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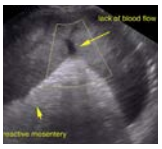
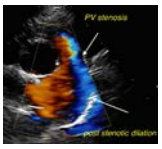
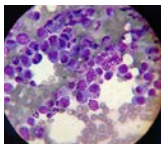
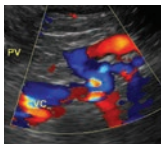

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1-800-838-4268 info@sonopath.com

PATIENT
Lily Nichols

SPECIES
Canine

BREED
Minni Dachshund

SEX
Spayed Female

AGE
11 Years

WEIGHT
13.3 Pounds

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

IMAGING PERFORMED BY
Dr. Adrianne Waffle

HOSPITAL NAME
Torch Lake VC

REFERRING VET
Dr. Adrianne Waffle

INVOICE
33682

DATE
12/23/21

PRESENTING CLINICAL SIGNS

Admitted to ER clinic 12/21 for vomiting and diarrhea of 24 hour duration. Blood noted in stool. Hospitalized at that time. Regurgitation started 12/22 am and has continued for several episodes yesterday and single episode today. No interest in food. Urinating every 2-8 hours.
Abnormal PE/Chem/CBC/UA Results: TPR WNL. Has been tx with cerenia, pantoprazole, plasmalyte 27 mL/hr (D/C this am). Clindamycin 70 mg BID IV. Buprenorphine - .09 mg Q 8 hrs. Metaclopramide - 1.2 mg TID. Sucralfate 500mg Q 8 hrs. Recheck bloods this am rising neutrophilia with L shift. WBC - 20.03, pO2 - 83.9; cSO2 97.2; PCO2 26.7; pH 7.481, iCa - 0.78; BUN 0.6; Lipase – 1808

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 (3.81 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 (3.5 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.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.41 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 0.38 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.

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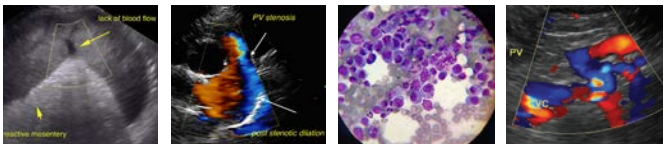

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Gastrointestinal

The stomach is severely dilated with fluid and irregular shadowing material, most consistent with normal ingest and gas. It measures at a normal thickness of less than 0.7 cm with some variability due to the present 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 visible portions of the pyloric outfow tract appear free of obstsruction.

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 measured 0.34 cm. Jejunum wall measured 0.35 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 liquid fecal material and gas shadowing distally. The distal colon appears very mildly thickened at 0.24 cm. There is no evidence of 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, 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 increased echogenicity in the cranial abdomen.

ULTRASONOGRAPHIC FINDINGS

- Severe gastric fluid distention – correlate findings with radiographs. Differentials include delayed gastric emptying or a complete or partial outflow tract obstruction. No obstruction is visualized on today's scan, but this cannot be 100% excluded as a possibility.
- Moderate fluid distention of the colon – This is consistent with the current/impending diarrhea reported.
- Cranial abdominal inflammation – While there is no evidence of an inflamed pancreas visualized, pancreatitis is still a possibility.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is severe gastric distention, which correlates with the regurgitation mentioned in the history. This is typically secondary to severe gastric ileus or an outflow tract obstruction. No evidence of an outflow tract obstruction is observed on today's scan, but continued close monitoring is warranted, as this cannot be completely excluded. Recommend passing a nasogastric tube and emptying the stomach in conjunction with promotility medication (if already given sub q intermittent Metoclopramide, try a CRI) and monitor closely. If gastric distention does not resolve, serial radiographic imaging or exploratory surgery would need to be considered.

Based on the fluid distention of the colon, I suspect ongoing diarrhea in this patient. Diarrhea is more consistent with a gastroenteritis than with an upper GI tract obstruction. Consider a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate to further evaluate for pancreatitis and dysbiosis, etc.

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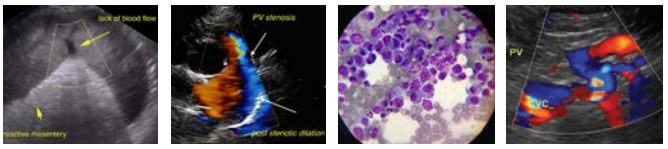

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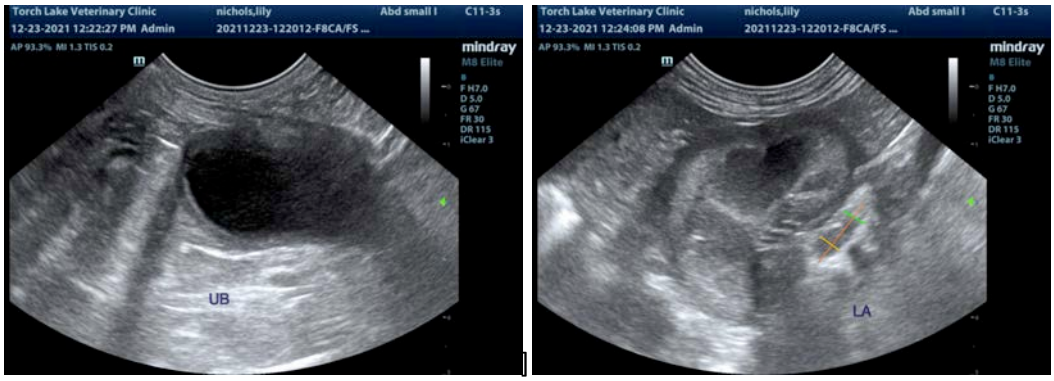
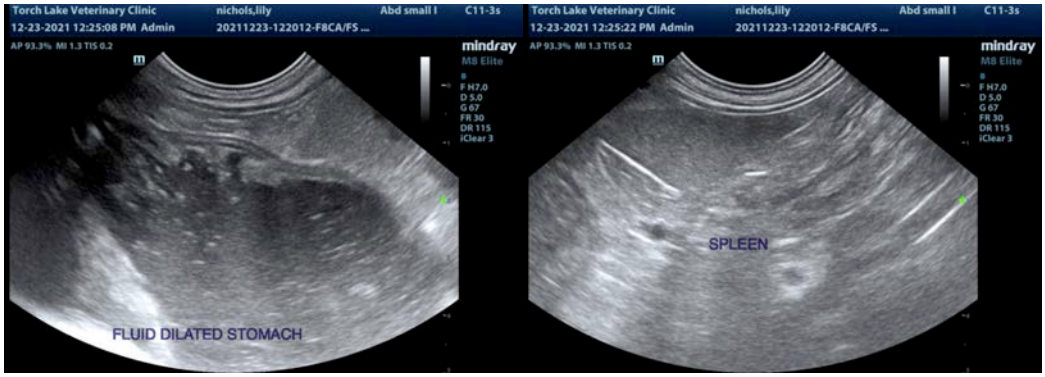
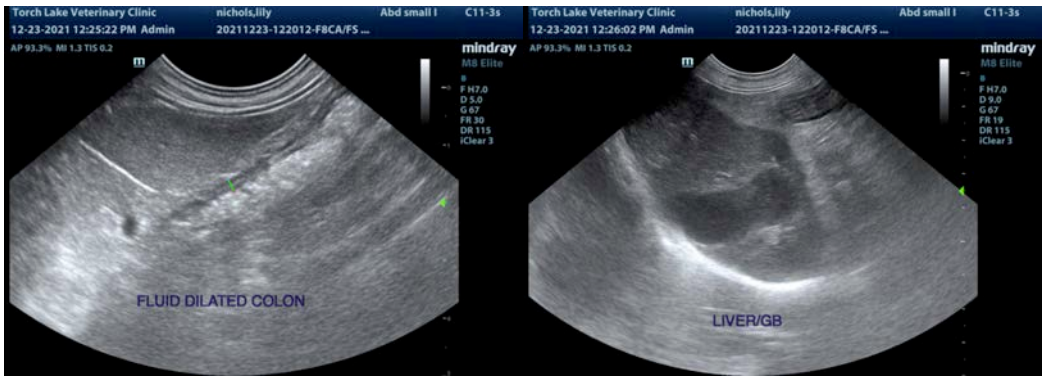
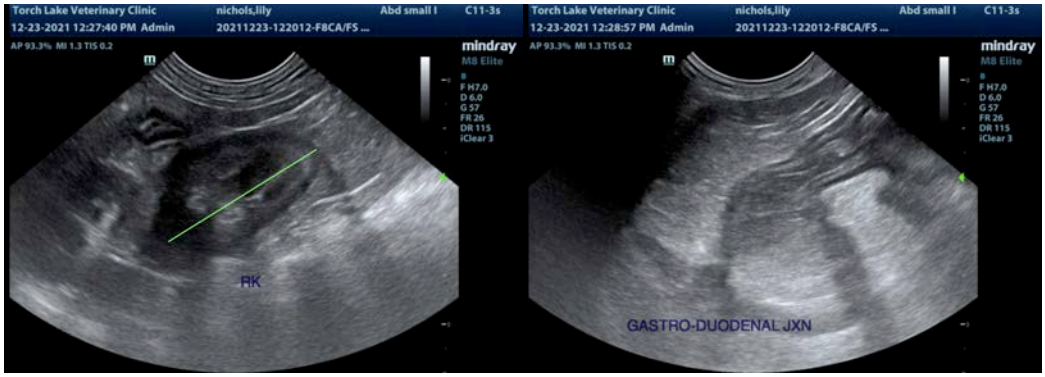
Recommend continued intensive support with fluids, pain medications, promotility medications, antibiotics, etc. Recommend 3-view thoracic radiographs to rule out esophageal disease. Hopefully this is a case of severe gastroenteritis with secondary gastric ileus, but close monitoring is warranted.









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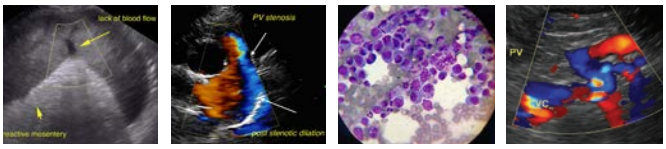

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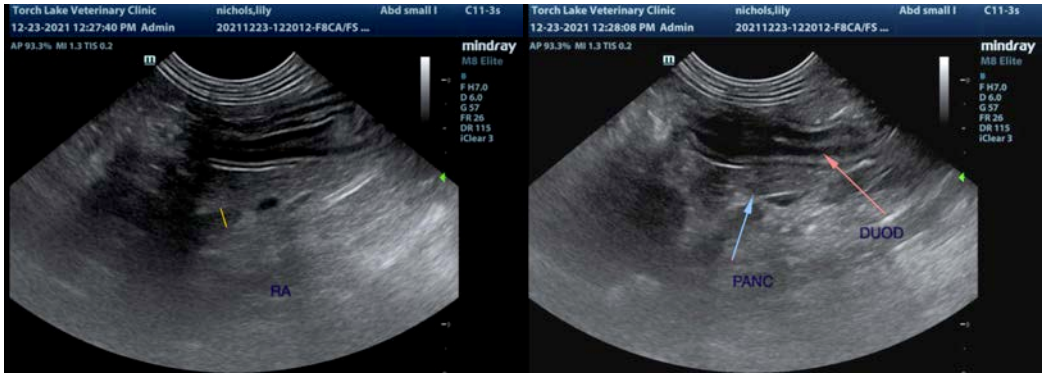

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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