



**PATIENT**

Cooper Battaglia

**SPECIES**

Canine

**BREED**

Boxer

**SEX**

Neutered Male

**AGE**

7 Years

**WEIGHT**

70 Pounds

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Carter

**HOSPITAL NAME**

Willamette VH

**REFERRING VET**

Dr. Martiny

**INVOICE**

46110

**DATE**

3/23/23

**PRESENTING CLINICAL SIGNS**

3.19.23 ER HX: \_The pt ate his breakfast yesterday then V+ 2 hrs after. The pt started being leth and eating grass. The pt cont to V+ through the day and night bile. The pt is very leth and seems to be uncomfortable. The O said no D+ noted ur wnl and Drinking Wnl. The pt has a hx of panc and had a FB sx last year. Immune IBD diag last year after his fb SX. The fb sx was an enterotomy no R & A was done. O doesn't know of any FB consumption recently 3.22/23 MPE ER HX: D/C monday 3/20. Has not V+, an hr before their next medication to be taken O noted pt seems to get uncomfortable begins to pant a lot but not described to be considered as difficulty breathing. E/D/UR/BM- pts eating habits have not been great,=, has had small BM's they've been soft lately, 2 tablespoons of D+ yest. drinking water fine, UR wnl, no signs of C/S. O has not seen pt attempt to eat grass doesn't seem too lethargic but pt doesn't really have desire to do anything since pt has been home. O would describe pt not being their normal self, has been drooling, does not feel bloated but does seem a little uncomfortable here & there.

Abnormal PE/Chem/CBC/UA Results: CONCLUSIONS: 1. Minimal residual gastric and small intestinal material could be due to delayed transit and delayed gastric emptying, though foreign material within the stomach is also considered, given time since last radiographs and persistence. There is no evidence of small intestinal obstruction, though residual mild positive contrast could indicate some foreign material without dilation.

**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 (1.4 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 (5.73 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 (7.78 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 0.64 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 region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.



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**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 hilum 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 mild and primarily anechoic. The cystic and common bile ducts are normal/not visible.

**Gastrointestinal**

The stomach is mildly to moderately distended with fluid and some rounded hyperechoic, mildly shadowing material. The gastric wall largely appears to be of normal thickness. In some images, there is questionable thickening at the gastroduodenal junction/pylorus where there is a large amount of surrounding inflammation. Gastric fluid appears mobile and gives the impression of reduced progressive motility. No hard shadowing material is visualized.

Most of the visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal to mild 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 measures 0.63 cm. Jejunum wall measures 0.42 cm. Visualized peristalsis appears appropriate. There is a lot of focal inflammation visualized in the right cranial abdomen. The pylorus appears somewhat prominent, and more distally there is a section of bowel with focal dilation with no apparent shadowing material. This could be fluid or even thickened hypoechoic wall. This section of bowel measures 1.8 cm in diameter.

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**

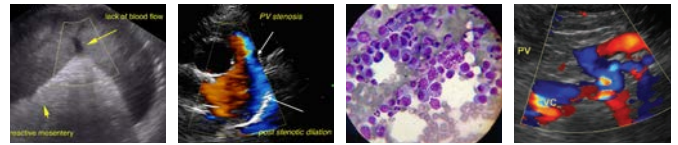
The pancreas is large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with mild pancreatitis, primarily in the right limb.

**Free Abdomen**

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is no lymphadenopathy, but there is significant inflammation in the right cranial aspect of the abdomen.

**ULTRASONOGRAPHIC FINDINGS**

- Prominent, hypoechoic right limb of the pancreas – The pancreatic changes are most consistent with mild pancreatitis/pancreatic inflammation. Recommend fPLI testing and continued monitoring for improvement or possible development of a pancreatic abscess. Consider fine needle aspirate if not improving.



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- Mild amount of fluid in the stomach with some hyperechoic soft shadowing material and lack of progressive motility – Findings could be consistent with a partial outflow tract obstruction or delayed gastric emptying.

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- Questionable thickening of the pyloric wall – The stomach wall thickening could be consistent with inflammation, edema, infiltrative neoplasia, imaging artifact due to rugal folds, other.

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- Focal small bowel dilation – The significance of this lesion is unclear. This could represent an area of fluid accumulation secondary to an obstruction that is not readily visualized. Additionally, it could represent partially thickened hypoechoic wall and a small mass effect.

**SEX**

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

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There is a large amount of inflammation in the right cranial abdomen. The single source of this inflammation is not readily apparent. There is a small amount of foreign material visualized within the stomach. This does not appear particularly obstructive, but there is a lack of progressive motility noted of the fluid. Subjectively, the pyloric wall appears somewhat irregular and thickened. This could be due to focal inflammation, edema, or even neoplastic infiltrates.

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Additionally, the right limb of the pancreas appears inflamed in this region. This could be a primary source of vomiting or be secondary to inflammation due to other causes.

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Additionally, more distally, there is a focal section of small intestine that appears dilated and has questionable wall thickening. This could represent a small area of obstruction, an early mass effect, etc.

Unfortunately, there is no definitive lesion here, but many suspicious areas. Options moving forward would be to continue medical management, treating for gastroenteritis, pancreatitis, etc., and serial imaging (radiographs +/- barium), or you could consider surgical explore to evaluate the abnormal section of bowel, the thickened pylorus, etc.

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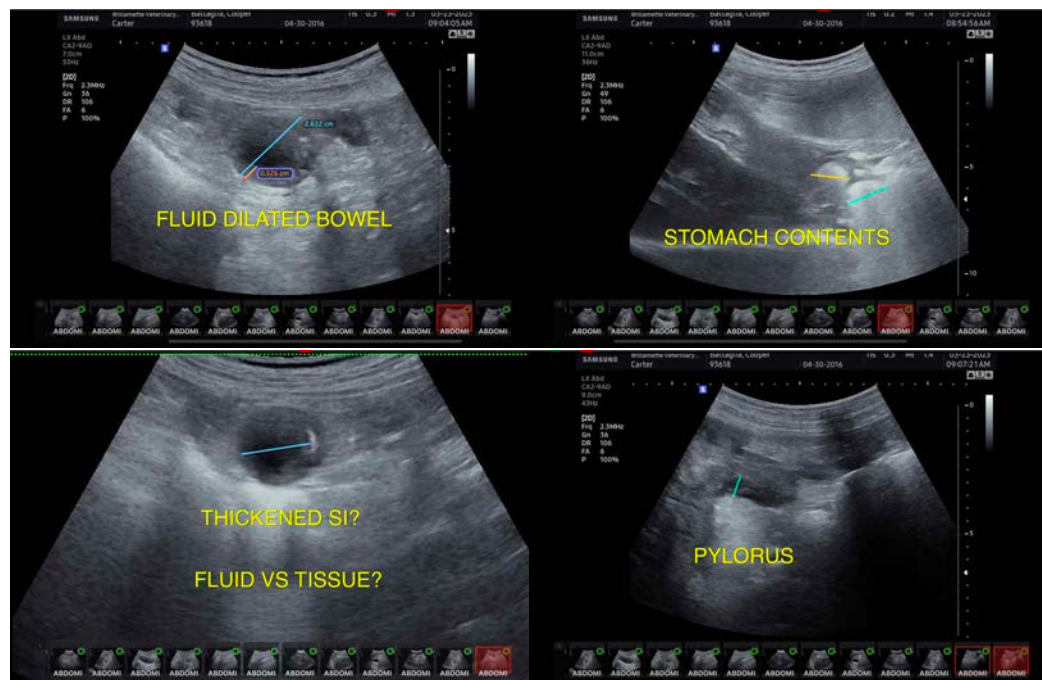
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