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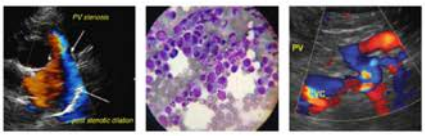
fredgromalak@gmail.com



SonoPath
Clinical Sonography & Telecytology
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PATIENT

Webster Uphoff
10697C

SPECIES

Canine

BREED

Yorkshire Terrier X

SEX

Neutered Male

AGE

1 Year

WEIGHT

5.3 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Tom McNeill

HOSPITAL NAME

SVS Imaging CT

REFERRING VET

Madison VS
Dr. Graham

INVOICE

40710

DATE

8/24/22

PRESENTING CLINICAL SIGNS

Webster started vomiting on Friday and has vomited a few times daily since then. Last night he ate dinner and vomited it back up and has vomited several times today and Webster has been unable to keep water down either. Today Webster has been lethargic and had no interest in food or water. Owner took to PCDVM who took x-rays, gave cerenia, and SQ Fluids then dosed with barium to have them come back for repeat x-rays in the morning. On the ride home Webster vomited the barium back up so owner took back to PCDVM who gave another dose of barium but he vomited that back up 15 minutes after getting home. Owners say that he always vomits during car rides. Webster has been fasted and has not vomited since friday afternoon.

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 prostate is normal in size (0.94 cm) and shape for this neutered male dog. The parenchyma is homogenous and the external margins are smooth. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (3.98 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 (4.19 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 0.41 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 0.38 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 with smooth peripheral margins. It is mildly hypoechoic with prominent portal markings. The parenchyma is homogenous echotexture. No focal nodules or cystic lesions are observed.

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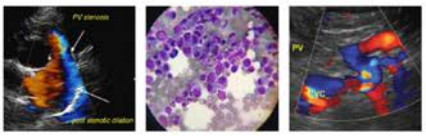

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The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach is moderately dilated with fluid and irregular shadowing material most consistent with normal ingesta and gas. 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 layering 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. Duodenum wall measured 0.41 cm. Jejunum wall measured 0.31 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 (0.1 cm). 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 visible isoechoic mesenteric lymph nodes, one of which measures at 0.61 cm. Additionally, there is a right medial iliac lymph node visualized at 0.31 cm.

ULTRASONOGRAPHIC FINDINGS

- Moderate dilation of the stomach with fluid and ingesta – Correlate with feeding history. If this patient was adequately fasted, then consider such differentials as delayed gastric emptying or partial outflow tract obstruction (none observed).
- Subjectively mildly hypoechoic liver with prominent portal markings – The significance of this is unclear. Correlate with bloodwork. If liver enzyme elevations are present, recommend a liver function test and Leptospirosis screening.
- Visible/prominent mesenteric lymph nodes – This is a common normal finding in young animals and could be an indicator of inflammation.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Today's scan is relatively normal for a young dog. The stomach is moderately distended with fluid and some ingesta, which would be abnormal in a fasted/vomiting patient, so this could indicate a level of delayed gastric emptying, gastric foreign material, etc. Consider possible metabolic causes for vomiting. Recommend screening for Addison's disease, +/- liver function test. If metabolic disease is thought unlikely, then consider differentials such as food allergy/dietary intolerance, GI parasitism, viral enteritis, dysbiosis, ingested foreign material, etc.

Additionally recommend thoracic radiographs to rule out possible regurgitation instead of or in addition to vomiting.

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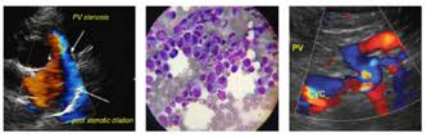

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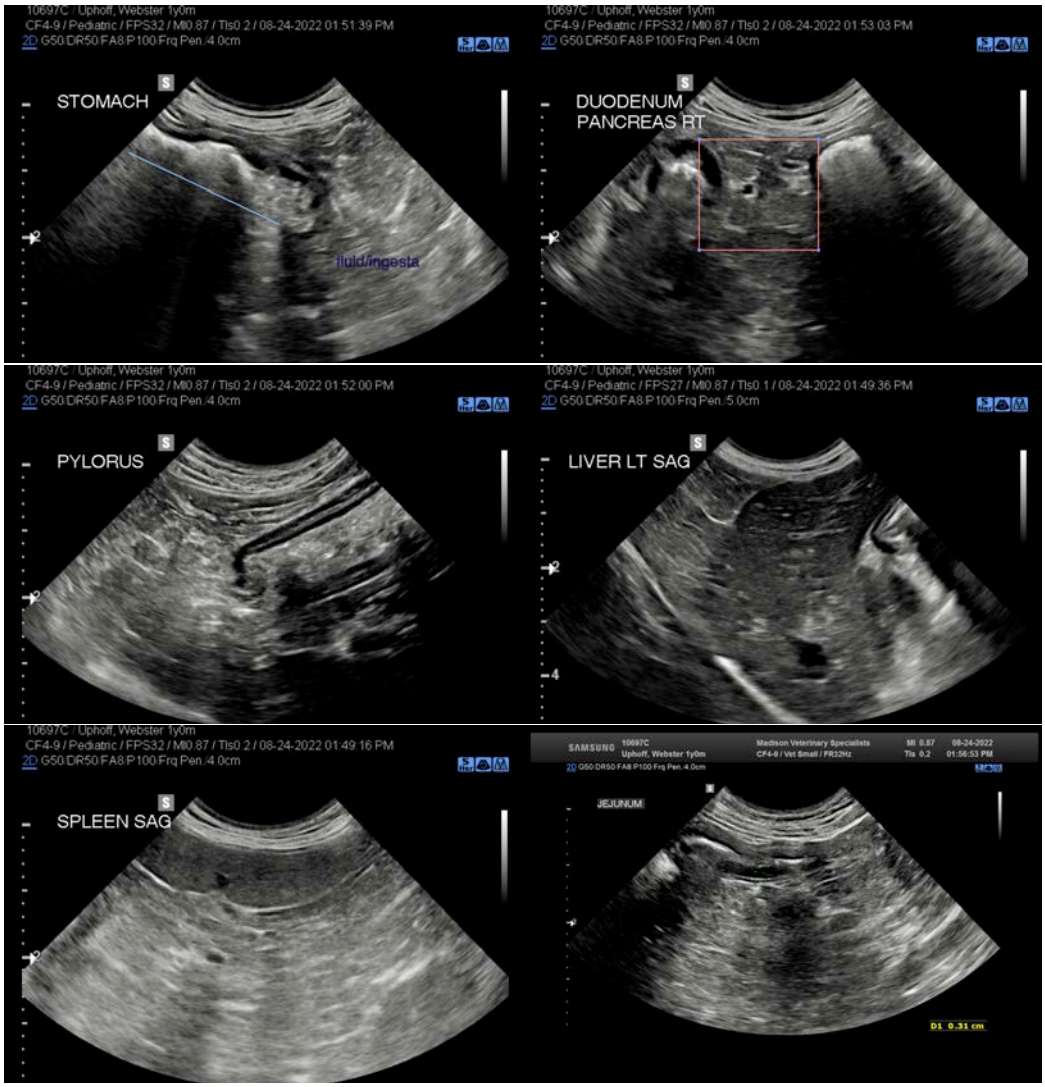
- Consider a novel protein/hydrolyzed protein prescription diet in the case of a dietary sensitivity.
- Recommend screening for Addison's disease +/- liver function test.
- Recommend empirical treatment for and screening for GI parasites.
- Recommend 3-view thoracic radiographs to evaluate the esophagus.
- Recommend serial radiographs with barium to try and determine the patency of the GI tract (if the patient will keep barium down).
- Consider screening for viral enteritis, if appropriate.

If symptoms persist, some method of nutritional support would need to be considered, and further evaluation of the GI tract, whether it be surgery with biopsies, scoping, etc. I saw no evidence of a clear obstructive pattern or foreign material on today's scan, but this is difficult to definitively rule out and should always be considered.



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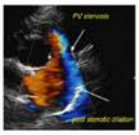
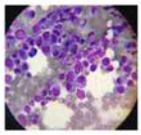
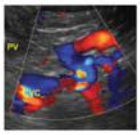

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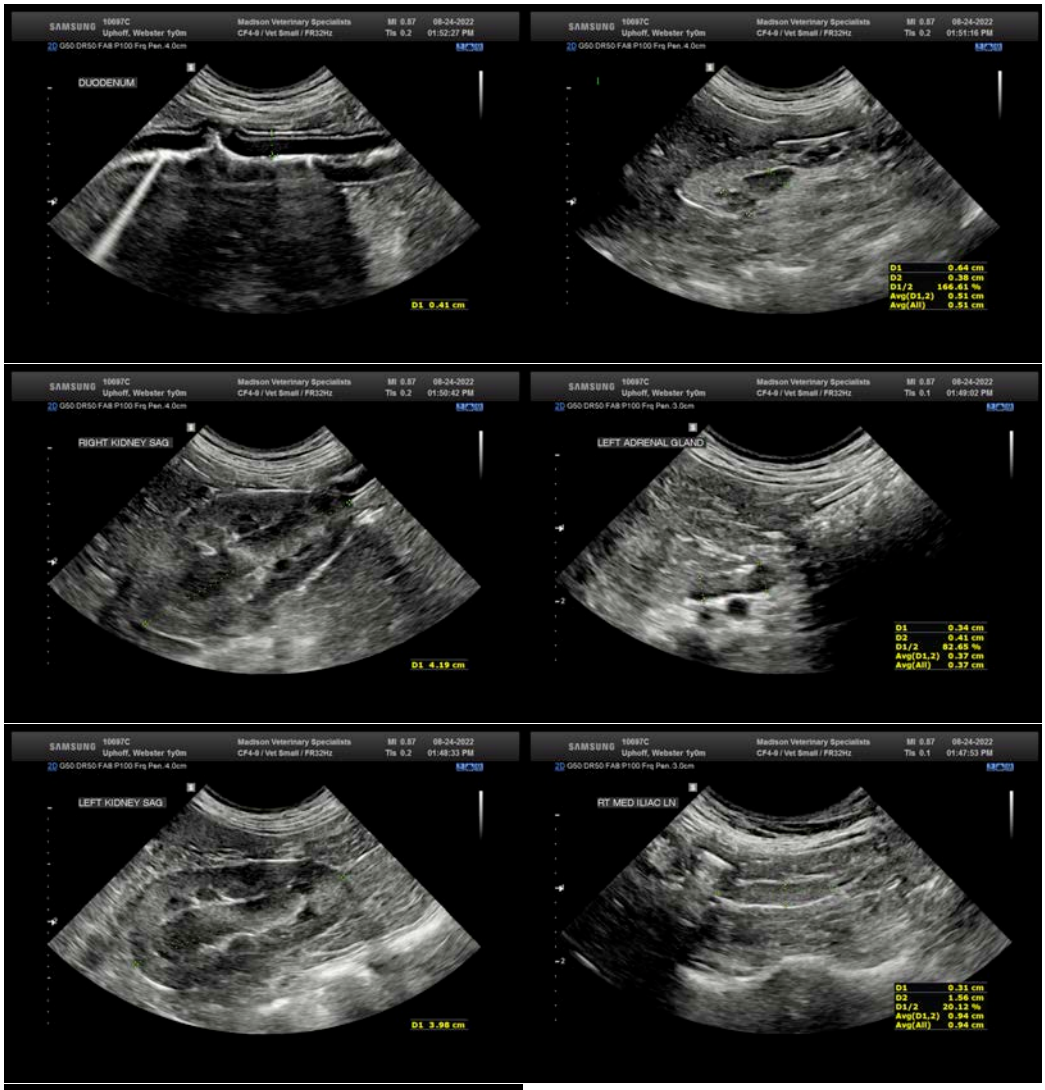

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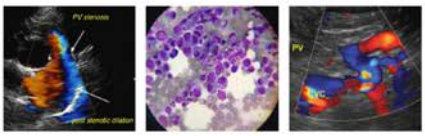

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

kathleen.sennello@sonopath.com