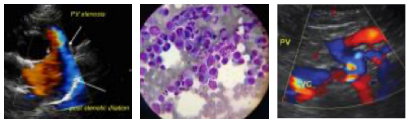
IMAGING PERFORMED BY

IntraPet.com



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DATE

4.28.2023

PATIENT

Molly McCarthy

SPECIES

Canine

BREED

Beagle

SEX

Female Spayed

AGE

9/20/2019

WEIGHT

36.2 lbs

INTERPRETED BY

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

HOSPITAL NAME

Chadwell AH

REFERRING VET

Dr. Mengers

INVOICE

12894

PRESENTING CLINICAL SIGNS

ER presentation for suspect HGE on 4/5/22. Bloody diarrhea and vomiting. Doing well now but similar occurrence around the same time last year.

Current Medications: No current meds at the time of 2 wk post-ER recheck; left ER on the following meds Clavamox Tablets 250mg - Give 1 BID for the next 7 days, Metronidazole Tablets 250mg - Give 1 BID for the next 7 days, Ondansetron 8mg - Give 1 tablet BID, Gabapentin 100mg -Give 2 capsules by mouth every 8 hours if/ as needed for pain, Sucralfate Tablets 1gm - Mix 1/2 tablet with water in provided syringe to form a slurry. Give slurry by mouth every 8 hours for the next 6 days. Omeprazole Capsules 10mg - Give 1 BID for the next 7 days, Entyce soln. 30mg/ml - Give 1.5 mL by mouth every 24 hours if/as needed for appetite stimulant, Proviable Kit - 3ml paste by mouth every 8 hrs x 3 days then 1 cap over food once daily until gone

Lab Results: At ER, consistently low total prot and albumin, electrolyte abnormalities consistent with vomiting, low total solids and high PCV consistent w/ hemoconcentration
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Torbugesic IV.
Stat Report: Not requested.
Imaging Performed By: Stephanie Warga RDCS, RVT.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with echogenic 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 (5.54 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 (4.94 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 0.43 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 0.64 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 borderline small, 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 gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contains moderate debris. The cystic and common bile ducts are normal/not visible.

Gastrointestinal
The stomach is moderately dilated with fluid and irregular shadowing material most consistent with normal ingesta and gas. 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 layering 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 uniform diameter (duodenum 0.49 cm / jejunum 0.34) with minimal fluid distension. There is mild mucosal speckling of the duodenum. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. 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.

Other
A normal appearing uterine stump is visualized.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Echogenic debris in the urinary bladder - The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus. Recommend urinalysis and culture.

- Moderate gall bladder debris - The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting but seems unlikely to be causing a current issue. Recommend continued monitoring.

- Large shadowing ingesta within the gastric lumen - Correlate with the feeding history and abdominal radiographs. If the patient was adequately fasted consider such differentials as delayed gastric emptying, a partial outflow tract obstruction (none seen) or ingested foreign material.

- Prominent small intestine with mild mucosal speckling - Bright mucosal speckling has been postulated to represent dilated lacteals or focal accumulations of mucus, cellular debris, etc. in the mucosal crypts.

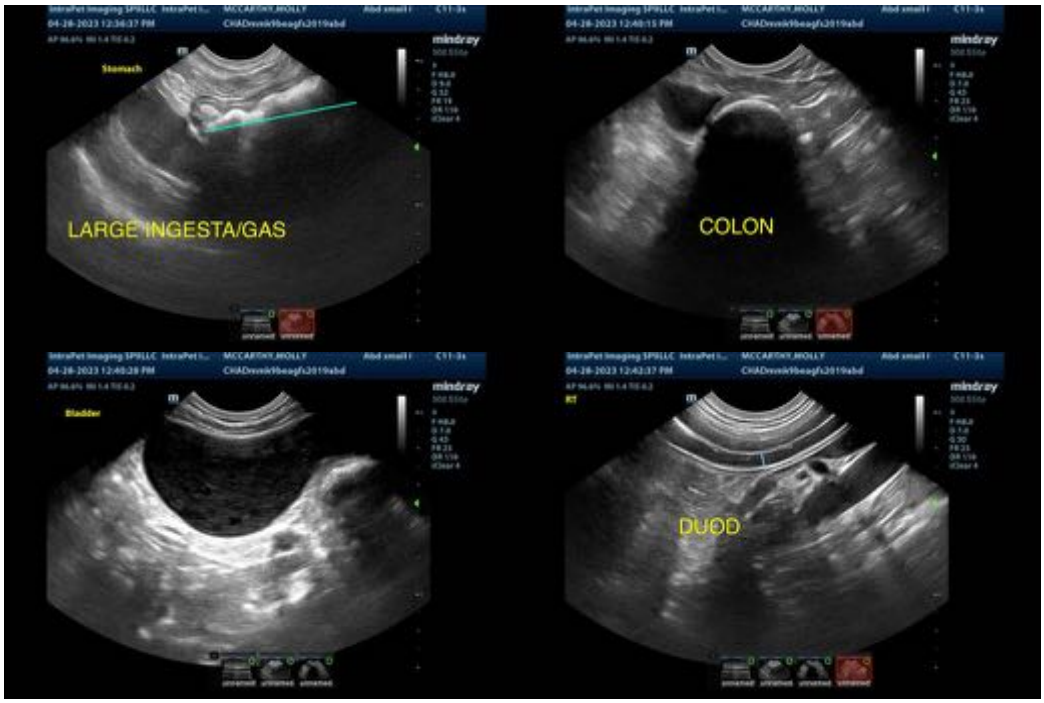
Secondary Findings

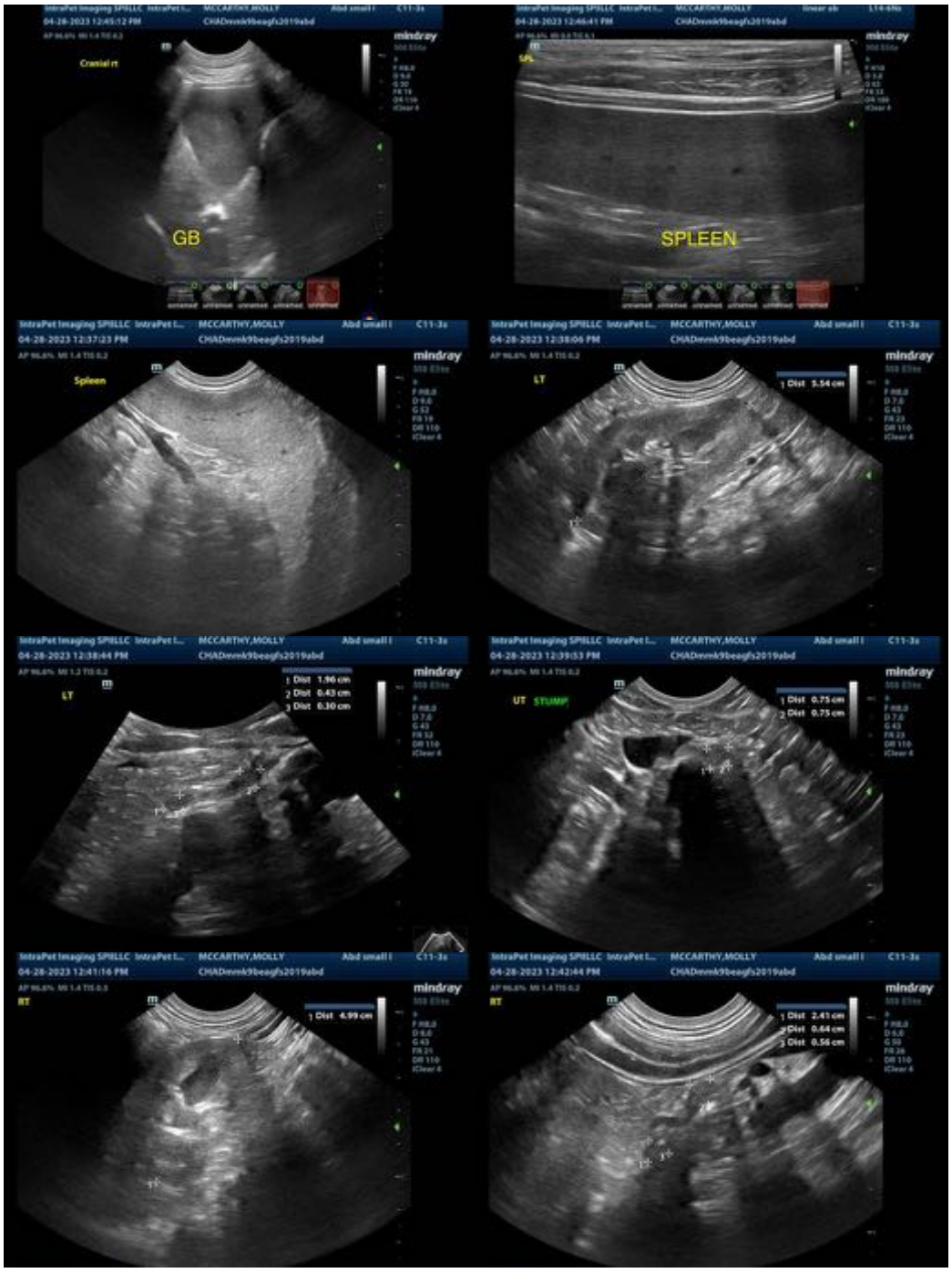
- Borderline small liver. This is mild and subjective. Correlation with the abdominal radiographs. If confirmed, consider liver function testing.

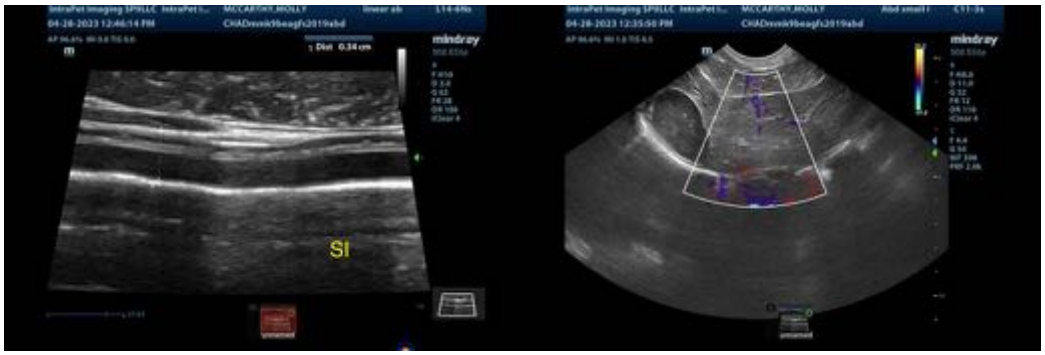
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes observed on today's scan are relatively mild. No focal GI lesions are observed, and I do not see any evidence of pancreatic inflammation. The small bowel appears slightly prominent, and there is some mild mucosal speckling. This could be consistent with a primary enteropathy if this is suspected, but I would expect those symptoms to be more chronic in nature.

Unfortunately, the true cause for HGE is not known, so it is difficult to prevent. Close evaluation of the timeline for similarities (i.e., any dietary indiscretion, change in food, stress, etc.) is recommended. I would consider starting chronic probiotic therapy, as this does seem to have a significant bacterial component. Additionally, if symptoms persist, you could consider screening for Addison's Disease. If chronic GI signs are present, then I would consider a novel protein/hydrolyzed protein diet prescription diet. I would consider a GI panel to Texas A&M for a qualitative TLI, PLI, cobalamin and folate. If symptoms are persistent, you could consider obtaining GI biopsies.




Cranial rt
GB
SPL
SPLEEN
Spleen
LT
1 Dist 3.54 cm
LT
1 Dist 1.96 cm
2 Dist 0.43 cm
3 Dist 0.30 cm
UT STUMP
1 Dist 0.75 cm
2 Dist 0.75 cm
RT
1 Dist 4.99 cm
RT
1 Dist 2.41 cm
2 Dist 0.64 cm
3 Dist 0.56 cm



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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