

**DATE PRESENTING CLINICAL SIGNS**

5/5/22 3 weeks- decreased appetite. Eats be evening. Signs of nausea- lip licking swallows with effort (per owner). No vomiting and normal stool.

PATIENT

Mona Silvers

Current Medications: 5/4PM- Cerenia 8-mg PO, Omeprazole 20mg PO.

Lab Results: Chem/CBC/UA WNL.

Radiographs: Significant gas dilation- stomach, entire bowel.

Date of Previous IntraPet Ultrasound: No previous.

SPECIES

Canine

Sedation: IV sedation: Butorphanol 0.3ml. Dexdomitor 0.1ml (yesterday heart rate was 30 on dexdom 0.3ml). Panting heavily during scan.

BREED

German Shepherd

Stat Report: Not requested.

SEX

Spayed Female

AGE

12/26/14

WEIGHT

67 Pounds

INTERPRETED BY

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IMAGING PERFORMED BY

Rachel Brilhart RDMS

HOSPITAL NAME

Timonium AH

REFERRING VET

Dr. Kauder

INVOICE

37422

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 (6.93 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 (5.99 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 0.60 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 0.75 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 is severely dilated with fluid and irregular shadowing material most consistent with normal ingesta and gas. In general, the gastric wall appears to be of normal thickness, measuring at <0.7cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layering overall is adequate and there is no impression of reduced peristaltic activity. The area of the pyloric outflow tract appears relatively normal, although visualization of some areas is impeded by gas shadow and extreme panting. The area of the esophageal inlet appears somewhat thickened with a reduction of layering. Evaluation of this area is also difficult due to the panting and motion artifact.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension and some gas shadowing. 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 (between 0.3-0.5cm in wall thickness) and the jejunum measured as normal (between 0.2-0.47cm.) 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 prominent and mottled 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

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.

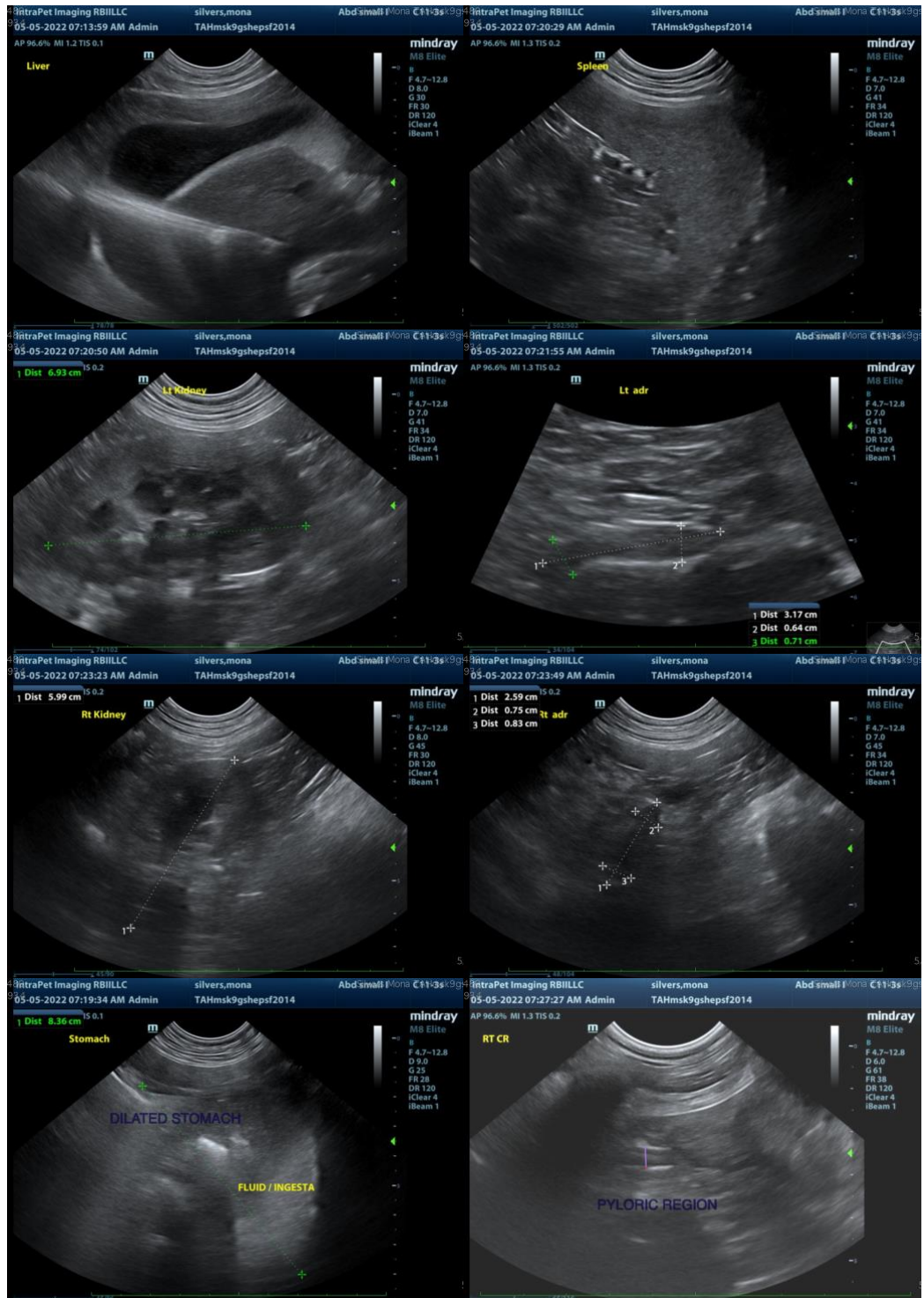
ULTRASONOGRAPHIC FINDINGS

- Severely dilated stomach with possible thickening and reduced layering at the esophageal inlet – Findings are concerning for an outflow tract obstruction, but none is observed. This could also be severe ileus. The changes observed at the esophageal inlet could be consistent with inflammation or infiltrative disease (neoplasia).
- Mildly mottled pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The stomach is severely dilated with fluid and ingesta. This has the appearance of an outflow tract obstruction, but none is clearly visualized. Correlate with abdominal radiographs and serial radiographic imaging. You could even consider administering some barium to evaluate the esophageal inlet and outflow tract in a series (once the stomach has emptied somewhat). A low dose of prokinetics could be considered in case severe ileus is present, but if this causes vomiting, then it should be discontinued. Recommend 3-view thoracic radiographs and consider either upper GI endoscopy to further evaluate the stomach and

esophagus (the fluid and ingesta would need to be cleared prior to scoping), or you could consider a CT scan, making sure to include the caudal thorax and cranial abdomen.





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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