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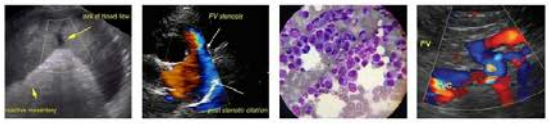

IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Pachuco Romero

SPECIES

Canine

BREED

Lab Mix

SEX

Neutered Male

AGE

11 Years

WEIGHT

30.75 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT LVT

HOSPITAL NAME

Roundhill AH

REFERRING VET

Dr. Carl Kelly

INVOICE

38921

DATE

6/21/22

PRESENTING CLINICAL SIGNS

History: Pachuco" Ana Romero Male, neutered 11 years old Dog has been vomiting off/on past several weeks after eating. cPL is normal. No abnormal bloodwork

Abnormal PE/Chem/CBC/UA Results: sedated rompun and butorphanol IM-

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was mildly subnormal in size owing to lack of urine distention, yet without overt pathology. No inflammatory or neoplastic criteria. Mild anechoic urine present.

The residual prostate was symmetrically normal in size (1.5 cm) with uniform parenchyma and slight coarse echotexture.

The area of the aortic trifurcation was free of pathology.

Normal size and margination were 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 5.7 cm. The right kidney measured 5.8 cm.

Adrenal Glands

The adrenal glands were uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.58 cm at the cranial pole and 0.53 cm at the caudal pole. The right adrenal gland measured 0.77 cm at the caudal pole.

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 mild congealed debris. The cystic duct and common bile ducts were normal without evidence of dilation.

Gastrointestinal

The stomach presented intact yet prominent wall layering owing to generalized prominent gastric mucosa exhibiting mild asymmetrical luminal surface, margination, and subjective prominent rugal folds. The lumen of the stomach was primarily empty with mild retained anechoic fluid. No evidence of loss of gastric wall layering or overt gastric masses. No evidence of gastric foreign material. Ventral gastric body wall measured 0.89 cm. Ventral pylorus wall measured 0.87 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. Duodenum wall measured 0.45 cm. Jejunum wall measured 0.44 cm.

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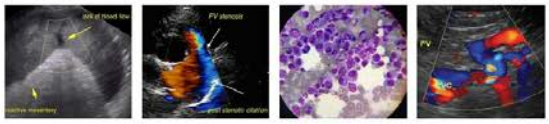

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Normal visible colon wall layers were present with apparent formed feces in lumen.

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

Intermittent mildly prominent to enlarged gastric and pancreaticoduodenal lymph nodes were present. Example measured 1.2 cm diameter. The lymph node was essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5).

PRIMARY FINDINGS

- Gastritis pattern
- Intermittent mild gastric and pancreaticoduodenal lymphadenopathy – subjectively benign/reactive.
- Sonographically unremarkable small bowel

SECONDARY FINDINGS

- Mild gallbladder debris (non-mucocele) – likely incidental, potentially secondary to fasting.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Sonographically, the gastric presentation is most consistent with gastritis, given the prominent yet intact wall layering. Minor potential for early infiltrative gastric disease (i.e., neoplasia) considered a less likely differential diagnosis. Dietary intolerance/food hypersensitivity or occult parasitism may possible be considered contributing factors 3-view chest radiographs suggested to rule out occult thoracic or esophageal pathology. Some or all of the following protocol or alternative protocol with empirical coverage of helicobacter could be considered. Ultimately, upper gastrointestinal endoscopy may be indicated if vomiting continues without evidence of concurrent gastrointestinal signs (i.e., diarrhea, weight loss, etc.). Although thought less likely given the normal sonographic presentation of the adrenal glands, resting cortisol to rule out occult Addison's disease could be 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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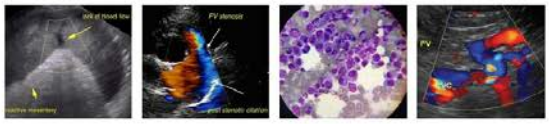

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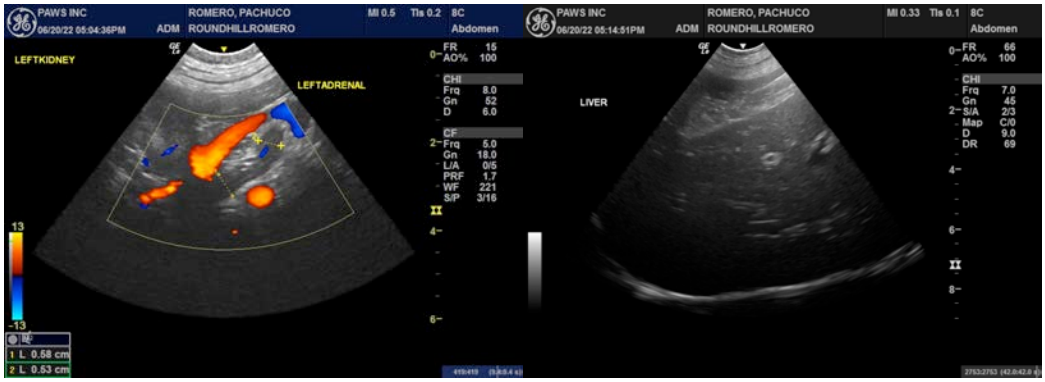

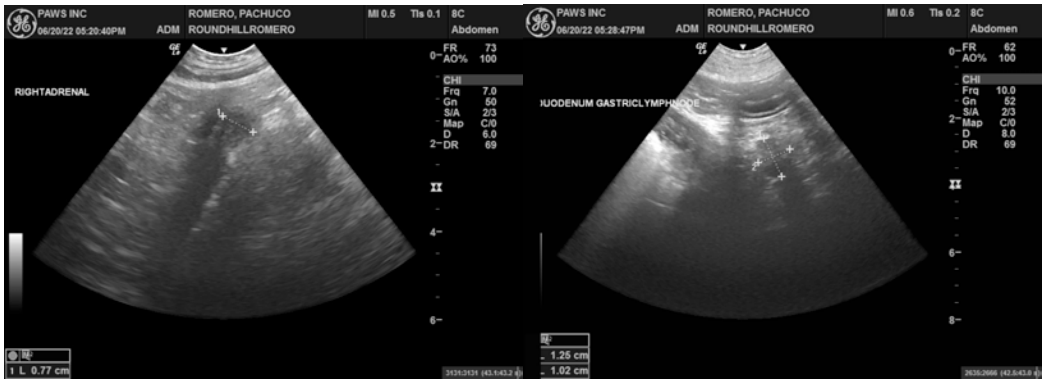

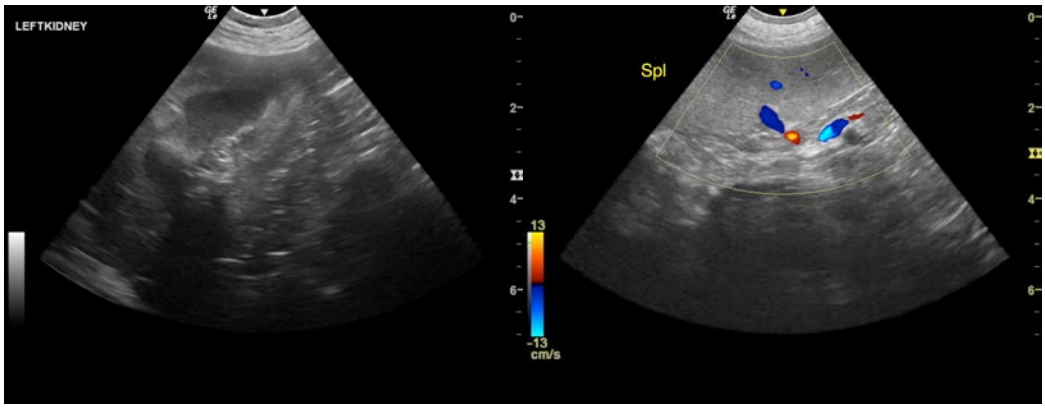

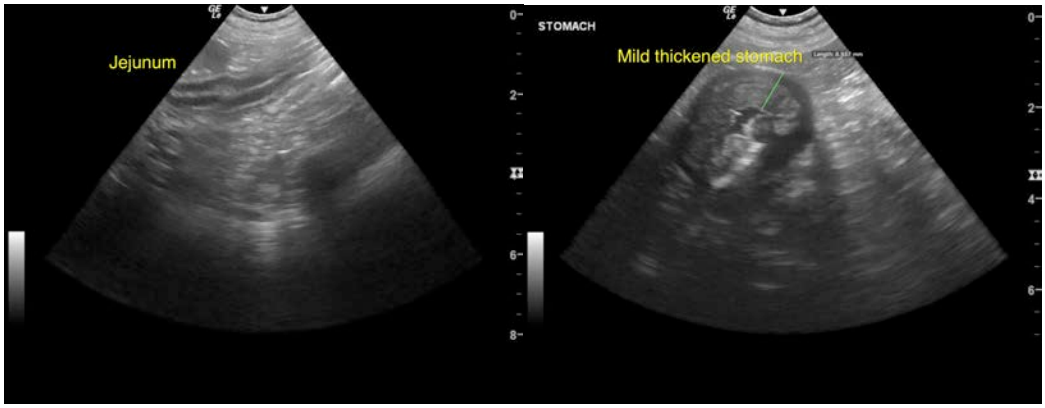

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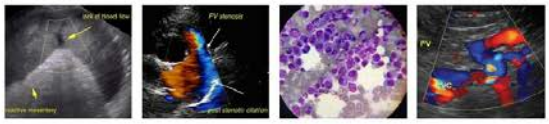

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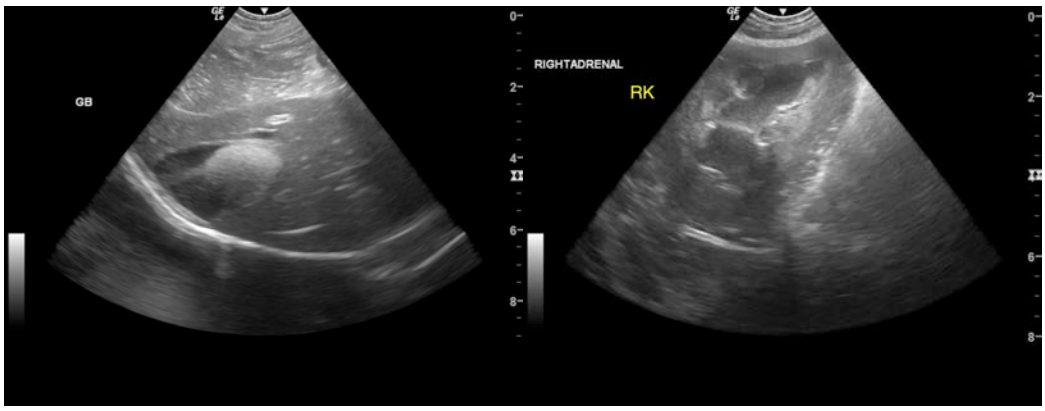

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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