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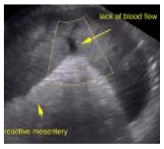
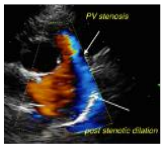
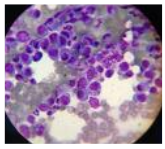
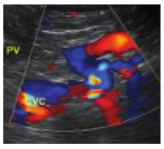

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Austin Carista

SPECIES

Canine

BREED

English Bulldog

SEX

Neutered Male

AGE

8 Years

WEIGHT

57 Lbs.

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY

JK

HOSPITAL NAME

Hamburg VC

REFERRING VET

Dr. DenHeyer

INVOICE

13917

DATE

2/14/22

PRESENTING CLINICAL SIGNS

History: Sporadic vomiting. On omeprazole daily
Abnormal PE/Chem/CBC/UA Results: Blood normal

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 4.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted. Aortic trifurcation was normal.

The residual prostate was symmetrically normal in size with uniform parenchyma and slight coarse echotexture measuring 0.91 cm in diameter.

Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 5.1 cm in length. The right kidney measured 5.9 cm in length.

Adrenal Glands

The left and right adrenal glands were not distinctly visualized.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was non-distended in size with thin walls and primarily anechoic content with mild particulate luminal debris. The cystic and common bile ducts were normal.

Gastrointestinal

The visualized gastric walls were sonographically normal, exhibiting intact wall layering, without evidence of mural pathology. The lumen of the stomach contained moderate non-shadowing ingesta without signs of obstruction or foreign material. No overt evidence of mechanical pyloric outflow obstruction. The pylorus wall measured 0.47 cm. The gastric body wall measured 0.41 cm.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. The duodenum wall measured 0.41 cm. The jejunum wall measured 0.40 cm.

Normal visible colon wall layers were present with formed to semi formed feces in lumen.

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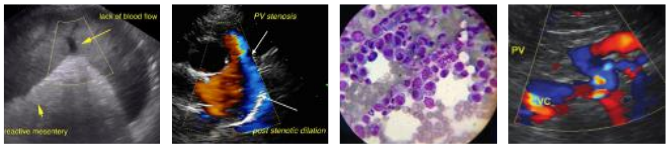

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Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

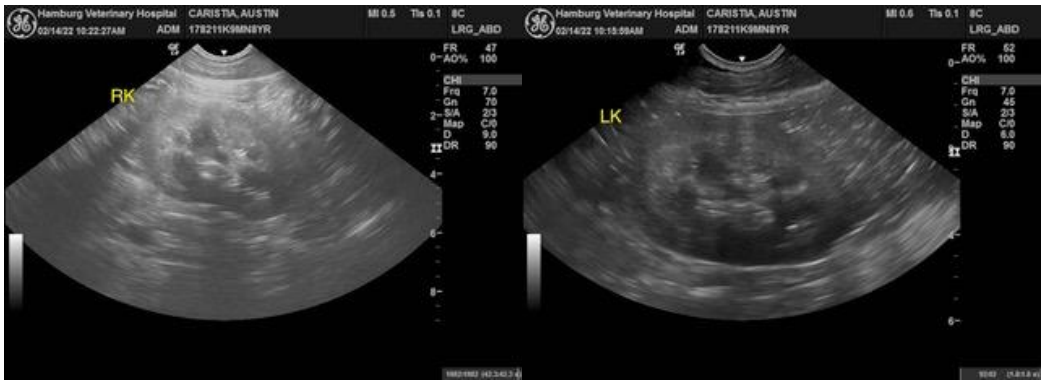
- Overtly normal gastrointestinal tract with mild to moderate gastric ingesta
- Minor gallbladder debris- incidental

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The presence of gastric ingesta may indicate postprandial presentation, correlation with most recent meal ingestion recommended. If documented NPO, the presence of gastric ingesta may suggest some degree of metabolic gastric stasis or nonobstructive delayed gastric emptying. Dietary intolerance/food hypersensitivity, occult parasitism, or structurally insignificant gastrointestinal disease may be possible. Resting cortisol level to rule out occult Addisons disease may be considered. If not done, three-view chest radiographs warranted to assess for or rule out occult thoracic or esophageal pathology, which may be a contributing factor to the patients intermittent vomiting. Empirically, some or all of the following protocol maybe considered.

Helicobacter/Gastritis protocol

A clinical trial of **Zithromax (*Dogs:*** 5-10 mg/kg p.o. q24h. May increase dosing interval to q48h after 3-5 days of treatment)**, Metronidazole** (10-20 mg/kg p.o. b.i.d.), **Pepcid** (0.5-1 mg/kg s.i.d.) and **Sucralfate** (0.5-2 g/dog PO) or **Omeprazole** (1 mg/kg p.o. s.i.d.) over the next 3 weeks along with a **novel-protein or hydrolyzed diet** with slurry feeding b.i.d./t.i.d. over the next 2-4 days and then increase to canned diet bid. Dry food should be avoided over the next 4 weeks. A recheck sonogram to assess GI improvement or progression would be ideal in 4 weeks.



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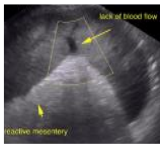
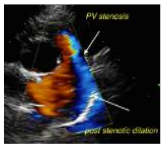
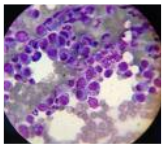
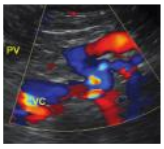

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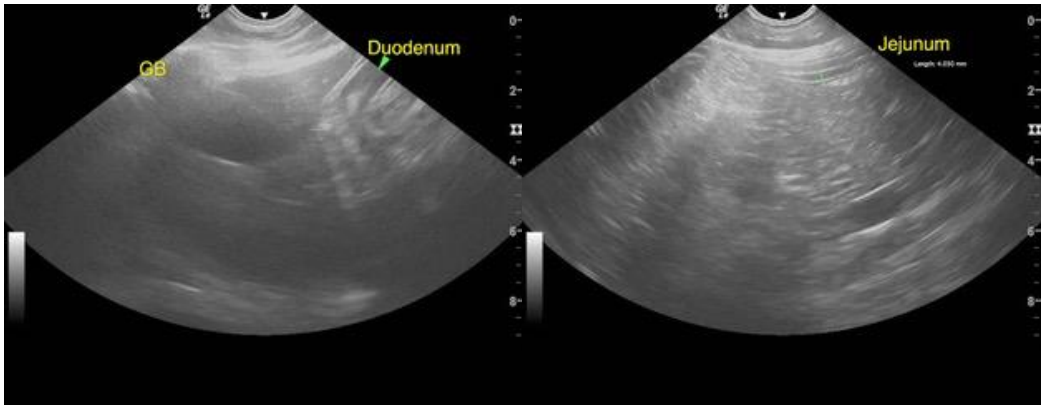

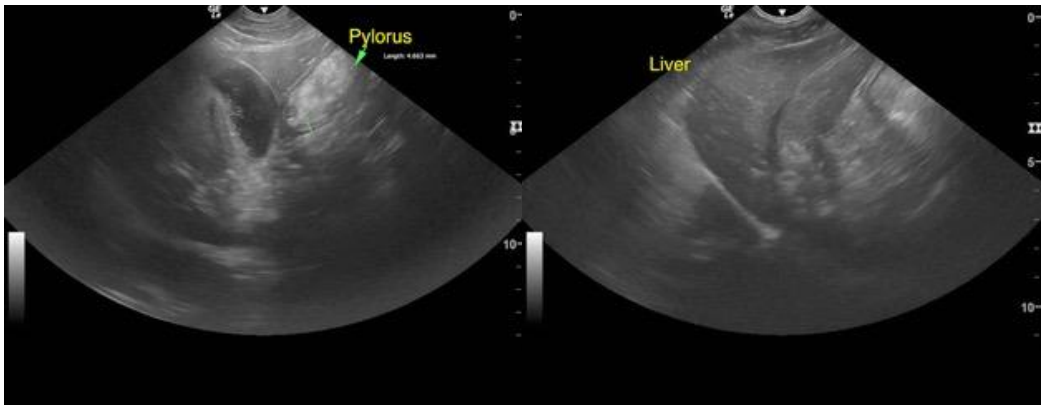

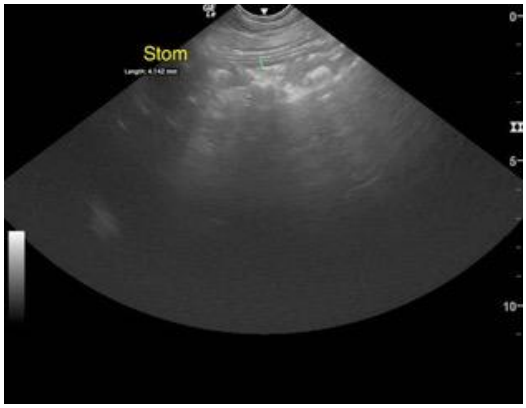

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)
info@SonoPath.com