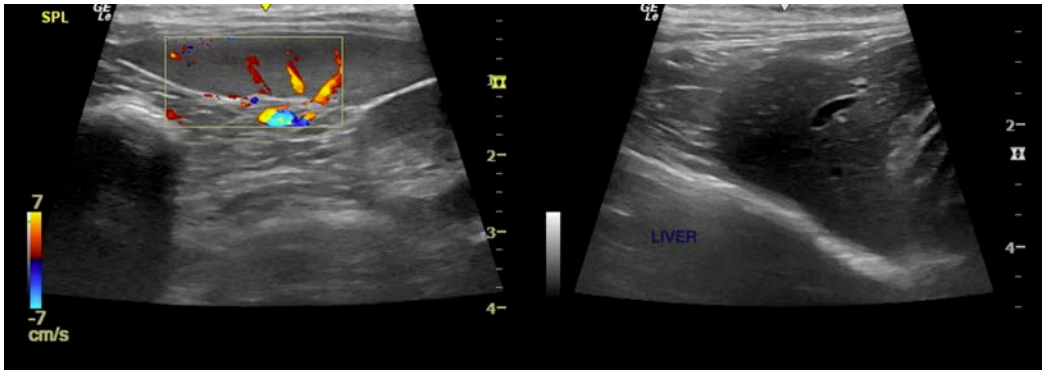

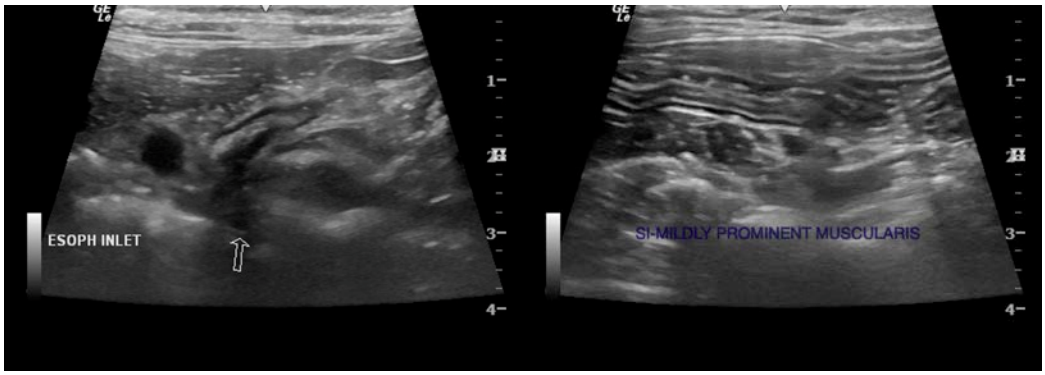

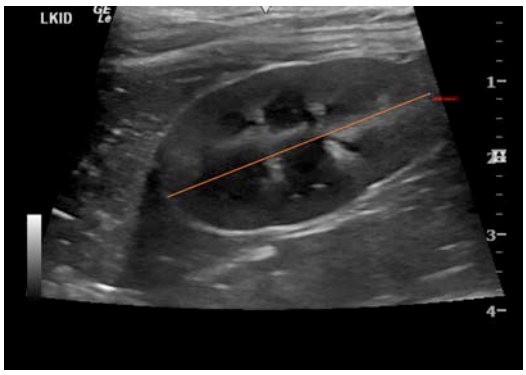

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

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