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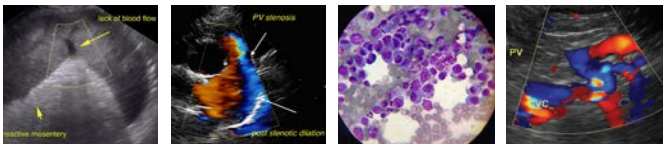

PATIENT
Buddy Keck

SPECIES
Canine

BREED
American Bulldog X

SEX
Intact Male

AGE
6 Months

WEIGHT
54.6 Pounds

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

IMAGING PERFORMED BY
Saum Hadi

HOSPITAL NAME
Bethany Family PC

REFERRING VET
Dr. Kiera Hanrahan

INVOICE
33835

DATE
12/29/21

PRESENTING CLINICAL SIGNS

P has been ADR for the last few days. Ate part of a potty pad prior to symptoms. started vomiting irretractably overnight vomiting white foam- vomited ~ 20 times. unable to keep down water. Abdominal rads with stat consult by a board certified radiologist was WNL. Staff pet.
Abnormal PE/Chem/CBC/UA Results: PE: P quiet, alert, responsive. CBC revealed a mild neutrophilia and monocytosis. Chem + lytes revealed a moderate ALT increase (258 U/L) with BUN low normal (9 mg/dL). Rest WNL. USG: 1.006. Bile acids pending. cpl normal

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 large in size (1.5 cm) but has a regular shape with smooth external margins. The parenchyma is heterogenous but no discrete focal lesions are present. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (5.2 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 (6.5 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 0.65 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 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.

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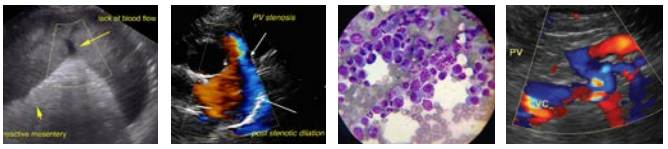

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Gastrointestinal

The stomach is moderately dilated with fluid and some gas. It measures at a normal thickness of less than 0.7 cm 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. The outflow tract appears relatively normal, but there are images with shadowing bowel in that area, which could be consistent with a partial outflow tract obstruction.

The visualized areas of 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 proximal duodenum is of normal thickness and there is some dilation with some shadowing material within. There is evidence of inflammation surrounding this bowel loop. This could be consistent with a partial outflow tract obstruction. Visualized peristalsis appears appropriate. Findings are concerning for a possible proximal duodenal obstruction.

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, 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 around the duodenum.

ULTRASONOGRAPHIC FINDINGS

- Moderately fluid distended stomach with shadowing material within the bowel in the region of the proximal duodenum – Based on the history, signalment, and appearance of this lesion, there is concern for a possible outflow tract obstruction.

- Prostatic enlargement – Prostatic changes are most consistent with benign prostatic hyperplasia. Other differentials include bacterial prostatitis and prostatic neoplasia. However, given the lack of lower urinary tract symptoms, these differentials are considered less likely in this patient.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The stomach is moderately dilated with fluid. On some views, the proximal pylorus appears relatively clear, but as you move distally, there is a section of shadowing bowel, which is concerning for possible outflow tract obstruction/proximal duodenal foreign body. This is not clearly visualized in every view, so it cannot be confirmed, but there is a lack of bowel dilation distally, and there is inflammation surrounding the shadowing bowel, which is concerning for foreign material. Correlate with abdominal radiographs, clinical assessment etc... If the patient continues to not fee well, or concern is high, consider exploratory to evaluate for a foreign body in that area. It is very suspicious.

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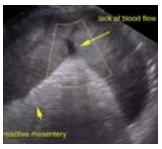
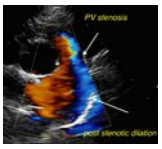
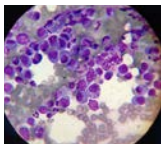
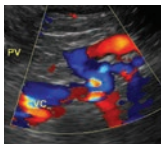

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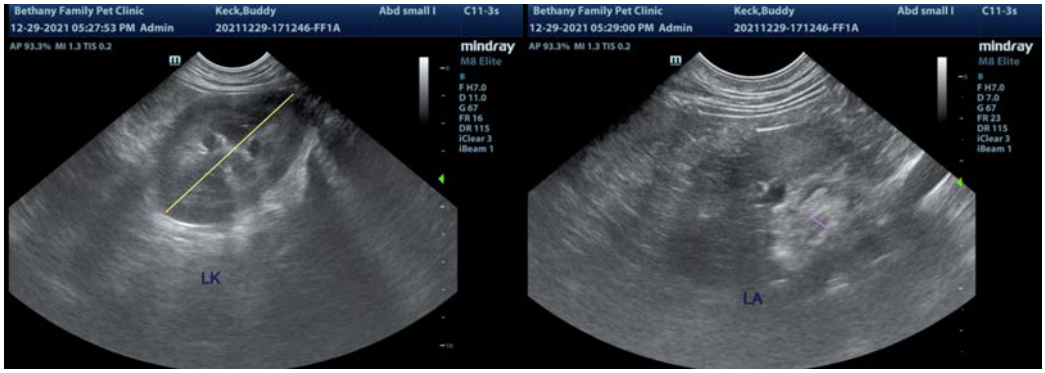

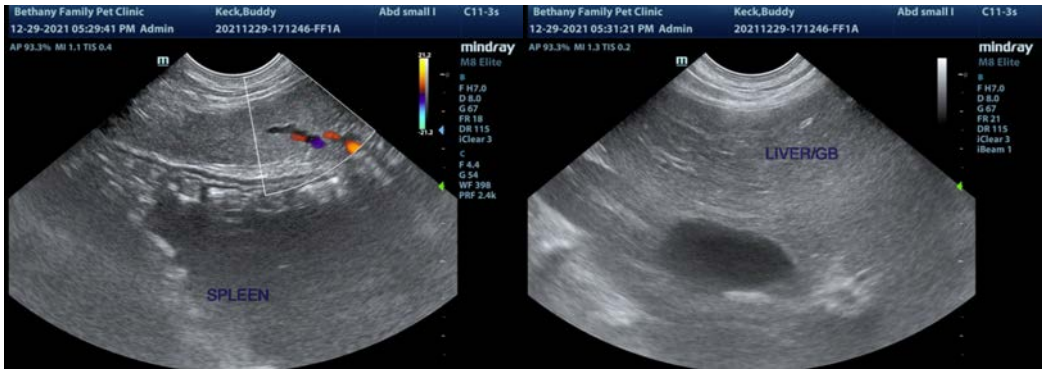

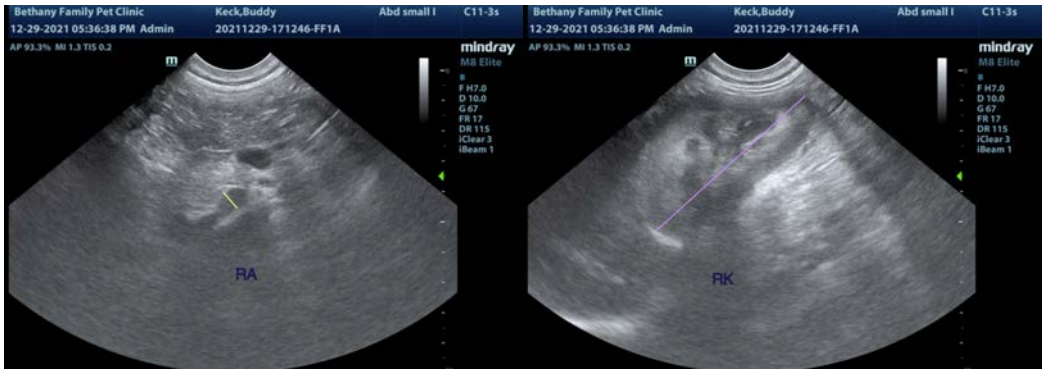

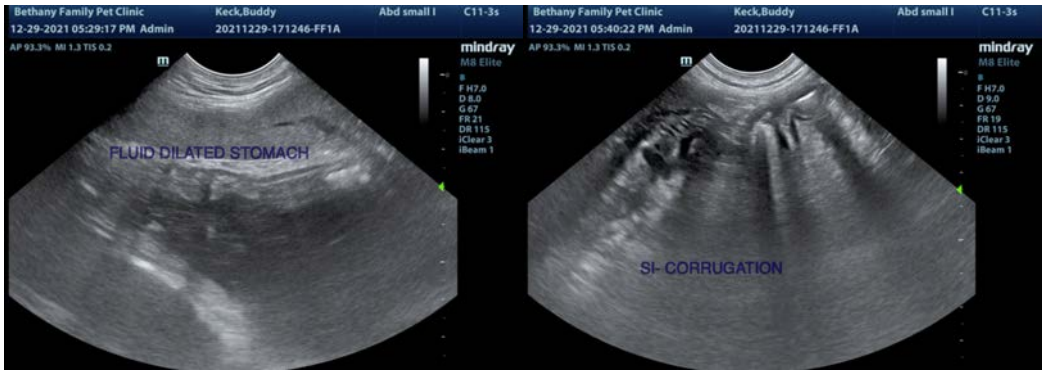

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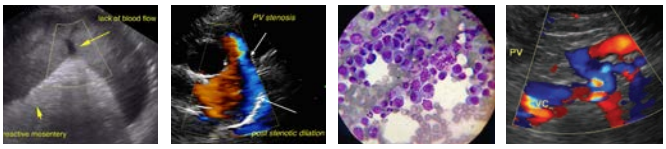

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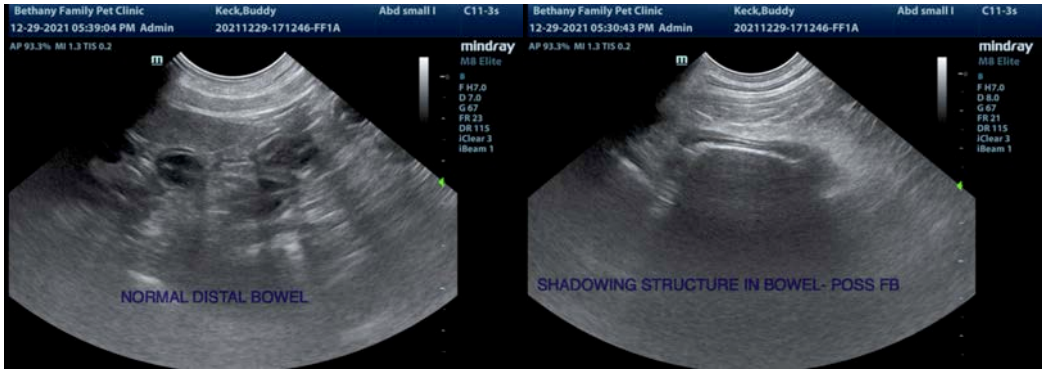

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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