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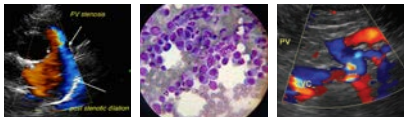
IntraPet.com



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DATE

11/22/22

PATIENT

Boo Boswell

SPECIES

Canine

BREED

Labradoodle

SEX

Neutered Male

AGE

11/22/17

WEIGHT

70.8 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Rachel Brilhart RDMS

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Dr. Kalwa

INVOICE

42902

PRESENTING CLINICAL SIGNS

vomiting in sleep- worried for P choking and aspiration- vomited foam/ yellow. Concern for breathing Hx: sensitive stomach- has Rx dog food PC: - C/S started sunday- NE am, ate pm - stomach noises - Didnt eat monday – Vomiting since sunday- twice this week when sleeping; overnight slept and vomited on other dog - vomit looked projectile- white foam – Trouble breathing after vomit (O very worried about aspiration) Other information: - No diarrhea - Urinated - Neighbors have a dog with severe diarrhea; another neighbor with a dog with parvo or distemper History: - Sensitive stomach (intermittent vomiting, anything upsets stomach and diarrhea)- diagnosed IBD 4 years ago. O unsure what diagnostics were performed to diagnose. P has been on Purina Pro plan EN since and has had intermittent mild episodes (O also intermittently feeds chicken, turkey, instant mashed potatoes) doesnt feed rice- goes through him - Sensitive dog- P gets stressed when O is stressed -this may upset his stomach. P very high strung - family members moved in - P has been very nervous with P there. - UTD flea/tick/hw

Current Medications: Unasyn, Protonix, Buprenorphine, Vitamin B12.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

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 prostate is normal in size (0.97 cm) and shape for this neutered male dog. The parenchyma is homogenous, and the external margins are smooth. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (6.72 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 (5.76 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 0.75 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 0.82 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 gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a mild amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

Gastrointestinal
The stomach is mildly to 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 uniform diameter with minimal fluid distension. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. Jejunum wall measures 0.37 cm. Duodenum wall measures 0.48 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 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.

Free Abdomen
Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are prominent lymph nodes visualized at the root of the mesentery. One of these measures 0.65 cm in width. The omentum is mildly hyperechoic in the cranial abdomen.

ULTRASONOGRAPHIC FINDINGS

- Prominent, mottled pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.
- Moderate gastric dilation with fluid and a small amount of ingesta – Correlate with feeding/drinking history. If the patient was adequately fasted, consider such differentials as delayed gastric emptying/ileus or a partial outflow tract obstruction (none observed).
- Mild mesenteric lymphadenopathy – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Subjectively thickened small intestine – The mild small intestinal wall changes may be a normal variant in this patient or could be consistent with an inflammatory process (e.g., inflammatory bowel disease).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

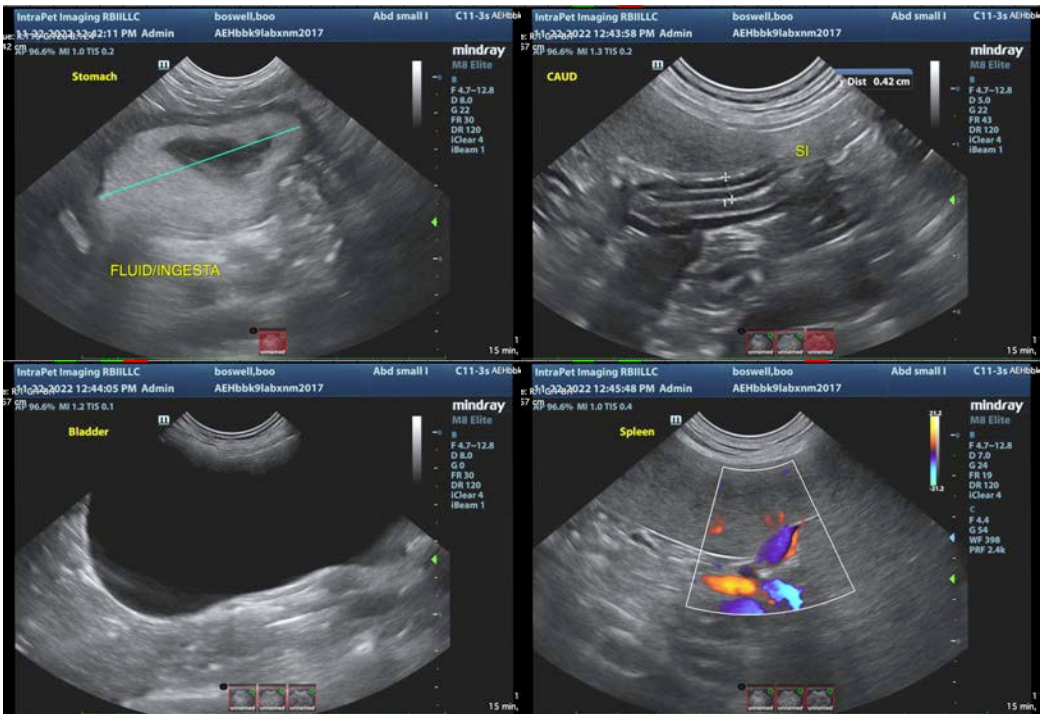
No obvious mass effects or obstructions were visualized on today's exam, although ingested foreign material cannot be definitively ruled out. The pancreas appears somewhat hyperechoic and mottled. These changes could be consistent with a previous episode of pancreatic inflammation or a current episode of mild inflammation. Correlate with a quantitative cPLI level and consider empirical treatment for acute gastroenteritis/pancreatitis.

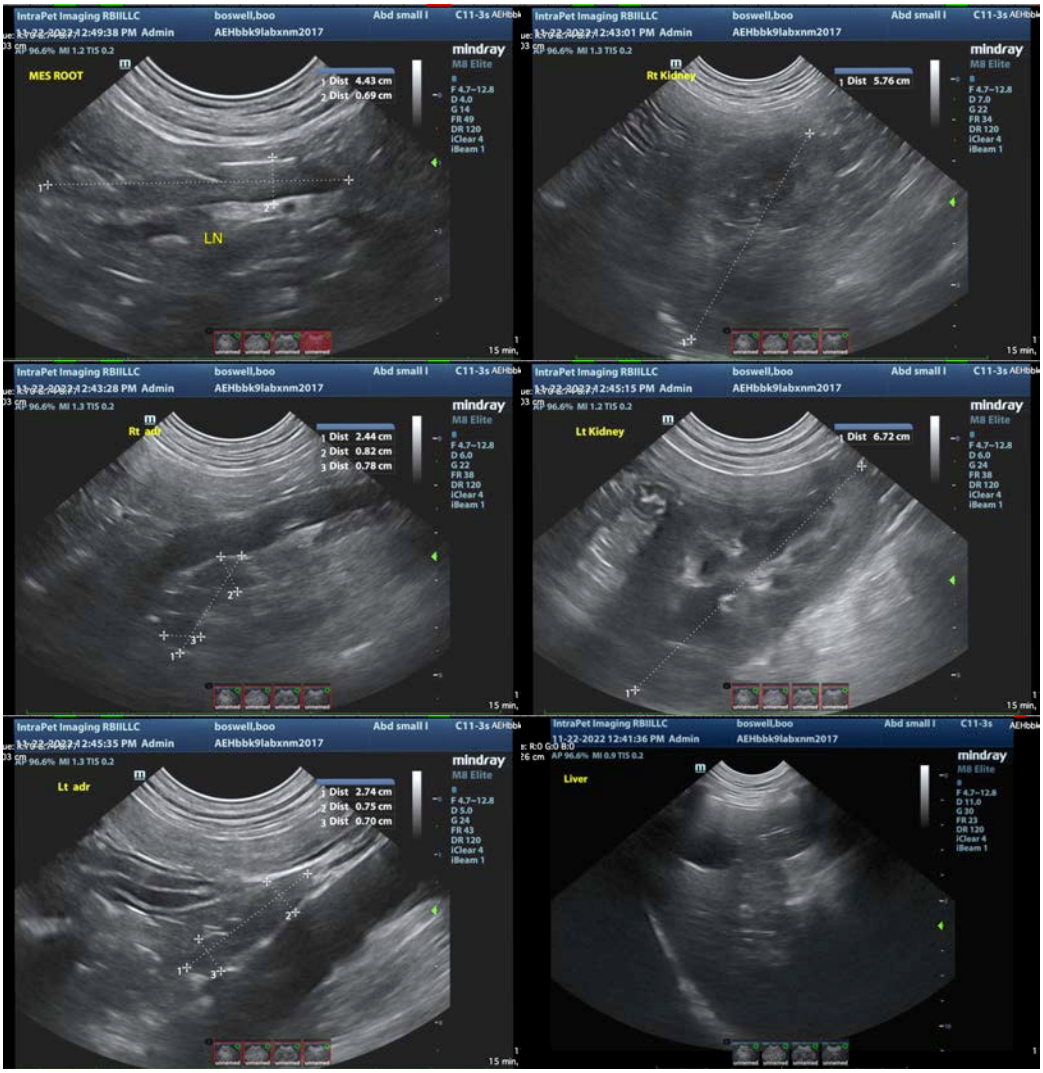
There is a moderate amount of fluid retained in the stomach. This could be due to delayed gastric emptying or gastric ileus, which can be secondary to primary gastrointestinal disease or partial obstruction, but no evidence of an obstruction is visualized. Recommend 3-view thoracic radiographs to evaluate for possible regurgitation. A barium swallow could be considered to evaluate both the esophagus and to look for evidence of delayed gastric emptying.

The bowel appears subjectively thickened. This is mild but could be an indicator for primary gastrointestinal disease.

Consider such differentials as food allergy/dietary intolerance, GI parasitism, pancreatitis, dysbiosis, recurrent dietary indiscretion, IBD and less likely neoplasia, etc.…

- 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.
- Recommend chronic probiotic therapy.
- Recommend screening for Addison's disease.
- If symptoms persist, consider obtaining GI biopsies.





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.

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