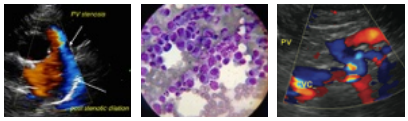
IMAGING PERFORMED BY

IntraPet.com



SonoPath
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DATE

8/10/2023

PATIENT

Ripley Martinez-Hernandez

SPECIES

Canine

BREED

English Lab

SEX

Spayed Female

AGE

8/14/2020

WEIGHT

88lbs

INTERPRETED BY

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

HOSPITAL NAME

Noah's Ark Veterinary and Boarding Resort

REFERRING VET

Dr. Martinez-Hernandez

INVOICE

10405

PRESENTING CLINICAL SIGNS

Recent HX: in mid-July with HGE, inappetence for over a week , vomiting, Treated medically, lab work had NSF (Fecal , CBC/CHEM, CPL,GI panel, barium study), She still eats/shows interest in her food but for a lab and her normal personality not overly eager to eat and I am now noticing that she needs to have meals split into 3 times a day when normally I did not do a midday meal. She also has started to have increased stomach acid production in the morning if she does not eat early. Something is still off but not sure what. no known exposure to other treats/food/ toxin etc. previously on Royal canine Labrador adult but has since be transitioned to Purina Pro Plan EN. she was treated for a UTI after she improved with GI issues.

Current Medications: currently only Simpairica Trio, discontinued the Forti Flora
Lab Results: NSF.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Rachel Brilhart, 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 (6.55 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 (6.91 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 0.6 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 0.67 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 gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a mild amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. The gastric wall measures slightly thicken at 0.76 cm. 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 jejunum measured as normal (0.35 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

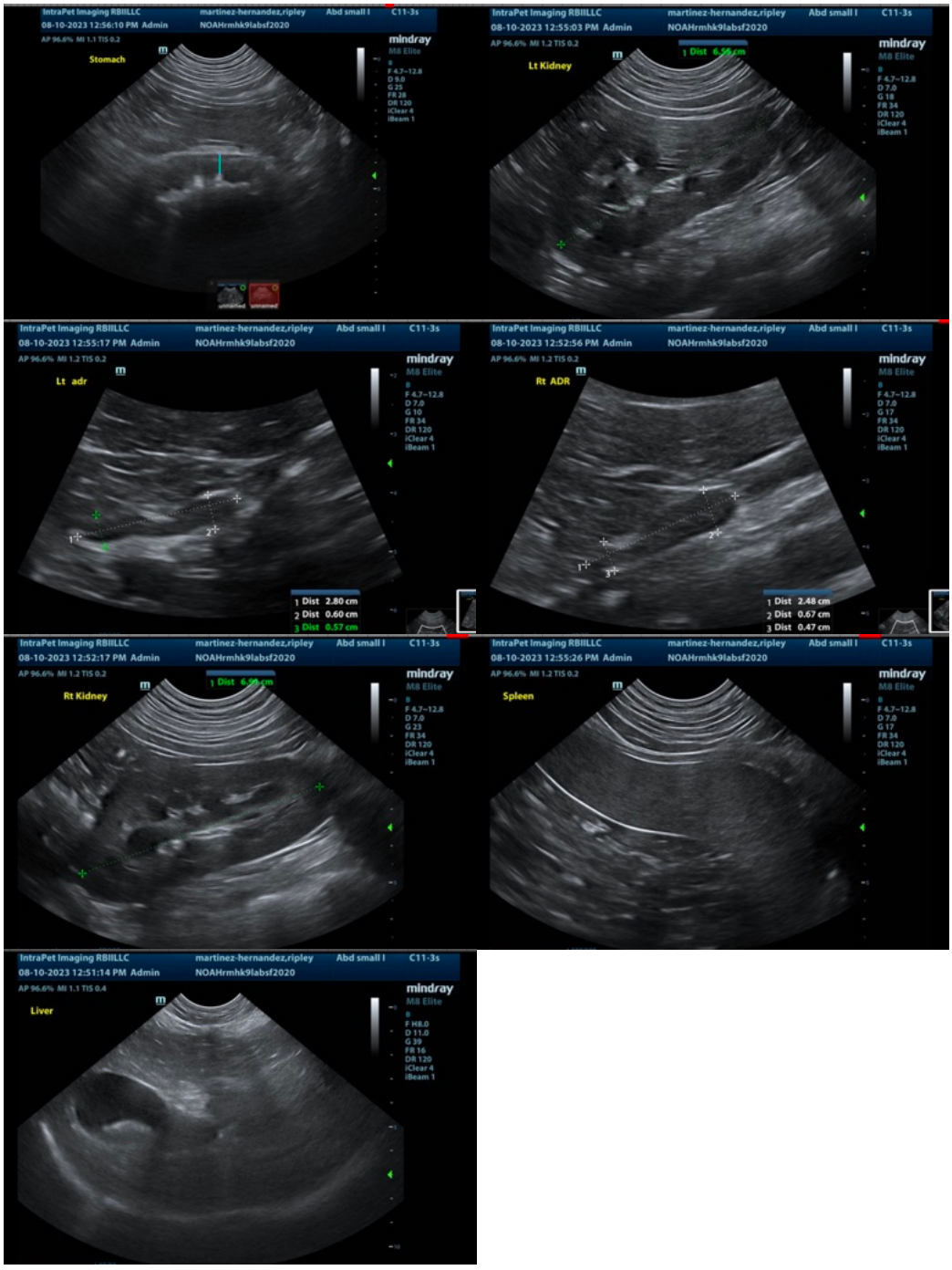
Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

PRIMARY FINDINGS

- Subjectively mildly prominent/thicken gastric wall. This is very subjective and could be secondary to rugal folding etc. Wall layering appears intact other differentials would include mild gastritis, hyper edema, etc.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Todays scan is relatively normal no prominent focal gastrointestinal lesions are observed to explain the inappetence reported. Subjectively the gastric appears sightly prominent but this can be misleading in an empty stomach. If not already done, consider a baseline cortisol. Additionally, I would consider a Cerenia trial if appetite picks up then low-grade nausea is very likely. Additionally, I would consider a novel protein or hydrolyzed protein prescription diet. If symptoms are persistent, you could consider an upper GI endoscopy to evaluate the stomach and possibly the approximal duodenum. In a larger dog surgical biopsies would be likely necessary to evaluate the more distal GI tract.



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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