

**DATE**

Spritz Brooks

PRESENTING CLINICAL SIGNS

Presenting Complaint: vomiting; diarrhea; lethargy.

History: Date: 09-11-2021 Patient was at AEH on Wednesday for vomiting and diarrhea. Full lab work- NSF, rads- NSF, 4dx neg.

PATIENT

Patient was sent home with Metronidazole, Omeprazole, and Provable. Owner said that patient has not gotten any better. Today, patient started vomiting. Patient still has D+ that no longer has blood in it but is now a yellow color. Owner has been feeding chicken and rice.

Canine

Assessment: Problems: -Diarrhea -Vomiting -Inappetence.

SPECIES

DDX: Foreign Body, Gastroenteritis, Pancreatitis, IBD, Neoplasia.

Terrier Mix

Plan: Hosp. 12-24hours; GI Meds; Antibiotics; Pain medication.

Current Medications: Unasyn, Buprenorphine, Pantoprazole, Entyce.

BREED

Lab Results: NSF.

Spayed Female

Radiographs: No obstructive pattern or foreign body noted.

Date of Previous IntraPet Ultrasound: No previous IntraPet scans.

Sedation: not needed

Stat Report: not requested

SEX

1/12/04

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**AGE****Urinary System**

12.8 lbs

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.

WEIGHT

12.8 lbs

The left kidney has a normal shape and size (4.38 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.

INTERPRETED BY

The right kidney has a normal shape and size (4.51 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.

Kathleen Sennello
DVM, MS, Diplomate
ACVIM (Small Animal
Internal Medicine)**HOSPITAL NAME****Adrenal Glands**Animal Emergency
Hospital

The left adrenal gland is normal in size measuring 0.56 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.

REFERRING VET

The right adrenal gland is normal in size measuring 0.54 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.

Dr. Roper

INVOICE**Spleen**

91791

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 contains minimal luminal contents. It measures at a normal thickness of <0.36cm 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 (0.44 cm) and the jejunum measured as normal (0.28 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.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS:

- No significant ultrasonographic lesions observed.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

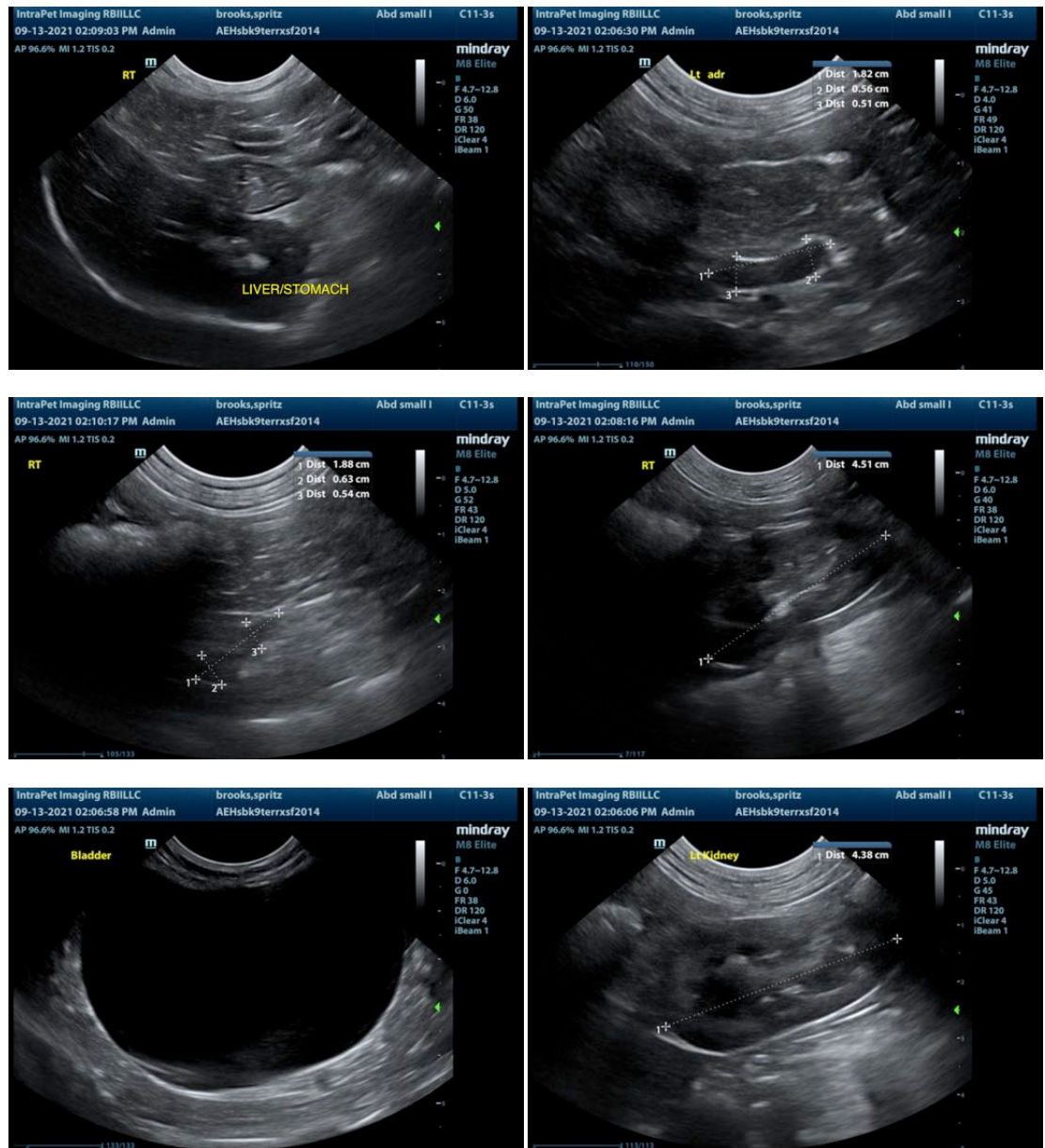
The ultrasound changes observed were relatively mild. Unfortunately, the severity of ultrasonographic changes do not always correlate with the severity of GI symptoms exhibited. Many causes for GI signs cannot be definitively diagnosed by ultrasound alone.

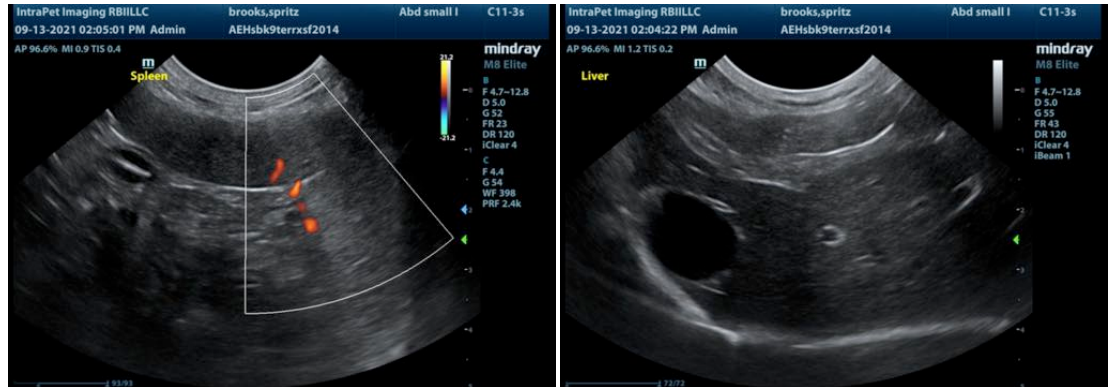
- Consider metabolic causes based on bloodwork, ACTH stim results, Liver function testing, Gi panel (TLI/PLI, folate, cobalamin.)
- Consider primary GI causes: GI parasitism, dietary indiscretion, mild pancreatitis, bacterial dysbiosis, food allergy, IBD and less likely intestinal neoplasia.

If primary GI disease is suspected In young patients with acute signs I would most strongly consider dietary indiscretion, ingestion of foreign material, GI parasitism, Addison's disease and pancreatitis, acute

colitis/gastroenteritis. Serial radiographs for evaluation of progressive obstruction/partial obstruction/foreign material is warranted.

Recommend symptomatic therapy and close monitoring, if symptoms persist, re-evaluate and consider surgery/endoscopy to obtain biopsies and evaluate for foreign material.





The information and recommendations provided are based on the images presented by the referring veterinarian. 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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