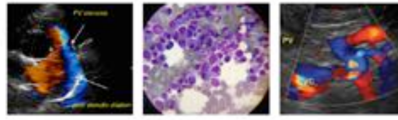


PATIENT

George Weber

SPECIES

Canine

BREED

Boston Terrier

SEX

Intact Male

AGE

16 weeks

WEIGHT

6 lbs

INTERPRETED BY

Lisa Carioto, DVM, DVSc, Diplomate ACVIM

IMAGING PERFORMED BY

Sarah Pender, CVT

HOSPITAL NAME

SVS Imaging QC

REFERRING VET

Dr. Shields

INVOICE

30267

DATE

5/10/22

PRESENTING CLINICAL SIGNS

This puppy has a 2 week history of vomiting. A tentative diagnosis of pyloric stenosis was made, and the patient was started on metoclopramide. The patient has continued vomiting. Was 7lbs 4/21 and today is 5.8lbs. Seems to mostly be regurgitating and is doing that several times a day. Did vomit brown liquid once in kennel while at clinic before scan. Clear fluid dripping from nose today. Sounds raspy when breathing. Has not eaten anything since 6:30pm night before.
Abnormal PE/Chem/CBC/UA Results: Radiographs showed an enlarged stomach that was full of material that appeared to be food. Bloodwork hasn't been done. Parvo test negative. Just after starting the scan while laying on his side with light pressure on abdomen he became dyspneic. Was let up and given a couple minutes and flow by O2 started. He seemed to do better but still had fluid dripping from nose. He regurgitated moderate amount of light brown fluid after scan.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic contents. The wall is smooth and regular. No abnormalities are noted with the trigone or proximal urethra, and there is no evidence of sediment, cystoliths, polyps or a mass.

Kidneys

The **left** kidney measures 3.92 cm. The capsule is smooth and its overall architecture, including the definition of the cortico-medullary junction, are preserved. There are no signs of nephroliths or pyelectasia. The surrounding mesentery is not hyperechoic.

The **right** kidney measures 4.23 cm. The capsule is smooth and its overall architecture, including the definition of the cortico-medullary junction, are preserved. There are no signs of nephroliths or pyelectasia. The surrounding mesentery is not hyperechoic.

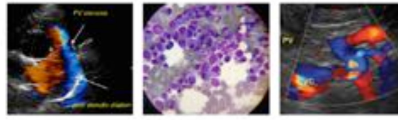
Aortic bifurcation/trifurcation

No abnormalities observed.

Adrenal Glands

The **left** adrenal gland measures 0.35 cm at the cranial pole, 0.34 cm at the caudal pole and 1.28 cm in length. No abnormalities are noted with the gland's overall architecture, echogenicity or echotexture. The phrenico-abdominal vein and surrounding vasculature and mesentery are unremarkable.

The **right** adrenal gland (boomerang shape). It measures 0.36 cm at the cranial pole, 0.28 cm at the caudal pole and 1.55 cm in length. No abnormalities are noted with the gland's overall architecture, echogenicity or echotexture. The phrenico-abdominal vein and surrounding vasculature and mesentery are unremarkable.



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Spleen

The spleen is within normal limits in size, architecture, echotexture, and echogenicity. The capsule is smooth. No abnormalities are observed with its vasculature, i.e. congestion and thrombi are not identified.

Liver

There are no obvious signs of hepatomegaly and its borders are smooth and sharp. The liver's echotexture is homogeneous and it is within normal limits in echogenicity. No abnormalities are observed with the hepatic vessels visualized.

The gallbladder wall is within normal limits in thickness and echogenicity. A very small amount of echogenic material is present within the GB. The cystic duct is visible and appears distended, however, it measures 2.7 mm (WNL, albeit at the high end of the normal reference range).

An obvious obstruction of the common bile duct is not observed.

Gastrointestinal

The lumen of the stomach is severely distended and dilated with a marked amount of fluid. Pyloric stenosis is noted. A very large amount of gas and ingesta are also present, however, an abnormal gas pattern with abnormal shadowing is visualized in certain views. The latter is highly suggestive of a foreign body. The stomach appears flaccid, i.e., a severe ileus (complete stasis) is present. The gastric wall is within normal limits in thickness and the wall layers are well defined. However the submucosa and muscularis appear thicker than normal.

A mild amount of gas and fluid are present within the lumen of the duodenum.

The small intestinal wall thickness, including the duodenum, is within normal limits and the definition of the wall layers is preserved. Abnormally dilated loops of bowel are not observed; in fact, the remaining loops of bowel lack contents within their lumen.

The colonic wall is not thickened and mural detail is considered normal.

Pancreas

No overt abnormalities are observed with the echogenicity or echotexture of the left or right limb. The surrounding mesentery is mildly hyperechoic, however, it is similar throughout the entire abdomen. Obvious signs of active pancreatitis are not appreciated.

Other

Lymph nodes Visualized, but no abnormalities are observed

Abdominal effusion A scant amount of anechoic fluid is visualized, which is not uncommon in young animals.

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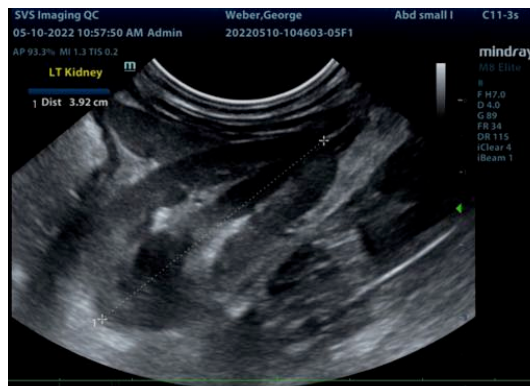
ULTRASONOGRAPHIC FINDINGS

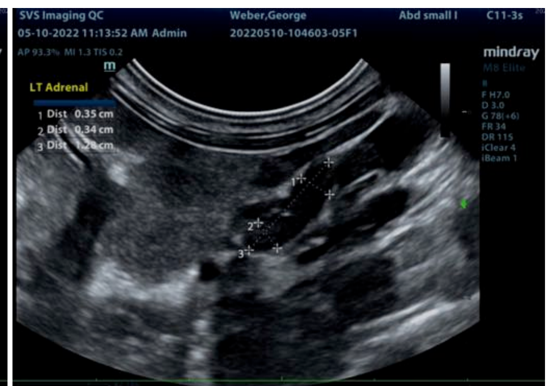
- Pyloric stenosis is noted with extremely severe gastric dilation with fluid and a marked ileus.
- An abnormal gas pattern is evident, which is highly suggestive of a foreign body. However, an obvious foreign body is not visualized.
- In conclusion, a high index of suspicion of a foreign body is present in addition to the presence of congenital pyloric stenosis. George likely became clinical for the pyloric stenosis following the ingestion of the foreign body.
- I am very concerned that George may be suffering from aspiration pneumonia.
- Nasal stenosis may develop if stomach contents continue to exit his nares.
- The adrenal glands are at the low end of the normal reference range; a baseline cortisol may be warranted in the future.

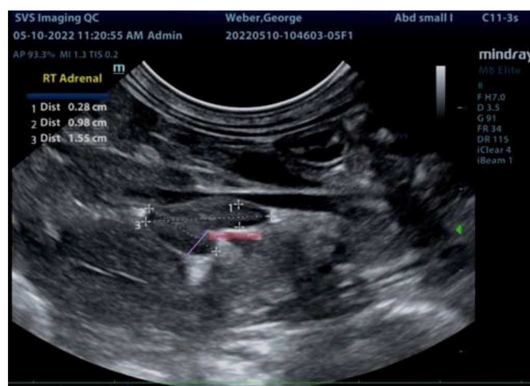
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

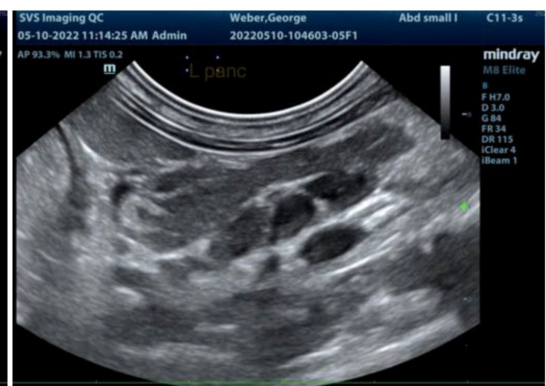
Passage of a nasogastric tube is strongly recommended to remove as much gastric fluid as possible and decrease the risk of vomiting and regurgitation and aspiration pneumonia, particularly prior to pursuing general anesthesia for removal of the foreign body.

Antibiotics for the treatment of aspiration pneumonia, as well as nebulization and coupage of the thorax are suggested to treat aspiration pneumonia, depending on the pulmonary lesions observed radiographically.









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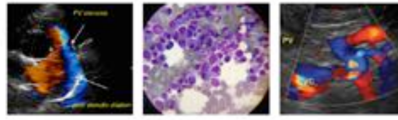

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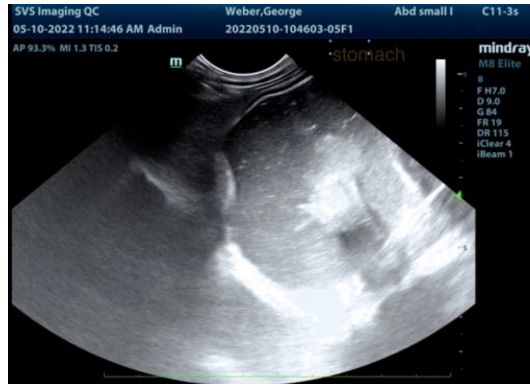

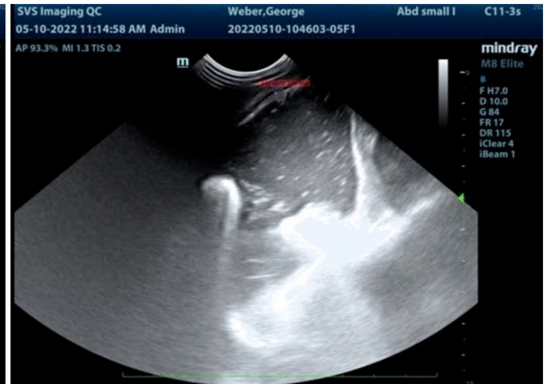

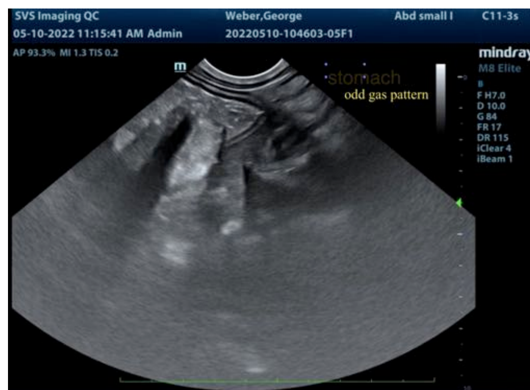

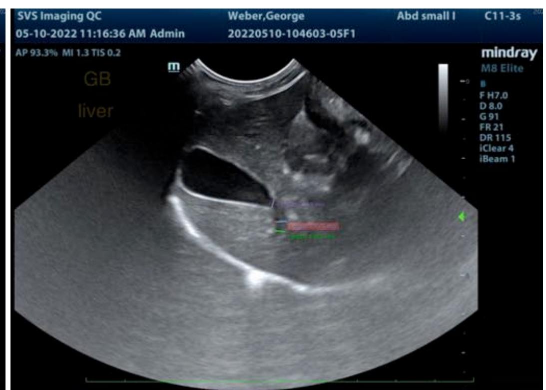

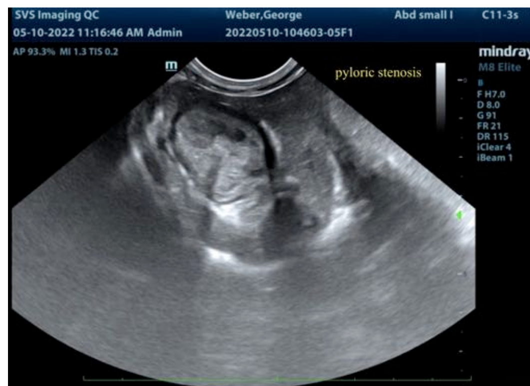

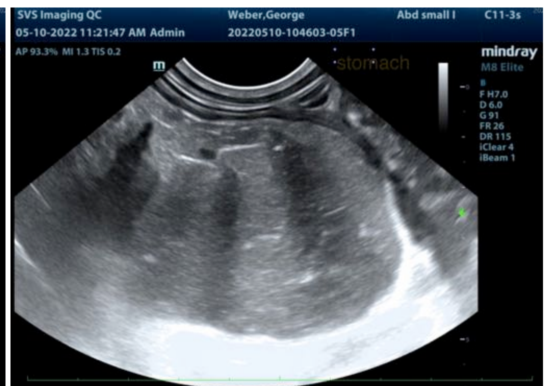

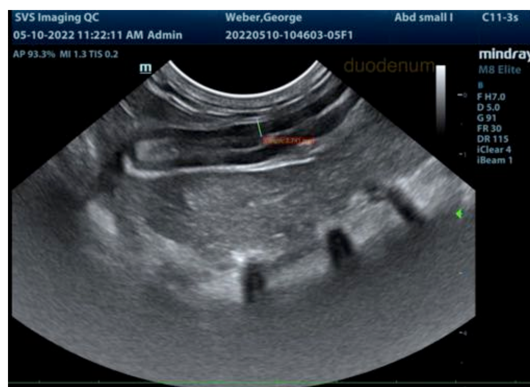

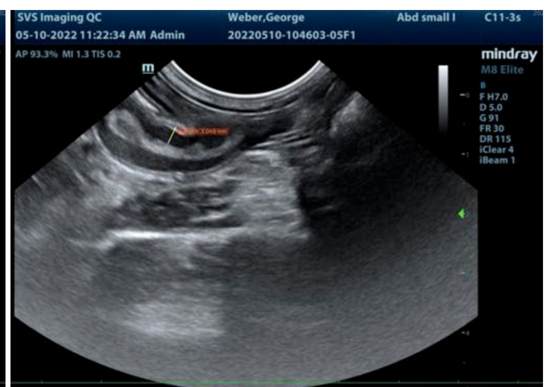

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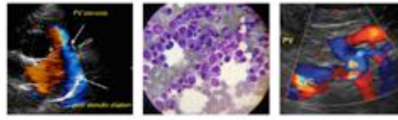

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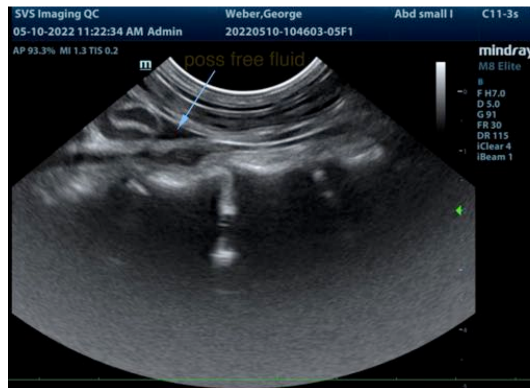

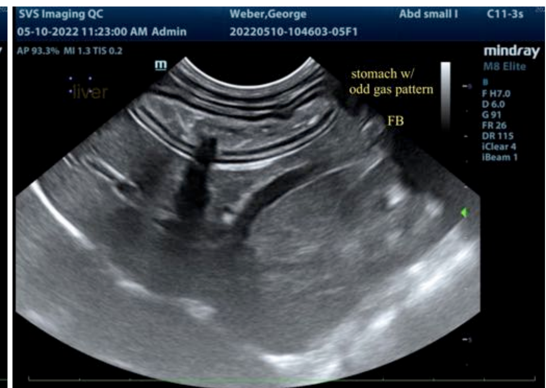

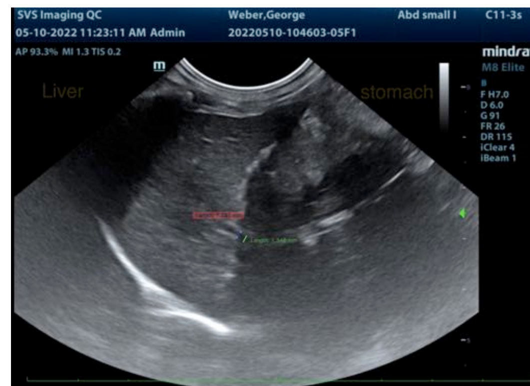

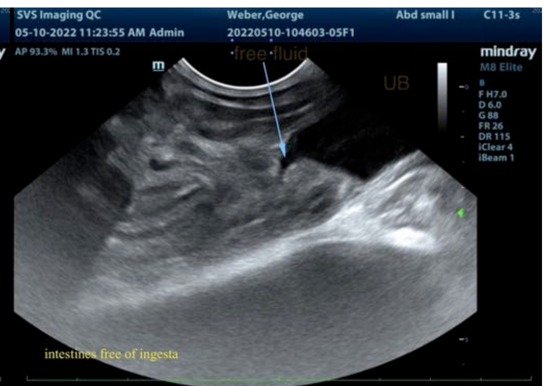

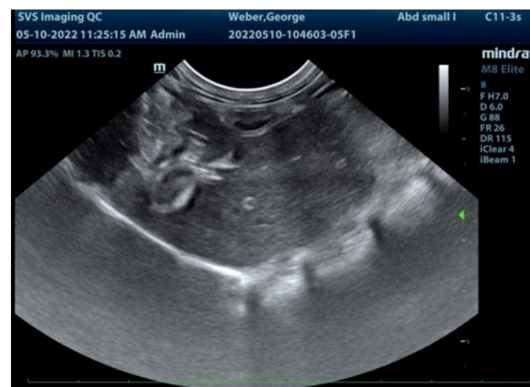

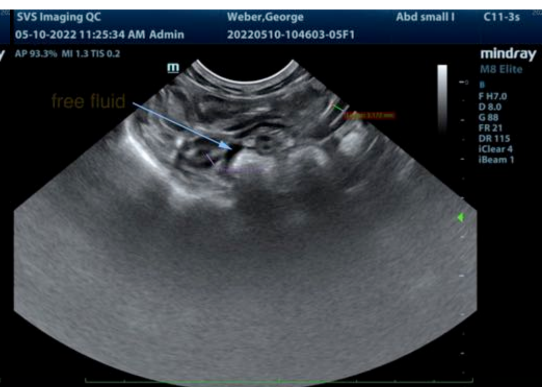

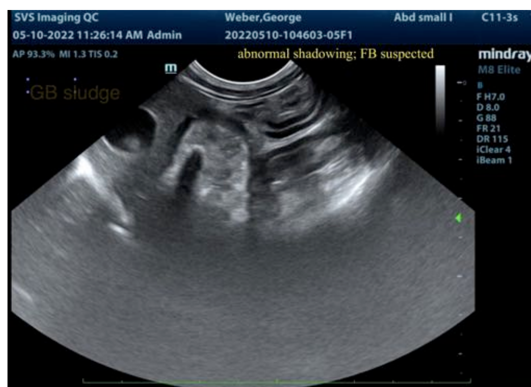

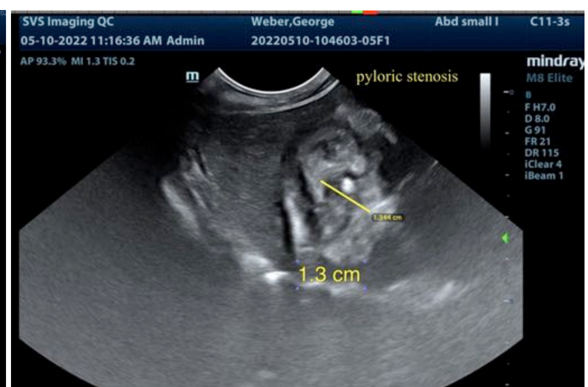

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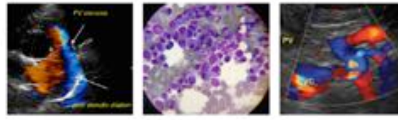

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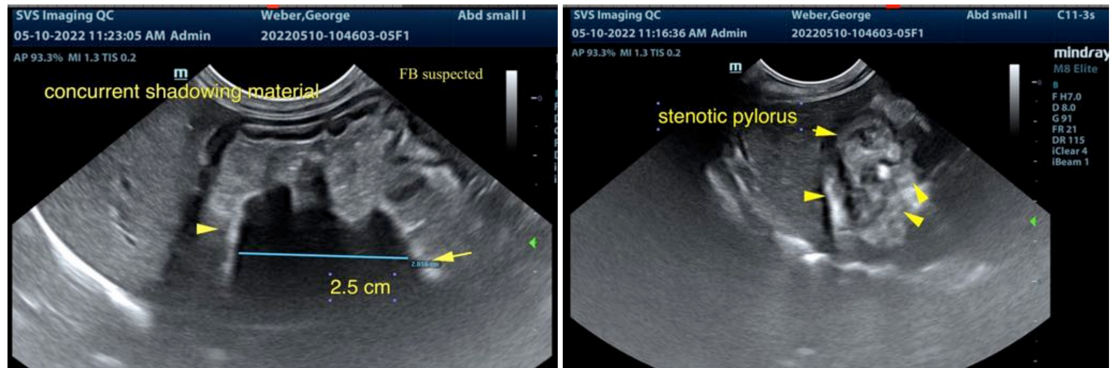

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Lisa Carioto, DVM, DVSc, Diplomate ACVIM

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