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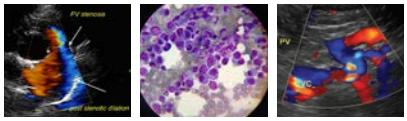
IntraPet.com



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**DATE**

5/24/22

**PATIENT**

Sebastian Betley

**SPECIES**

Canine

**BREED**

American Staffordshire Mix

**SEX**

Neutered Male

**AGE**

4/30/20

**WEIGHT**

68.6 Pounds

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Rachel Brilhart RDMS

**HOSPITAL NAME**

Animal Emergency Hospital

**REFERRING VET**

Dr. Goessling

**INVOICE**

37906

## PRESENTING CLINICAL SIGNS

Patient presented for acute Onset of bloody vomit and bloody diarrhea since yesterday morning. He is also not eating and not drinking. There has been no diet change. He has had ongoing GI issues for several months. He initially saw his regular veterinarian March 15 for blood in his stool, was softer stool with blood at the end. He was prescribed metronidazole and proviable forte, continued to have symptoms. Owner reports patient had had blood work the month prior that showed dehydration per their regular veterinarian. He had a negative fecal at the March 15 appointment. Patient continued to have waxing and waning GI symptoms. On April 7, he was seen by a different veterinarian and via fecal wet Mount, was diagnosed with bacterial overgrowth. A second fecal parasite screen was also negative for parasites. He was sent home with metronidazole and fortiflora, no changing condition was noted. It was recommended to try over-the-counter sensitive stomach food if his symptoms persisted. He had full blood work and x-rays at that visit. He was then seen on April 18 for vomiting and not eating, had lost 5 pounds since the April 7 visit. At that time he was prescribed sucralfate and panacur but vomited up the panicure upon administration. He was most recently seen on May 16 for ongoing symptoms and had blood work repeated. Per regular veterinarian, blood work showed dehydration. Owner reports that since the March 15 visit, she has noted patient is constantly smacking his lips and he does not chew on his toys and things like he use to. She has also noticed him scratching at his face and neck and feels that his chest feels puffy. She reports he has a mass on his side as well. Owner also remembers that patient had 2 previous veterinarian visits prior to his GI symptoms starting 4 general and nonspecific lethargy and shaking. No diagnosis was found during these visits.

Current Medications: Ondansetron, Omeprazole.
Radiographs: Gas dilated stomach but appears empty.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: IV Ace.
Stat Report: Not requested.

## 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 visualized areas of prostate and surrounding tissue appear normal. Unfortunately, the prostate is not fully visualized likely due to its intrapelvic location. Correlate with rectal exam findings.

The left kidney has a normal shape and size (6.41 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 (6.62 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 0.65 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 0.50 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 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 focal lesions are observed in the stomach, but overall, there is the subjective appearance of a prominent gastric wall. Layering appears intact, and when measured, the gastric wall is variable, but tends to measure on the thick side of normal. Findings are likely consistent with gastritis, but underlying infiltrative disease cannot be excluded as a possibility.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. Jejunum wall measured 0.36 cm. Duodenum wall measured 0.65 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. There are prominent isoechoic mesenteric lymph nodes visualized, varying in size from approximately 0.45-0.95 cm. The omentum is of normal echogenicity.

## PRIMARY FINDINGS

- Diffuse subjective moderate small intestinal thickening – The bowel wall thickening could be consistent with inflammation, edema, or infiltrative neoplasia.

- Prominent mesenteric lymph nodes – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

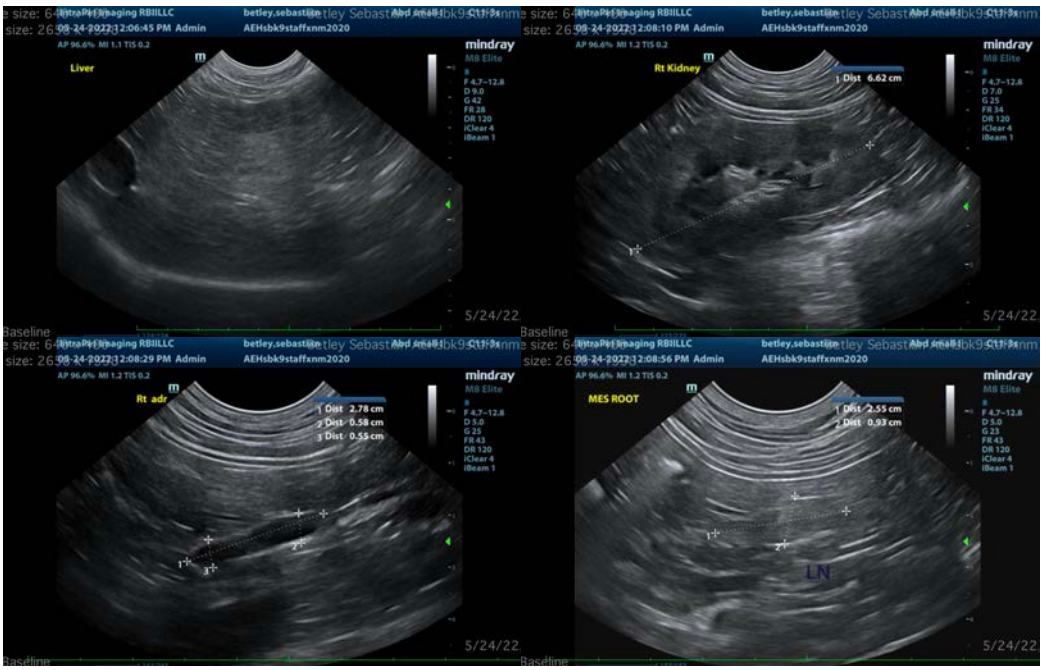
## SECONDARY FINDINGS

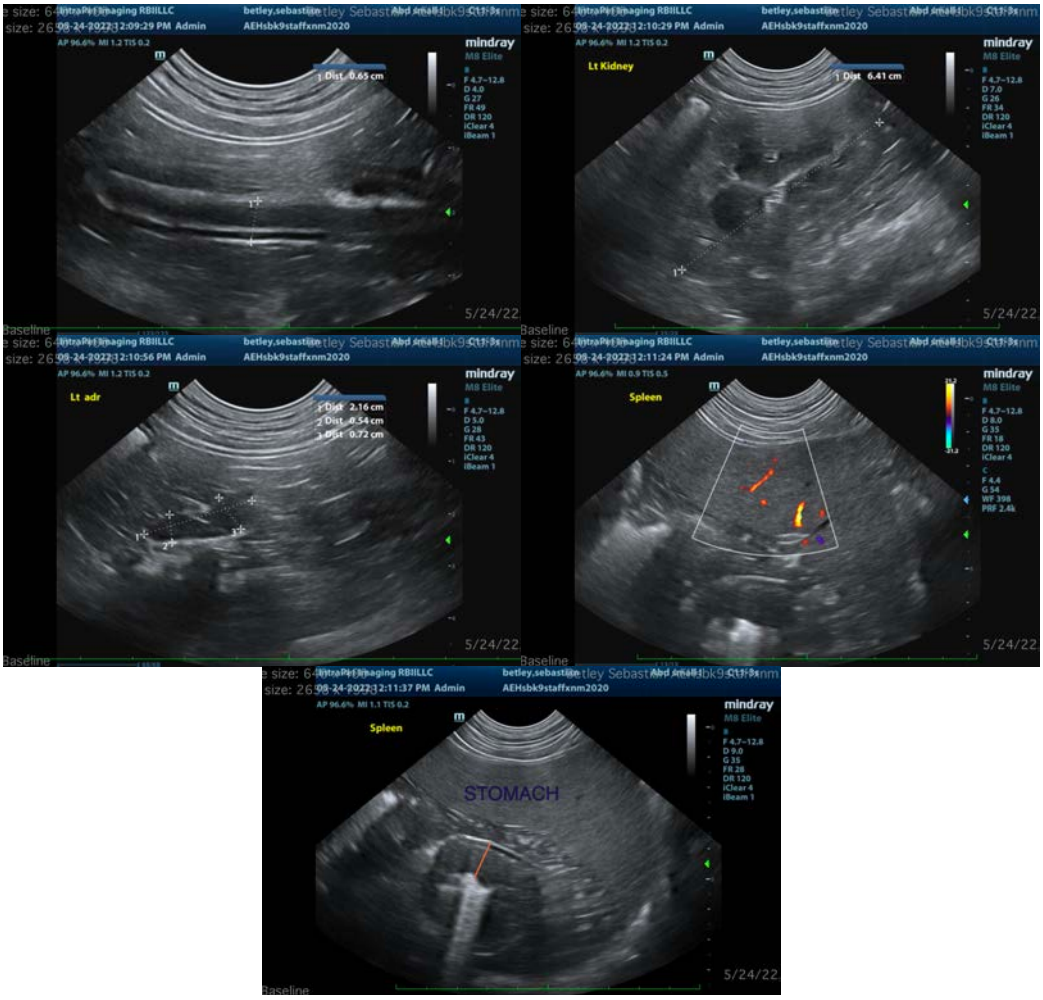
- Subjective gastric wall thickening – The stomach wall thickening could be consistent with inflammation, edema, infiltrative neoplasia, imaging artifact due to rugal folds, other.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No distinct focal lesions are observed involving the gastrointestinal tract. Unfortunately, there are many causes for vomiting and diarrhea that cannot be diagnosed by ultrasound alone. In a young dog like this, primary differentials would include Addison's disease (ruled out by normal cortisol levels), GI parasitism, dietary intolerance/food allergy, bacterial dysbiosis, and less likely intestinal neoplasia (other differentials exist).

- Consider a novel protein/hydrolyzed protein prescription diet in the case of the possible food allergy.
- Recommend chronic probiotic therapy.
- Recommend a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate to look for evidence of dysbiosis, B12 deficiency, etc.
- Recommend empirical treatment and diagnostics for GI parasitism.
- Based on the chronicity and the severity of the symptoms described, consider upper and lower GI endoscopy to obtain biopsies for histopath, and possible evaluation for histiocytic colitis, etc.






**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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