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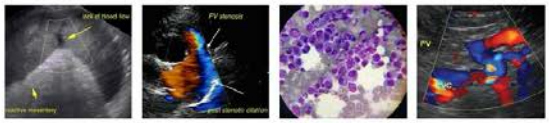


IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Louie Dimmitt

SPECIES

Canine

BREED

York Terrier

SEX

Male

AGE

11 Years

WEIGHT

11 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

Advanced PetCare

REFERRING VET

Dr. Alexis Hazelwood

INVOICE

26311

DATE

10/15/21

PRESENTING CLINICAL SIGNS

Primary Complaint: Gastrointestinal History: Clinical signs (), Vomiting duration (SUBACUTE vomiting (3-14 days)), Clinical signs summary (For the last 10 days the P has been throwing up their food right after eating. P is drinking a lot of water. P is lethargic and lacks their usual personality. P is not on any medications and does not have a history of eating things that they should not be eating.), Last ate (Patient last ate less than 12 hrs prior to exam) Physical Exam: Summary of PE findings (Soft, nonpainful abdomen, normal hydration, thin body condition (lost 3# since last recorded weight).), T (102.5F/39.2C), P (198), R (Sniffing), MM (pink/moist), Patient attitude/demeanor (patient demeanor- bright) Diagnostics: Completed diagnostics (In house chem 17/lytes/CBC- no significant abnormalities) Treatment: Tx Plan (Treatment pending image interpretation) Other: Main clinical question/concern (Any signs of foreign body?), DfDx (Pancreatitis?), Additional information () ABDOMEN October 11, 2021: 4 images are provided. FINDINGS: Peritoneal serosal detail is normal. The stomach contains a small volume of gas and questionably a small volume of soft tissue or fluid opaque material. There is a distended intestinal loop which contains fluid and particulate soft tissue to mineral opaque material which is seen in the caudal abdomen in the lateral views, which appears somewhat folded upon itself. This loop tracks caudally towards the pelvic inlet, although there is distention of a loop seen immediately ventral at the level of L5 through L7 which is similar in diameter. In the right lateral view there is an atypical, bilobed, gas distended intestinal segments seen just cranial to the pelvic inlet which is not seen in the left lateral view. In the ventrodorsal view the fluid distended segment tracks right of midline from the level of L7 to approximately the level of L2. There is poor definition of the transverse colon. There is mild segmental gas distention of the small intestine. Visible margins of the liver, spleen and kidneys are normal. The bladder margins are poorly seen. In the ventrodorsal view there are 2 rounded gas filled structures at the level of the right 12th rib which is thought to most likely correspond to the cecum. There are several small, stippled mineral opacities also noted within the intestine just caudal to this structure. No significant skeletal abnormalities are appreciated. The included thorax is normal.CONCLUSIONS: The most significantly fluid distended intestinal loop at least partially corresponds to the colon, although pathologic dilation of an additional small intestinal segment is possible. The mild, segmental gas distention of the small bowel may accompany gastroenteritis or partial mechanical obstruction. The colon likely courses right of midline in the ventrodorsal view as an incidental finding. A colonic torsion is thought unlikely. RECOMMENDATIONS: Abdominal sonography is recommended in this patient to exclude the possibility for a partial or developing small bowel obstruction. An upper GI contrast study could be performed if indicated or a pneumocolonogram to definitively confirm the dilated loops of bowel described correlate entirely to the colon.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

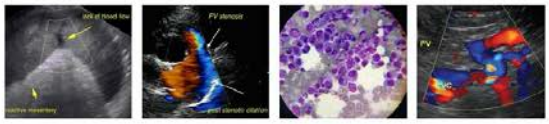
Urinary System

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 (3.85 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 3.97 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric



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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 0.62 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 0.60 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 hypoechoic 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. There is a 0.89 cm hyperechoic nodular visualized in the liver.

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 <0.7cm 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 have a relatively uniform diameter with minimal fluid distention. As you progress more caudally through the small intestine, jejunum and ileum become significantly fluid dilated. thickness is normal in all areas. Bowel loops largely follow a curvilinear path with distinct wall layering. The normal duodenum measures 0.5 cm. Distal jejunum measures 0.2 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileum is severely dilated up to the point where it approaches the ileocecal junction, which appears thickened with hypoechoic wall and reduced distinction of layering. Findings are suspicious for a focal partial obstruction in this area, and wall thickness of the bowel at the ileocecal junction is 1.0 cm.

The ileocecal junction is visualized and exhibited a thickened, hypoechoic wall with decreased or lack of wall layering, measuring up to 1.0 cm in thickness. Small bowel proximal to the ileocecal junction appears dilated. More distally, the colon appears empty and is devoid of fluid or fecal material. These findings are most consistent with a mass effect or severe thickening at the level of the ileocecal junction.

Pancreas

The pancreas is prominent and mottled 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.

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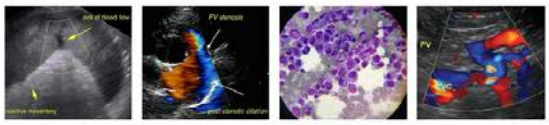

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Free Abdomen

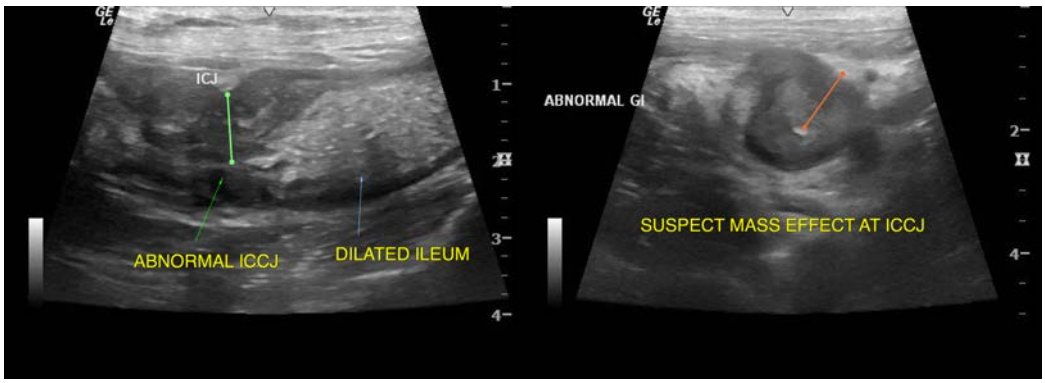
There is a small volume of free fluid present. There is a significant mesenteric lymphadenopathy present with a cluster of prominent lymph nodes around the ileocecal junction measuring 1.13 cm, 0.56 cm, and 0.69 cm. The omentum is of generally increased echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Suspect wall thickening and loss of layering at the level of the ileocecal junction, resulting in a partial obstruction. Findings could be consistent with inflammation, edema, or infiltrative neoplasia. There is concern for an obstruction and infiltrative disease at this site.
- Prominent, mottled pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Heterogeneous and hypoechoic liver with a hyperechoic nodule – 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. The hypoechoc echogenicity increases suspicion for possible inflammatory disease or round cell neoplasia. Recommend fine needle aspirate.
- Diffuse small intestinal bowel dilation – most consistent with a distal obstruction.
- Moderate lymphadenopathy surrounding the ileocecal junction – The moderate mesenteric lymphadenopathy is most concerning for a neoplastic process, although you can see significant lymphadenopathy in some cases of autoimmune/inflammatory disease, infectious disease(tick born disease-such as bartonella, fungal infections, etc. A fine needle aspirate with cytology is recommended for further evaluation.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small bowel is very dilated leading up to the ileocecal junction, which appears thickened with a decreased distinction of layering. There is concern for a partial or complete obstruction. Options moving forward include a fine needle aspirate of liver and ileocecal junction wall +/- enlarged mesenteric lymph node, or surgical explore with biopsies of the ileocecal junction and lymph nodes (+/- resection). Recommend 3-view thoracic radiographs.



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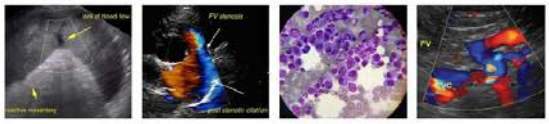

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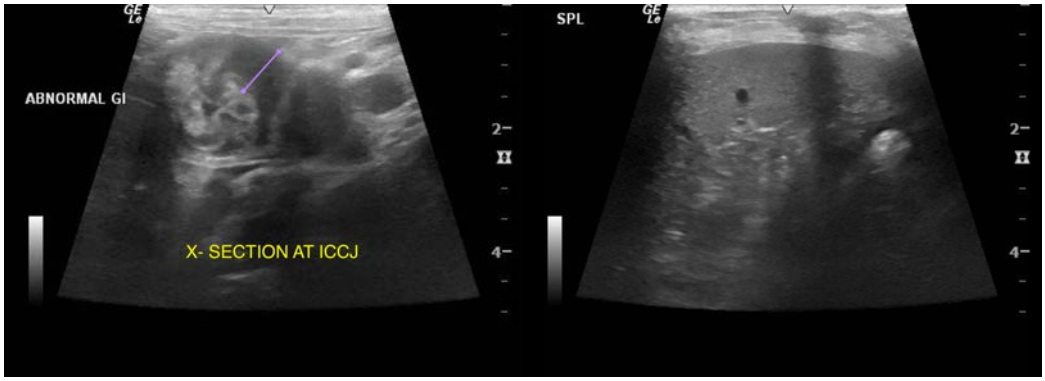

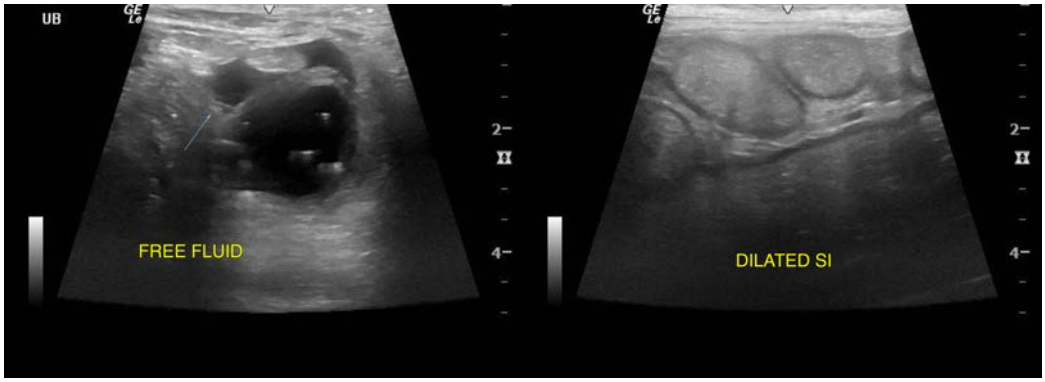

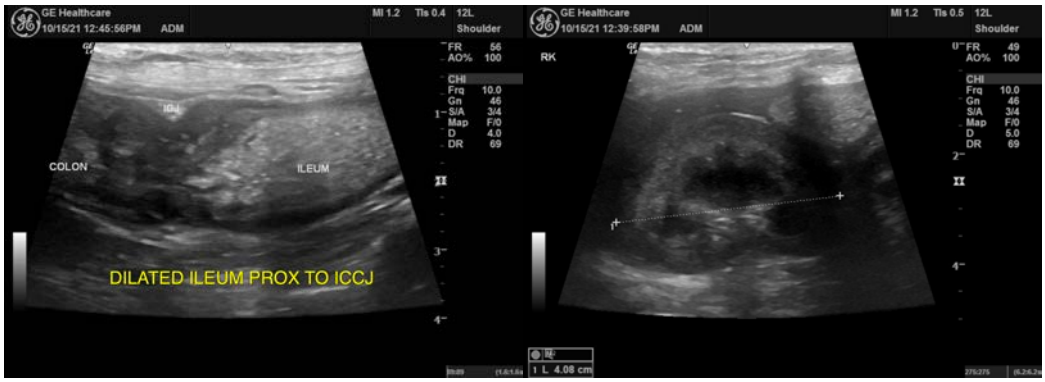

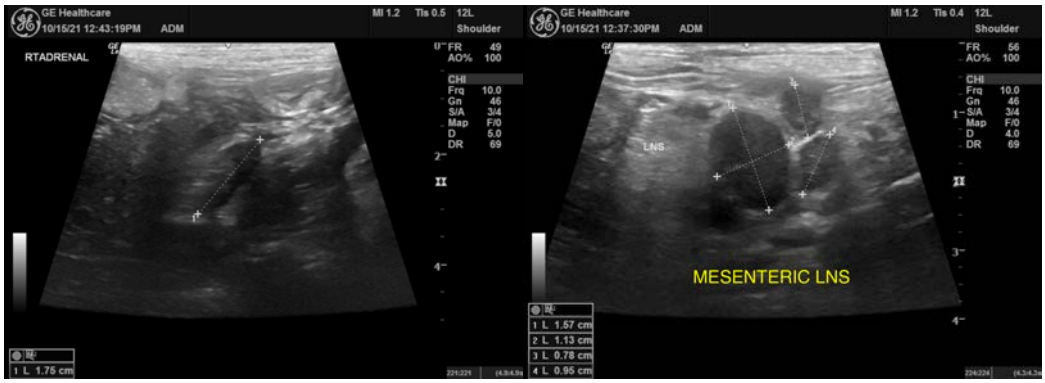

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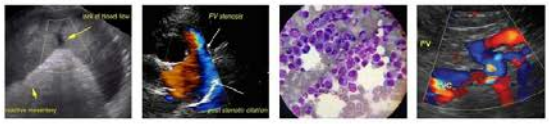

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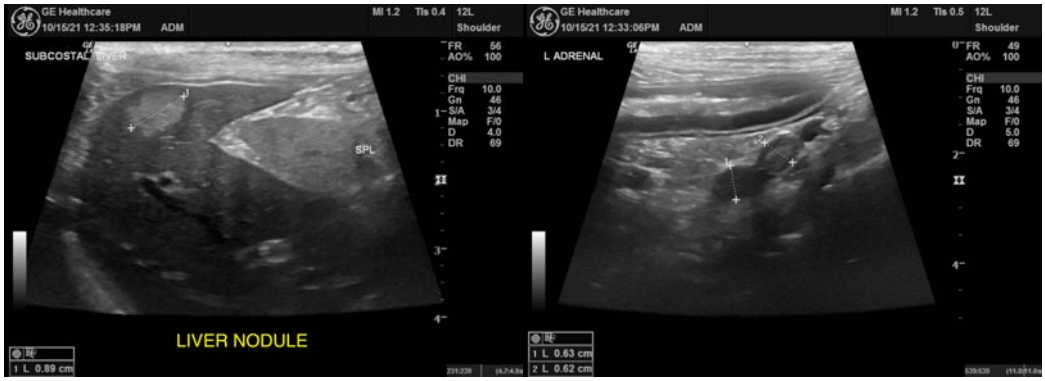

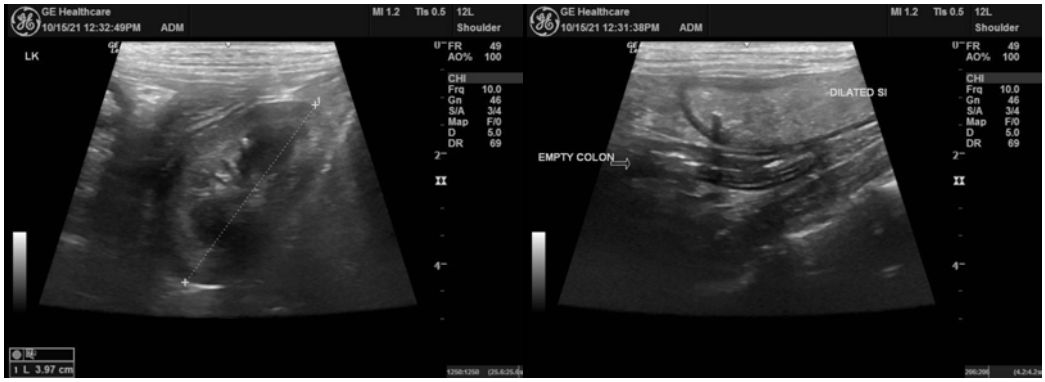

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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