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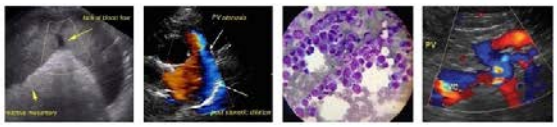


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Paris Walsh

SPECIES

Canine

BREED

St. Poodle

SEX

Spayed Female

AGE

7 Years

WEIGHT

28.2 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Graham AH

REFERRING VET

Dr. Lukacs

INVOICE

44064

DATE

7/18/23

PRESENTING CLINICAL SIGNS

Examined 5/12/23 and 5/16/23 for vomiting and diarrhea, decreased appetite (<1 week) - no known dietary indiscretion, no diet change - eats Purina ProPlan Sensitive Skin and Stomach salmon, dehydrated beef liver treats, occasional chews - possible food allergies? (skin dz, no definitive food trial performed previously) - PE unremarkable, no abdominal pain noted, vitals WNL, BAR - tx SQF, sulcrate 5 mL BID, famotidine 30 mg PO BID, cerenia 60 mg PO SID, tylosin 200 mg, GI probiotic paste, bland diet - UTD interceptor plus, bravecto Clinical signs resolved initially, but vomiting recurred 2 weeks later - vomiting every 2-3 days, in the morning, usually before breakfast, sometimes right after breakfast, vomit usually white foamy or bile, couple times pink tinged Recheck exam 6/22/23: - BAR, PE unremarkable, no abdominal pain or organomegaly noted, vitals WNL - CBC/chem 17/lytes: WNL except mildly elevated reticulocytes - Snap4dx negative - discussed further diagnostics, rads, u/s, medical management, food trial, etc - o elected to try conservative management at that time - re-started cerenia, sulcrate, probiotic, also omeprazole 20 mg PO SID in morning, and to divide up food into more frequent meals, strict food trial with Purina salmon 6/27/23 - owner switched foods around to different brand of salmon kibble - appetite decreased, developed diarrhea - owner restarted tylosin 300 mg PO BID 07/04/23 - telephone consult with owner - only receiving sulcrate and omeprazole, vomiting every 5 days or so, feeding bland diet but not strict food trial - otherwise appears bright and good appetite - seems to want to eat grass before vomiting - discussed food trial - switched to Hills Biome - 07/13/2023 - has vomited once since food switch, small amount but pink tinged Current Medications omeprazole 20 mg PO SID; sucralfate 5 mL PO BID on empty stomach

Abnormal PE/Chem/CBC/UA Results: CBC/chem 17/lytes: WNL except mildly elevated reticulocytes - Snap4dx negative Please see attached rads

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

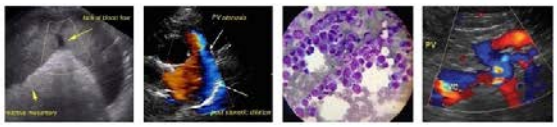
The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (5.99 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 (5.44 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 0.57 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.



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The right adrenal gland is normal in size measuring 0.48 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 was not clearly 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.

Gastrointestinal

The stomach has minimal fluid and gas. The gastric wall appears somewhat prominent and thickened in some areas, measuring up to 0.87 cm with some variability due to rugal folding. 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. Jejunum wall measures 0.23 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 area of 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.

PRIMARY FINDINGS

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

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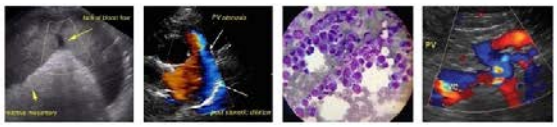

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SECONDARY FINDINGS

- Spleen not clearly visualized – This could be due to a small cranial or due to a previous splenectomy(?).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

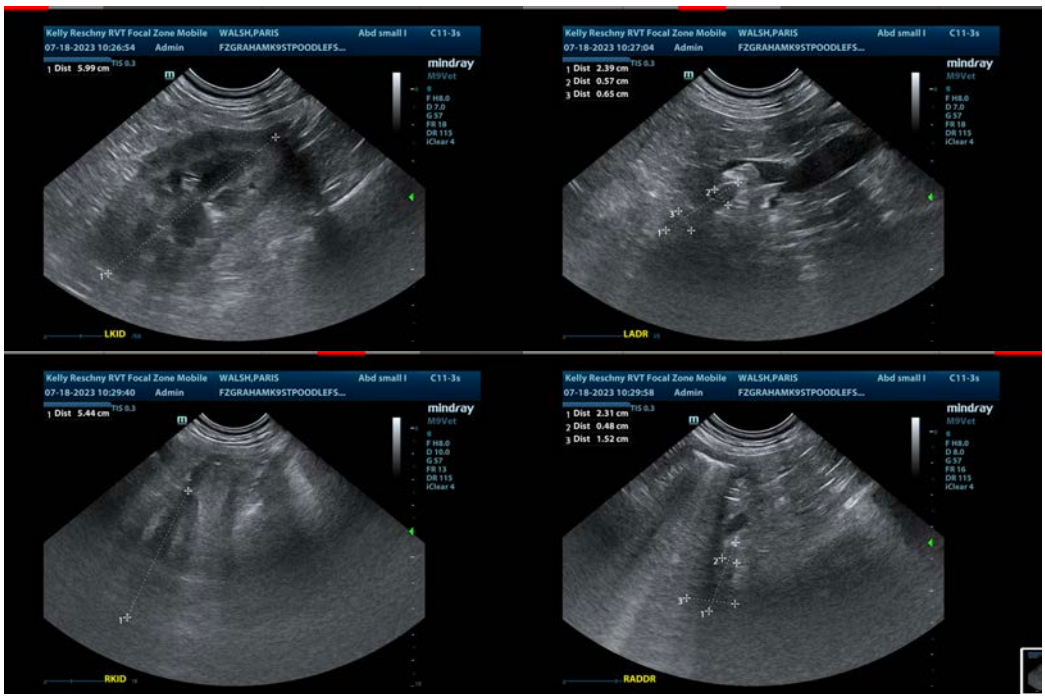
An obvious source for the chronic intermittent vomiting described is not observed on today's exam. The stomach wall subjectively appears somewhat thickened with intact wall layering, but slightly diminished wall layering. This could be consistent with gastritis, early infiltrative disease, etc. It is likely that biopsies of the gastric wall would be necessary to further evaluate. Consider the following:

Consider such differentials as food allergy/dietary intolerance, GI parasitism, chronic pancreatitis, IBD and less likely neoplasia, etc.. .

- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend chronic probiotic therapy.

If symptoms are persistent, consider obtaining biopsies of the gastric wall and small intestine (surgical biopsies may be necessary).

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.



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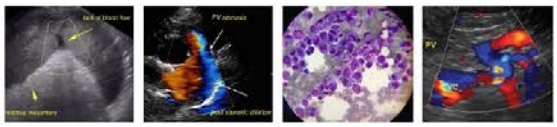

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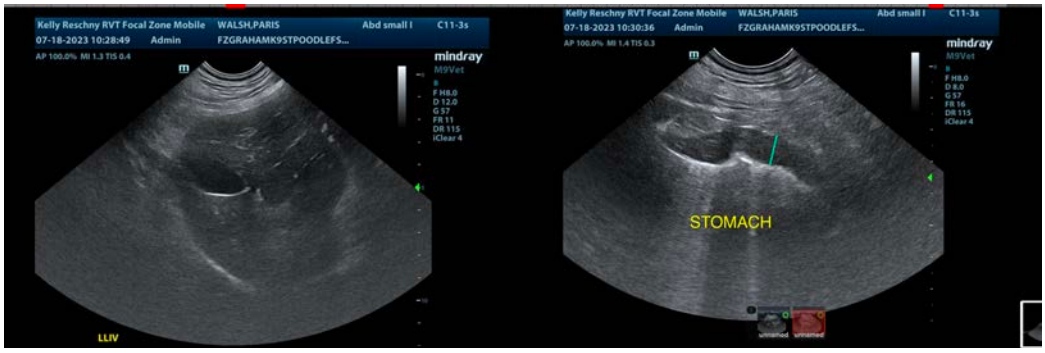

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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