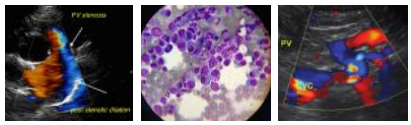
IMAGING PERFORMED BY

IntraPet.com



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DATE

1/27/2022

PATIENT

Buddy Miller

SPECIES

Canine

BREED

Labrador Retriever

SEX

Male Neutered

AGE

5-19-2014

WEIGHT
72.8 Lbs

INTERPRETED BY

Andrea Nicastro, DMV, Diplomate DACVIM (Small Animal Internal Medicine)

HOSPITAL NAME

Jacksonville Veterinary Clinic

REFERRING VET

Dr. Burk

INVOICE

10204

PRESENTING CLINICAL SIGNS

History: Vomiting, diarrhea, abdominal discomfort while recently in Florida. Treated for pancreatitis. History of pancreatitis. More comfortable now, eating bland, low-fat food, no vomiting currently, has mucus in stool.

Current Medications: Cerenia 24mg QD, Metronidazole 250mg BID, Amoxicillin 500mg BID, Gabapentin 200mg BID, Pepcid.
Lab Results: 1/25/22 Eos 1482 Superchem normal. Blood work in Florida showed increased lipase. US in Florida says thickened duodenum, ileum, mottled pancreas, distorted gallbladder with atypical contents. Rec in Florida was exploratory. (We do not have all Florida records, just some doctor notes).
Date of Previous IntraPet Ultrasound: 11-14-2014, 1-6-2020.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: STAT REQUESTED.
Imaging Performed By: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended with anechoic urine. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (1.00 cm in width) and shape. The parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney presented normal size (6.72 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney presented normal size (6.35 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.69 cm at cranial pole) (0.80 cm at caudal pole) (2.30 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.78 cm at cranial pole) (0.78 cm at caudal pole) (2.46 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.69 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver
The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed.

The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal.

Gastrointestinal
The gastric lumen is mildly to moderately distended with ingesta. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is segmentally dilated with chyme. The small intestinal wall is normal to mildly thickened (up to 0.43 cm) with a normal layering pattern and appropriate mural detail. There is disruption of the normal 1:3 muscularis to mucosal ratio in some segments. Discreet masses are not identified. The colonic wall is normal. The colonic lumen contains granular-appearing fecal material. There is no evidence of an obstructive pattern.

Pancreas
The base of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely hyperechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen
There is no evidence of free fluid. 1.87 x 0.51 cm medial iliac lymph node is visualized. One to two prominent mesenteric lymph nodes are also seen, the largest measuring 0.91 cm.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Bowel pattern most consistent with inflammatory bowel disease with some potential for emerging lymphoma.
- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.

Secondary Findings

- Age-related pancreatic remodeling with fibrosis. Low-grade pancreatitis may also be present, particularly if the patient exhibits on cranial abdominal palpation.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- If further GI workup is desired, consider the following:

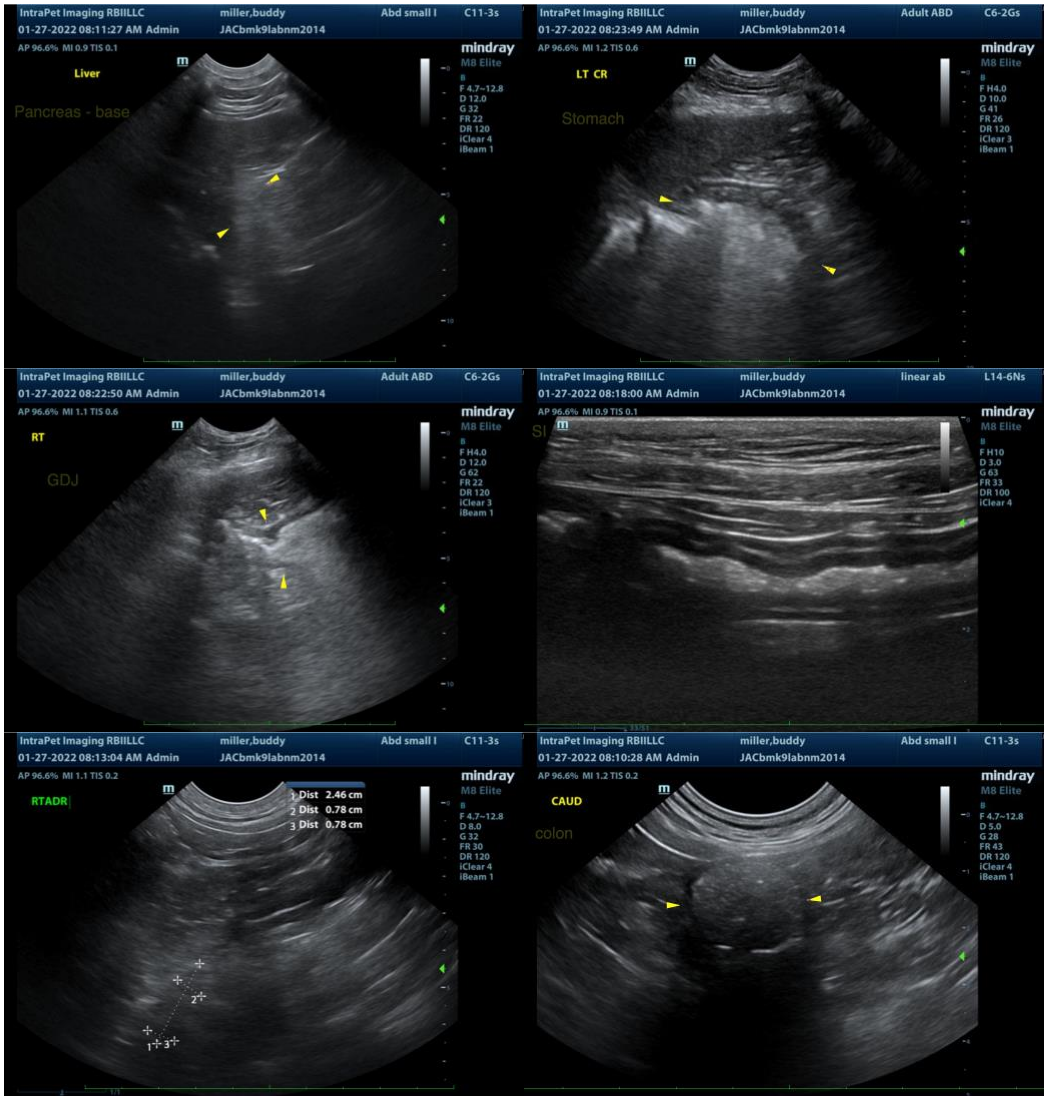
    1. Malabsorption panel including serum cobalamin, folate TLI and PLI
    2. A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended.
    3. Fecal evaluation for ova and Giardia

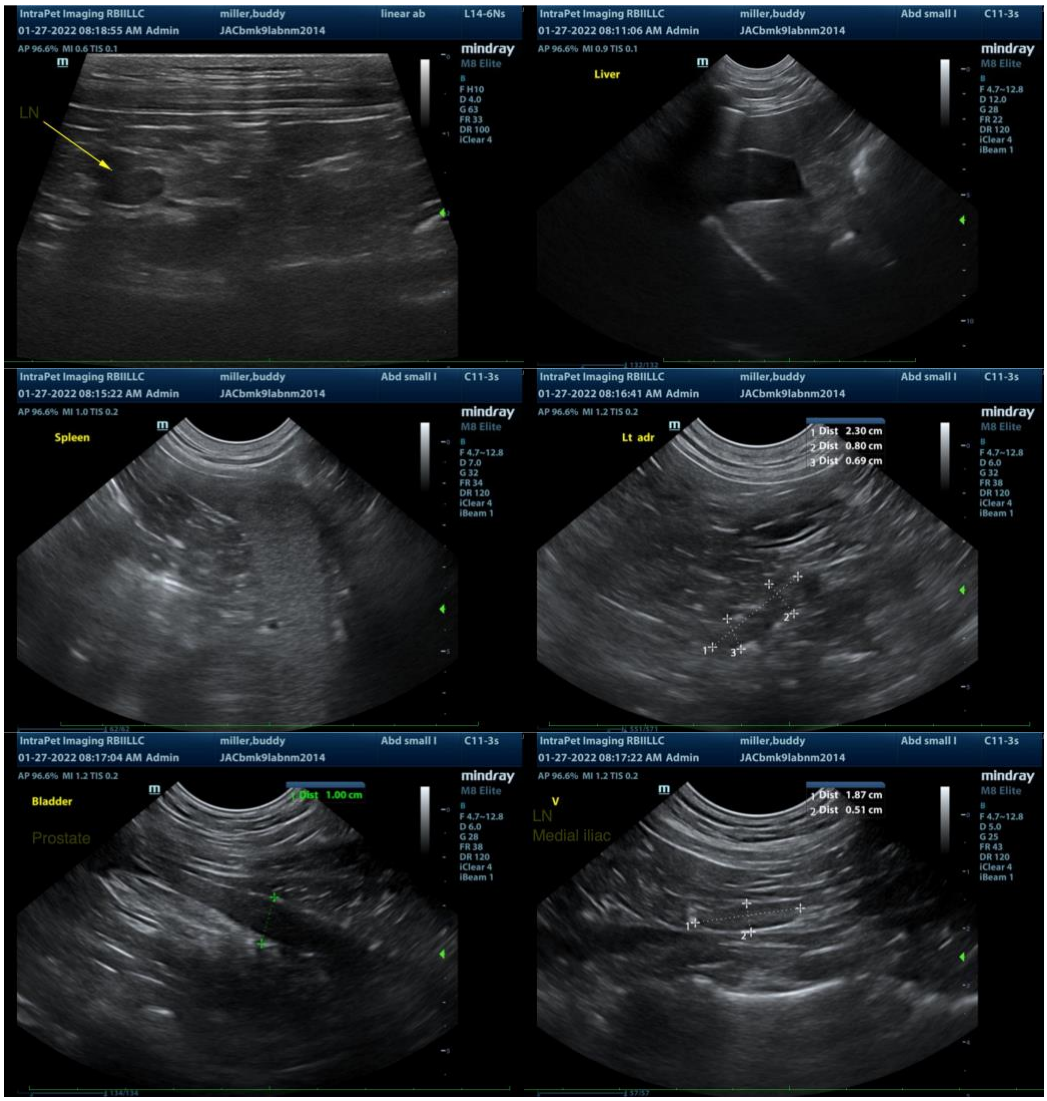
4. Prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.

5. A 6-week limited antigen diet trial to assess for food allergies

6. Depending on the results of the above diagnostics, endoscopic or surgical gastrointestinal biopsies may be necessary to get a definitive diagnosis.

7. Given the patient's age, three-view thoracic radiographs are recommended prior to any anesthetic event





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.

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