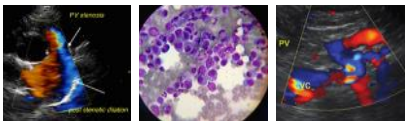
IMAGING PERFORMED BY

IntraPet.com



SonoPath

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DATE
05/27/2022

PATIENT
Fiona Versteegh

SPECIES
Canine

BREED
American Bulldog

SEX
FS

AGE
2 yr

WEIGHT
47.9 lb

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

HOSPITAL NAME
Greenbier Veterinary Clinic

REFERRING VET
Dr. Whitfeild

INVOICE
10687ag

PRESENTING CLINICAL SIGNS

Patient presented ~2 weeks ago PU/PD with unexplained weight loss for about 1-2 months. Full bloodwork was completed which was within normal limits aside from a mildly elevated SDMA (15) and a mild urinary tract infection. Patient was treated with Clavamox for 7 days and her food was swapped to Purina ProPlan Performance food. Her weight has since stabilized, but she remains PU/PD despite treatment of UTI. Patient also has significant anxiety and she is managed on Fluoxetine and Gabapentin daily with occasional use of Alprazolam as needed for separation anxiety.

Current Medications: Fluoxetine 1.8 mg/kg SID, Gabapentin 13 mg/kg BID prn, Amantadine 0.04 mg/kg SID prn, Clavamox 13.75 mg/kg BID 7 days, finished around May 17th.

Lab Results: SDMA 15, BUN and Creatinine well within normal. USG 1.067, rare cocci, trace struvites, mild inflammation.

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

Imaging Performed By: Andi Parkinson, BS, 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. 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 left kidney measured 5.699 cm in length.

The right kidney has a normal shape and size. 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. Th right kidney measured 6.59 cm in length.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.52 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 0.78 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 appears severely dilated with fluid and irregular shadowing material most consistent with gas and ingesta. 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 (0.51 cm in width) and the jejunum measured as normal (0.39 cm in width). 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.

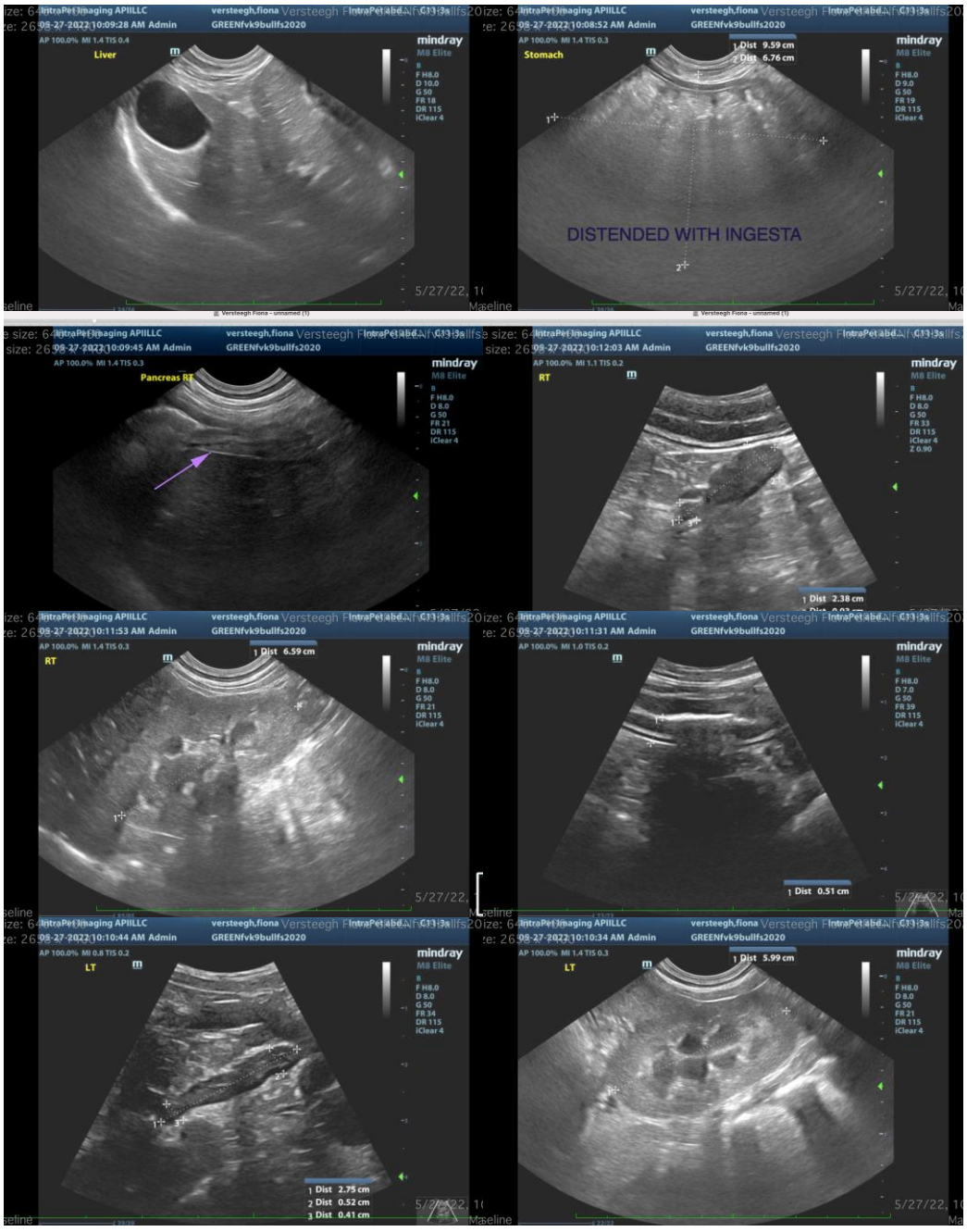
ULTRASONOGRAPHIC FINDINGS

- Severely distended gastric lumen with fluid and ingesta. Correlate these findings with feeding and drinking history and with abdominal radiographs. If the patient was adequately fasted, then consider differentials such as delayed gastric emptying or a partial outflow tract obstruction. Evaluation of the pylorus is extremely limited due to the large amount of ingesta within the gastric lumen.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Today's scan is largely normal other than the fluid and ingesta distended stomach. If this patient had a large breakfast, then this could be within normal limits. If she was adequately fasted then consider correlating with current radiographs and consider differentials such as delayed gastric emptying or a partial outflow obstruction.

An obvious cause for the PU/PD is not visualized. Fully evaluate bloodwork including Ca and electrolytes. Consider screening for atypical Addison's disease and leptospirosis. Additionally, I would recommend a UA and C/S. The UA reported has USG of 1.067 (could this be a typo?). If this is real, then the patient is unlikely to be PU/PD. Consider having the O quantitate water intake to confirm the concerns and confirm that the UTI has resolved as sometimes bacteria can induce PU/PD.



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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