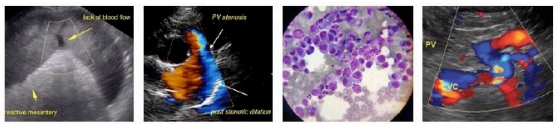

PATIENT

Brummell Kudelka

SPECIES

Canine

BREED

Welsh Terrier

SEX

Neutered male

AGE

3.5 years

WEIGHT

9.3 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Reshny, RVT

HOSPITAL NAME

Simcoe AH

REFERRING VET

Dr. Kennedy

INVOICE

92748

DATE

10/29/21

PRESENTING CLINICAL SIGNS

History: week long struggle with nausea, abdominal pain and poor appetite. radiographs could not confirm a FB. initially improved with 18hours IVF. has been up and down ever since. had cytopoint injection 24 hours before clinical signs started. Sucralfate, Cerenia, Hycodan, and Mirtazapine. and Gastro Low Fat diet.
Abnormal PE/Chem/CBC/UA Results: Please see attached radiographs and lab results/hosp sheet. CPL mildly abnormal.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with mild primarily suspended echogenic debris present. 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 calculi. Echogenic debris of this type can be associated with small crystals, cellular debris and proteinaceous debris.

The prostate is normal in size 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 (4.76 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 (3.92 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 0.39 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 0.42 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.

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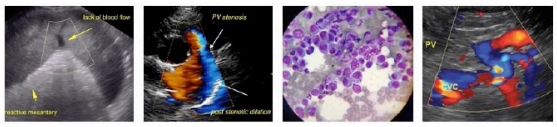

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Liver

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 gallbladder 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. The duodenum measured as normal (0.29 cm) and the jejunum measured as normal (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 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:

- Mildly dilated gastric lumen with mildly shadowing ingesta. The findings are most consitetn with normal ingesta. If the patient has been adequately fasted then you can consider such differentials as delayed gastric emptying or partial outflow obstruction, but none was seen.
- Mild, dependent debris in the urinary bladder. The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus. Recommend urinalysis and culture.

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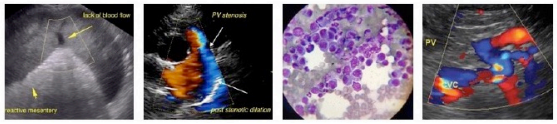

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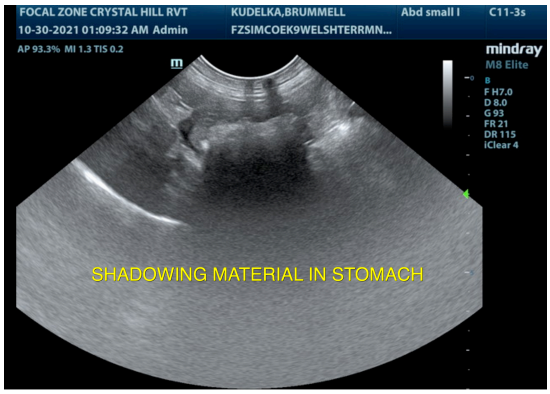
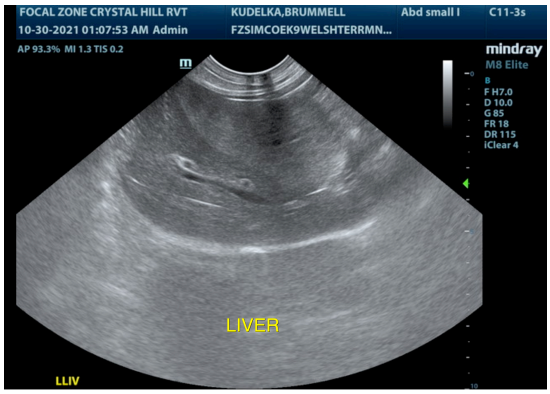
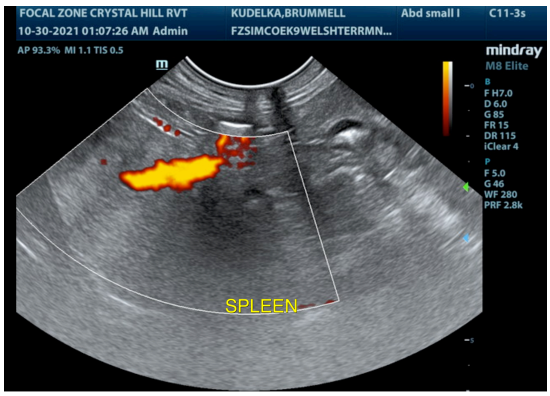
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

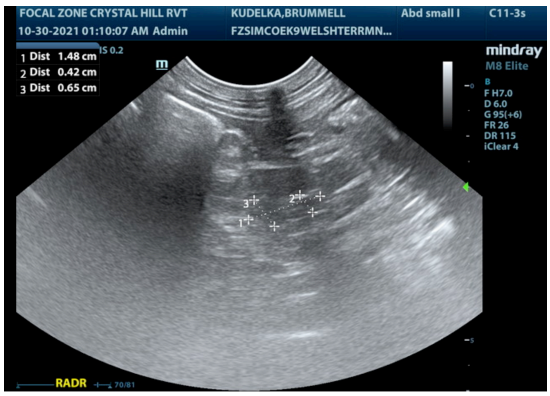
No large focal lesions were observed associated with the GI tract and an obvious cause for the nausea and abdominal pain described in the history is not visualized. Unfortunately there are may causes for vomiting that cannot be diagnosed by ultrasound alone. Correlate with abdominal radiographs and blood work findings. If metabolic disease is thought unlikely then you can consider other differentials for primary gastrointestinal differentials for vomiting such as GI parasitism, dietary indiscretion, mild pancreatitis, bacterial dysbiosis, food allergy, IBD and less likely intestinal neoplasia.

- Consider a GI panel with quantitative PLI, TLI, cobalamin and folate to further evaluate for possible pancreatitis that is not evident on today's scan or underlying small intestinal disease.
- Recommend fecal testing and empirical deworminyg. Consider ACT stimulation to test for Addison's or baseline cortisol. Consider a diet trail with a hydrolyzed protein or novel protein diet in the caser of food allergy or IBD.
- If the symptoms are not improving I recommend serial radiographs +/- barium to look for the evidence of partial obstruction and/or recheck ultrasound.
- If symptoms are persistent despite all efforts consider surgery or endoscopy to obtain GI biopsies and evaluate for a foreign material.









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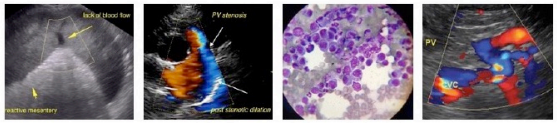

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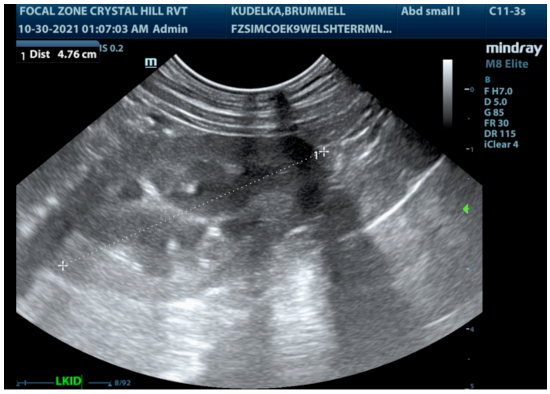

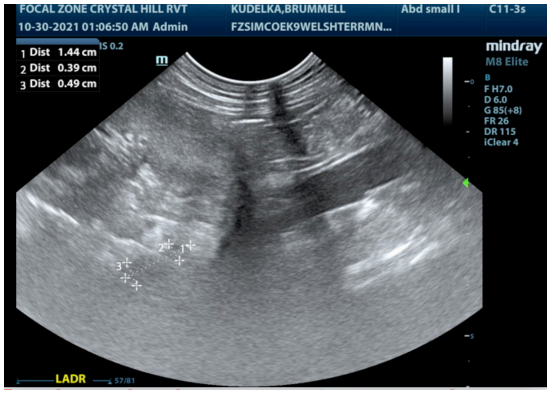

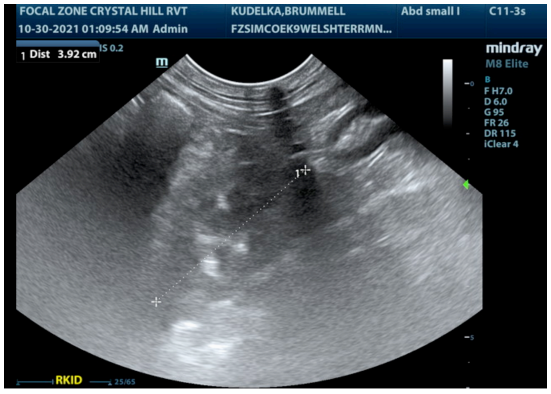

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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