

**DATE PRESENTING CLINICAL SIGNS**

2/17/22 History: Vomiting 3 days, anorexia, polydyspsia. Diarrhea one week ago-- resolved prior to vomiting.

PATIENT

Paxton Toich

Current Medications: Cerenia, IVFT with KCl, Pantoprazole, Unasyn.

Lab Results: WBC elevation. Electrolyte abnormalities.

Radiographs: Radiographs show object of increased opacity in stomach pylorus-- foreign body vs mass.

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: DVM requested stat report.

SPECIES

Canine

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**BREED**

Beagle

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.

SEX

Neutered Male

The prostate is normal in size (1.0 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.

AGE

2/16/16

The left kidney has a normal shape and size (5.79 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.

WEIGHT

31.9 Pounds

The right kidney has a normal shape and size (6.04 cm) with pinpoint non-obstructive nephroliths. 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.

INTERPRETED BY

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

Adrenal Glands

The left adrenal gland is normal in size measuring 0.79 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.

IMAGING PERFORMED BY

Stephanie Pearce
RDCS, RVT

The right adrenal gland is normal in size measuring 0.71 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.

HOSPITAL NAME

Eastern AH

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.

REFERRING VET

Dr. Sole

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.

INVOICE

35691

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 moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach is significantly distended with fluid and irregular shadowing material, most consistent with foreign ingested material. It measures at a normal thickness of <0.7 cm with some variability due to the presence of rugal folds. The distinction of gastric wall layering adequate. There is the impression of a partial or complete gastric obstruction with possible foreign material in the pylorus.

Many of the areas of particularly proximal duodenum and mid abdominal jejunum appear dilated and somewhat plicated with hard shadowing foreign material within the lumen. Wall thickness largely appear normal with intact wall layering. The duodenum measures normal between 0.3-0.5 cm in wall thickness. The jejunum measures as normal. Visualized peristalsis appears appropriate. Findings are most consistent with intraluminal foreign material.

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

There is scant free abdominal fluid. No lymphadenomegaly. There is hyperechoic omentum in the cranial abdomen.

PRIMARY FINDINGS

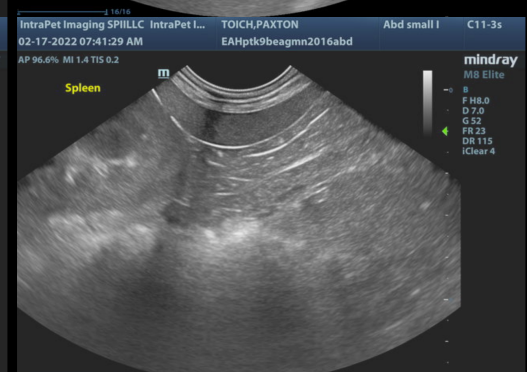
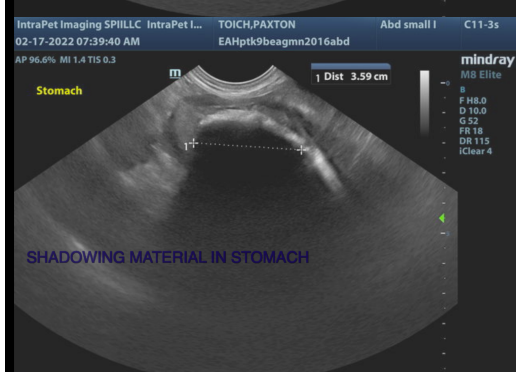
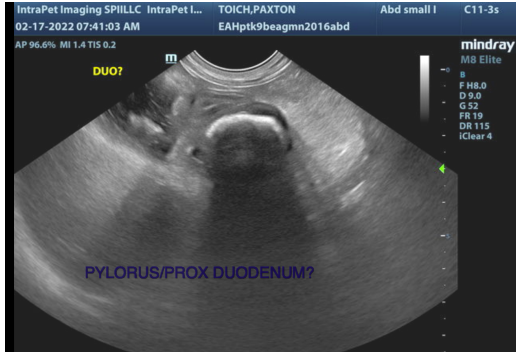
- Severe gastric distention with fluid and shadowing foreign material in the area of the pylorus, suggestive of a partial to complete gastric outflow tract obstruction.
- Small intestinal fluid dilation with plication and shadowing material within the lumen – Findings are most consistent with ingested foreign material. There is concern for both material in the proximal duodenum and mid jejunum.
- Scant free abdominal fluid

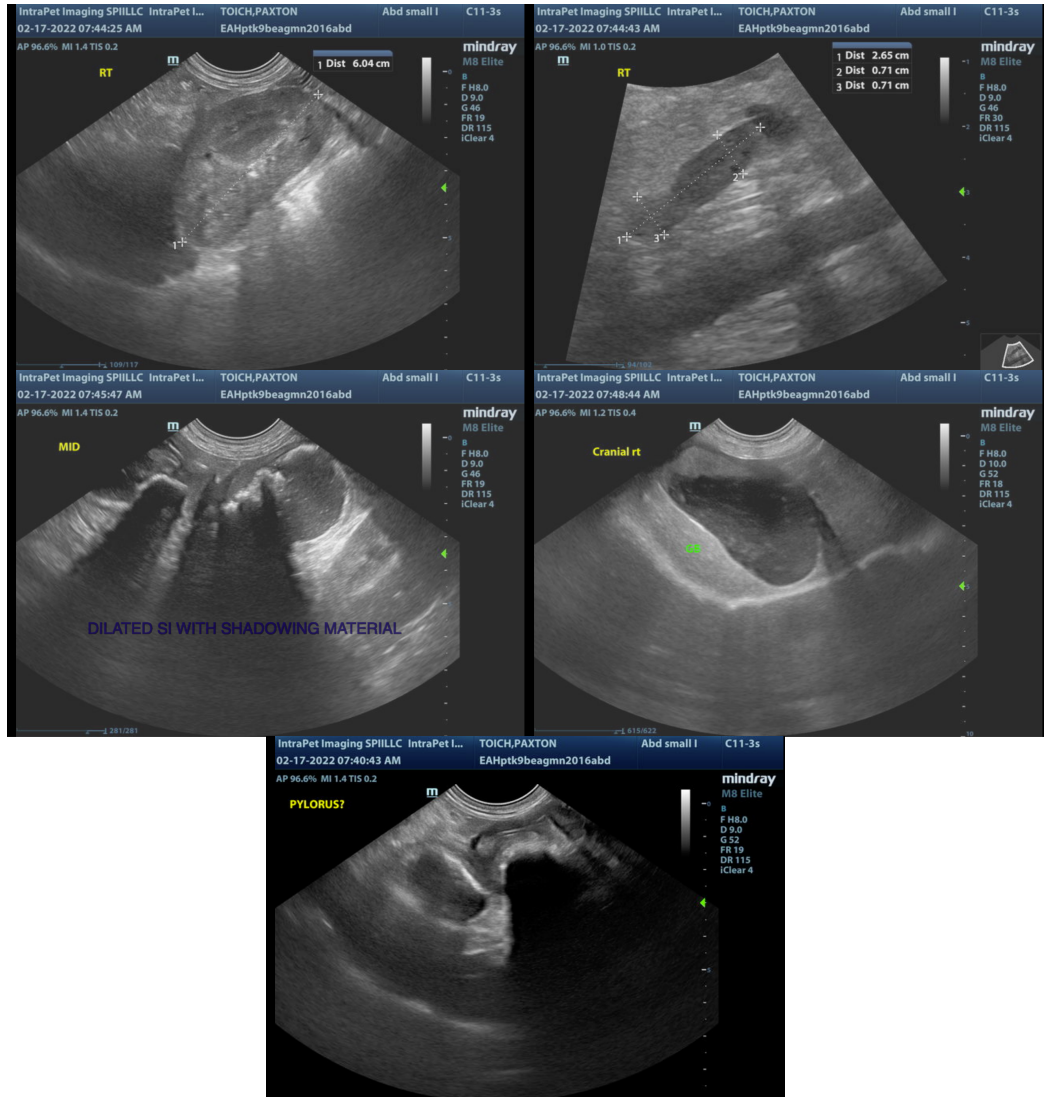
SECONDARY FINDINGS

- Moderate gallbladder debris – The significance of the aggregated gallbladder sludge is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The stomach is dilated and appears at least partially obstructed with shadowing foreign material in the area of the pylorus. The proximal duodenum appears somewhat plicated with shadowing material, and there is fluid distention in the more distal areas of small bowel with shadowing material. It is not clear if some of the more distal foreign material could pass, but with the combination of foreign material and the suggestion of an obstruction in multiple areas of the GI tract, I would recommend correlating these findings with radiographs and considering exploratory surgery once this patient is stabilized.





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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