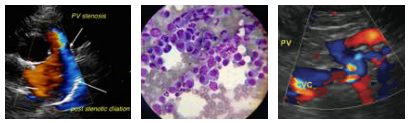
IMAGING PERFORMED BY

IntraPet.com



SonoPath
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DATE
2/8/22

PATIENT
Ginger Angelini

SPECIES
Canine

BREED
Maltipoo

SEX
Spayed Female

AGE
11/4/17

WEIGHT
11 lbs

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

HOSPITAL NAME
Animal Emergency Hospital

REFERRING VET
Dr. Saubier

INVOICE
95880

PRESENTING CLINICAL SIGNS

History: Presenting Complaint: Vomiting; Not Eating History: Date: 02-07-2022 Notes: Seen AEH 2/1/2022 - vomiting, had been given a new treat. Full BW at that time- elevated Lipase Was admitted - treated with IV fluids and symptoms improved. Did not eat in hospital - difficult to syringe feed - aggressive. Owner elected to try at home. Discharged with: Proviable, Entyce, Ondansetron, Famotidine and Clavamox Rechecked 2/6 - vomiting - SQ fluids and Maropitant injection given. Returned today - not eating this morning, vomited after drinking water, plan for abdominal US tomorrow. Assessment: Pancreatitis / vomiting / anorexia. Plan: Admit into hospital - IV fluids and continued care for vomiting / pancreatitis - US tomorrow.
Current Medications: Buprenex, Cerenia, Pantoprazole, Ampicillin.
Lab Results: PCV/TS 56%, 5.2. NA 153, K 3.5, Na/K 44, Cl 112.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Rachel Brilhart, RDMS.

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 (3.45 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. Rare, pinpoint, non-obstructive nephroliths were noted. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.25 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. Rare, pinpoint, non-obstructive nephroliths were noted. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.47 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 0.63 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 gallbladder 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, 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 duodenum measured as normal (0.31 cm) and the jejunum measured as normal (0.21 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 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 normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS
PRIMARY FINDINGS:

- Rare, non-obstructive pinpoint nephroliths in both kidneys. The hyperechoic mineralized foci observed at the corticomedullary junction of the both kidneys are consistent with small, non-obstructive nephroliths.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There are no significant lesions visualized associated with the GI tract or pancreas. Unfortunately, there are many causes for vomiting and anorexia which cannot always be diagnosed by ultrasound alone.

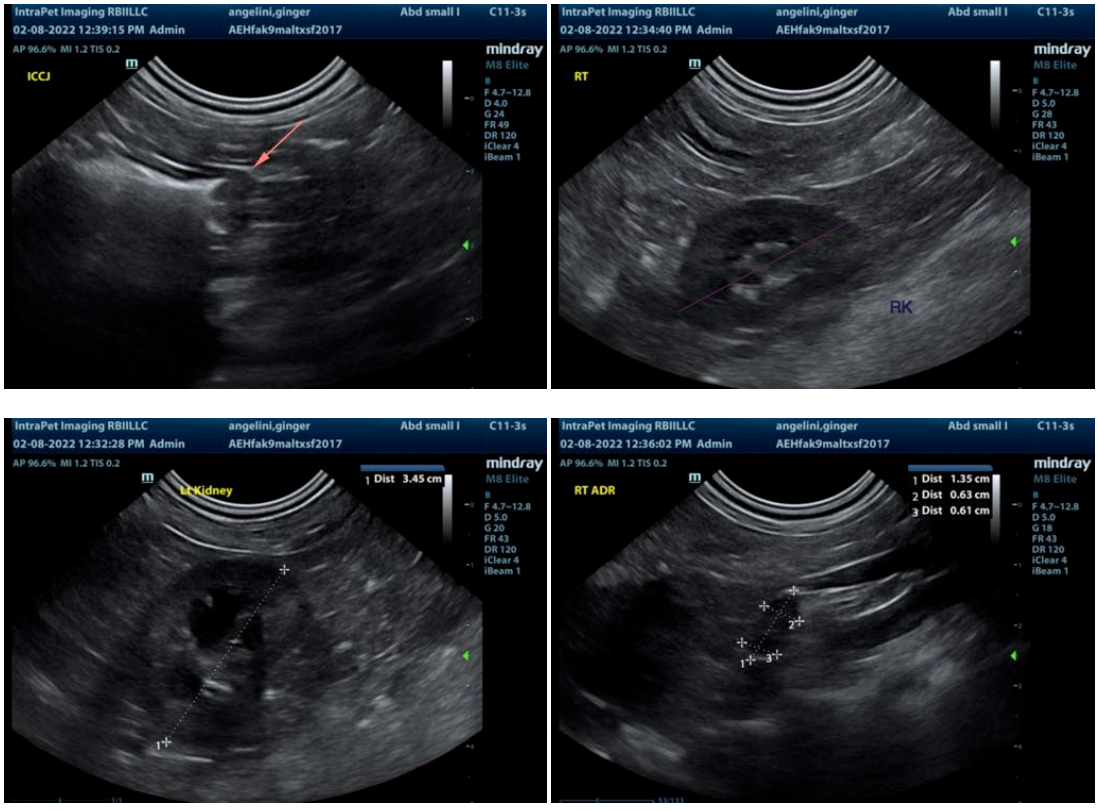
- Consider metabolic causes based on blood work, ACTH stimulation results, liver function testing, GI panel (TLI, PLI, cobalamin and folate).

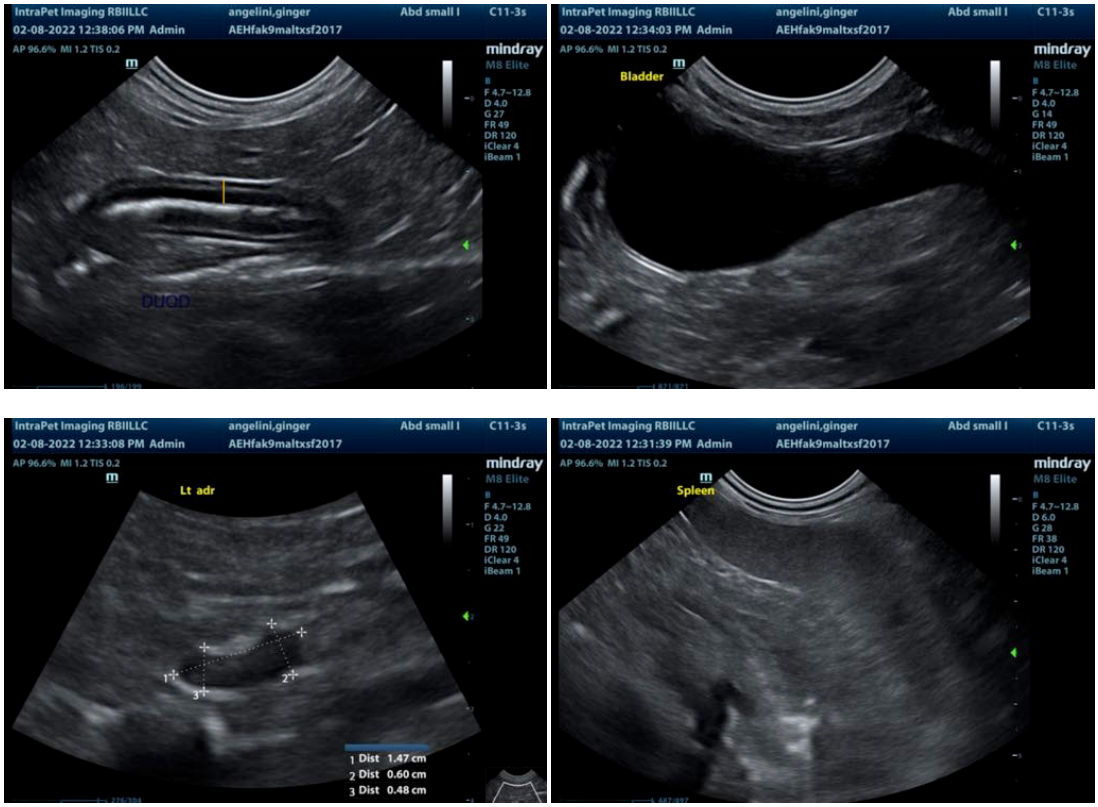
- Consider primary GI causes such as GI parasitism, dietary indiscretion/foreign body, mild pancreatitis, bacterial dysbiosis, food allergy, IBD and less likely intestinal neoplasia.

If primary GI disease is suspected In young patients with acute signs I would most strongly consider dietary indiscretion, ingestion of foreign material/FB, Gi parasitism, Addison's disease and pancreatitis, acute colitis/gastroenteritis. Serial radiographs for evaluation of progressive obstruction/partial obstruction/foreign material is warranted.

Recommend symptomatic therapy and close monitoring, if symptoms persist, re-evaluate and consider surgery/endoscopy to obtain biopsies and evaluate for foreign material.

- I recommend diet trial with a novel protein/hydrolyzed protein prescription diet.
- GI panel
- Baseline cortisol
- Consider GI exploratory to rule out foreign body and obtain GI biopsies if the symptoms are persistent.





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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