



PATIENT

Finn Torre

SPECIES

Canine

BREED

Miniature Poodle

SEX

Intact Male

AGE

13 Weeks

WEIGHT

10.6 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Diane McFadden

HOSPITAL NAME

AH of Roxbury

REFERRING VET

Dr. Elia

INVOICE

45815

DATE

3/9/23

PRESENTING CLINICAL SIGNS

giardia positive 3/3/23, finished panacur. Still having loose stool and vomiting for the past few days. decreased appetite, lethargic, mild pain cranial abdomen. On famotidine and fortiflora. Rads unable to R/O obstruction, not definitive; repeated fasted rads - gas pattern.
Abnormal PE/Chem/CBC/UA Results: Parvo snap neg; Phos 8, Mg decr 1.4, alylase decr 287, PSL decr 18, decreased neuts and lymphs

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 (0.74 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 (4.54 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 (4.97 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 0.41 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 0.32 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 mild and primarily anechoic. The cystic and common bile ducts are normal/not visible.



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Gastrointestinal

The stomach contains minimal luminal contents. The gastric wall is very prominent in some views with extensive rugal folding. There is the suggestive appearance of thickened gastric wall with a measurement of 0.65 obtained (normal is <0.70 cm). 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. Findings are most consistent with gastritis, but continued monitoring is warranted.

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 measures 0.36 cm. Jejunum wall measures 0.30 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 non-formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering. Colon wall measures 0.16 cm.

Pancreas

The pancreas is mildly prominent and hypoechoic as compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

There is mild inflammation in the cranial abdomen in the region of the stomach. There is a diffuse mild mesenteric lymphadenopathy with isoechoic lymph nodes measuring 0.63, 0.54, 0.52, and 0.96 cm in diameter. The omentum is mildly hyperechoic.

ULTRASONOGRAPHIC FINDINGS

- Mildly prominent, hypoechoic pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Prominent/mildly thickened gastric wall – Wall layering remains intact. Findings could be consistent with gastritis.
- Mild mesenteric lymphadenopathy – Prominent lymph nodes can be normal in young dogs.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized associated with the gastrointestinal tract to explain the vomiting reported. There is no evidence of an obstructive pattern, although I cannot definitively rule out the possibility of an ingested foreign material. Additionally, the gastric wall appears very prominent with prominent rugal folding. This is likely secondary to gastritis, but if symptoms persist, further evaluation could be warranted.

In a dog this age, the most common differentials to consider for diarrhea and vomiting include dietary indiscretion, GI parasitism, food allergy/dietary intolerance, dysbiosis, much less likely IBD neoplasia, etc. Additionally, recommend bloodwork to evaluate for metabolic causes, and consider a baseline cortisol to screen for Addison's disease.



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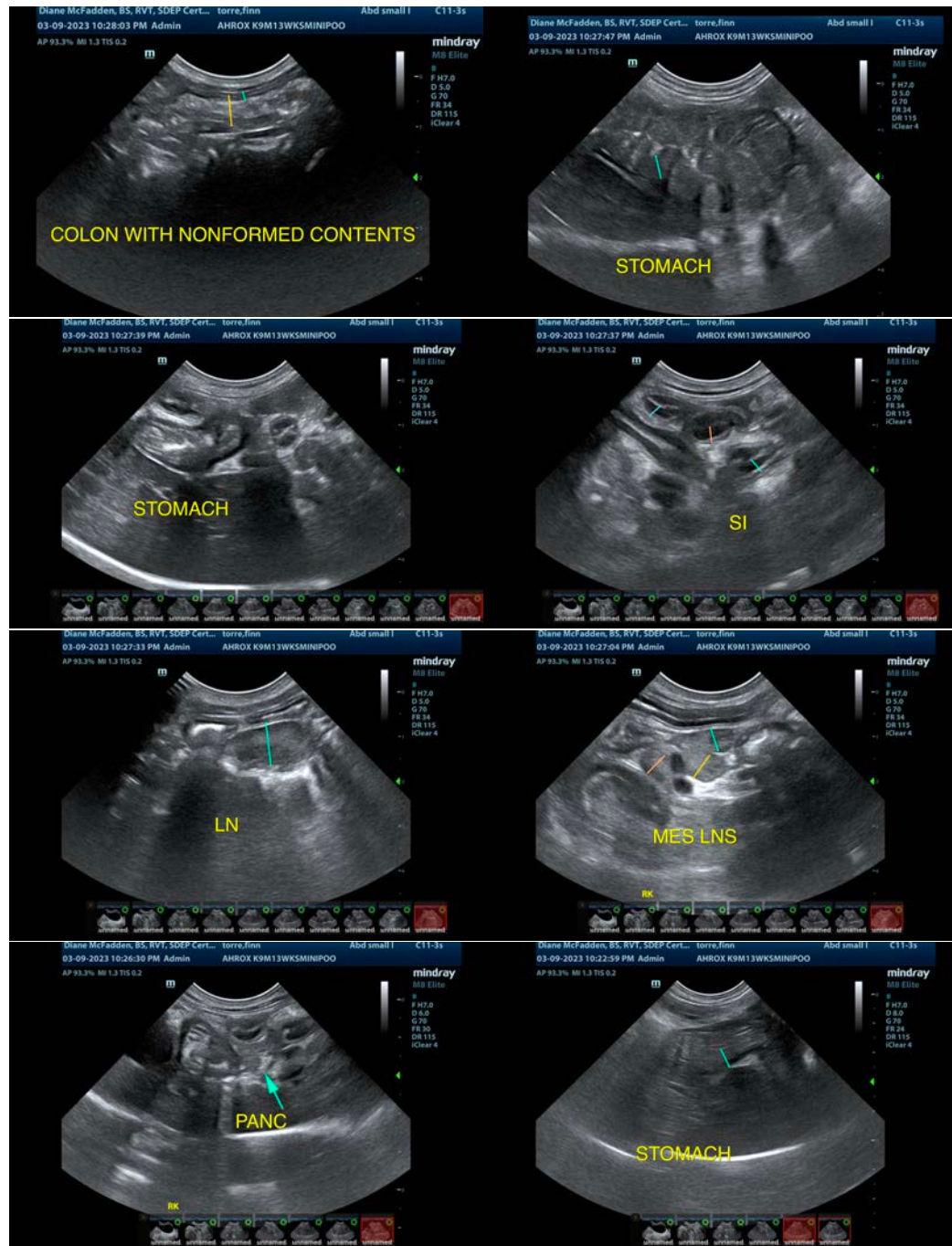
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- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- Recommend parasite screening and empirical therapy (I believe this has already been done).
- Recommend pre- and probiotic therapy.

If symptoms persist, recommend serial imaging, and consider further exploration if ingested foreign material is a large concern.





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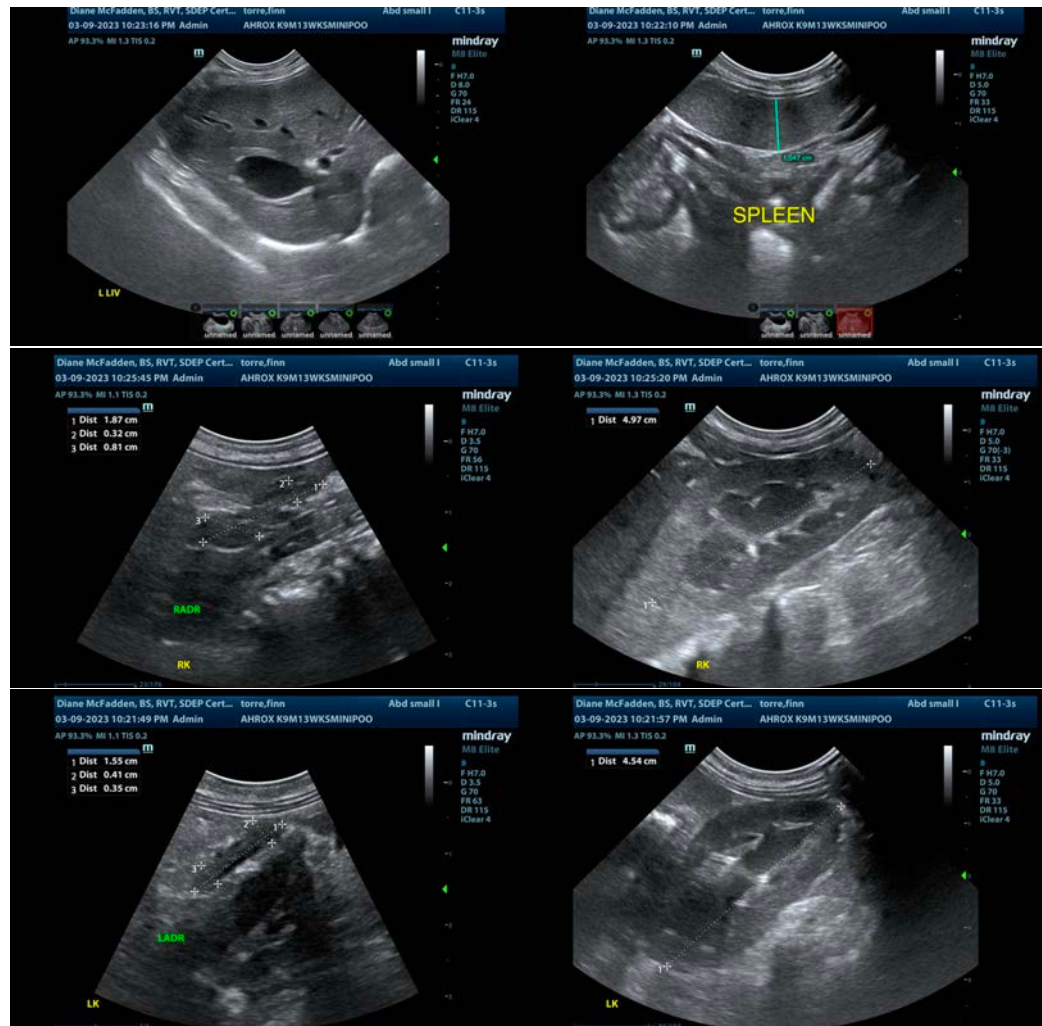
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

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