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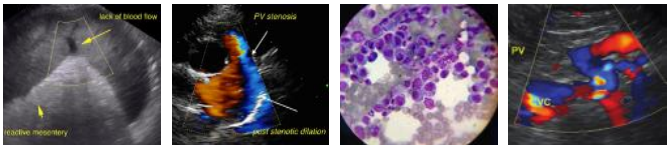


PATIENT

Stella Benitez de Suarez

SPECIES

Canine

BREED

Pomeranian

SEX

Female Spayed

AGE

10 years

WEIGHT

5.3 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Ferrer DVM

HOSPITAL NAME

Paseos Veterinary Center

REFERRING VET

Dr. Franco Ortiz

INVOICE

10250

DATE

2/2/2022

PRESENTING CLINICAL SIGNS

History: Presented for an abdominal ultrasound to evaluate diarrhea. The patient has been with on and off bouts of colitis radiographs - no overt evidence of dz 2 weeks ago the patient had blood work done and was normal fecal - neg recommended an abdominal ultrasound to rule out any other dz causing colitis /gastritis Was recently treated with patient: Metronidazole oral, DiaGELm famotidine and Cerenia injections and oral famotidine. Started RC HP hydralyzed diet.
Abnormal PE/Chem/CBC/UA Results:

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 left kidney is normal in size (2.74 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild to moderate loss of corticomedullary distinction. A hyperechoic medullary band is observed adjacent to the corticomedullary junction. Several hyperechoic shadowing diverticular foci are observed. A few nonobstructive nephroliths are visualized. Trace pyelectasia is present. There is no evidence of infarcts or hydroureter.

The right kidney is normal size (2.71 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild to moderate loss of corticomedullary distinction. A hyperechoic medullary band is observed adjacent to the corticomedullary junction. A 0.30 cm cortical cyst is observed at the cranial aspect. A few nonobstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal size (0.40 cm at cranial pole) (0.42 cm at caudal pole) (1.09 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 (0.63 cm at cranial pole) (0.31 cm at caudal pole) (1.17 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.

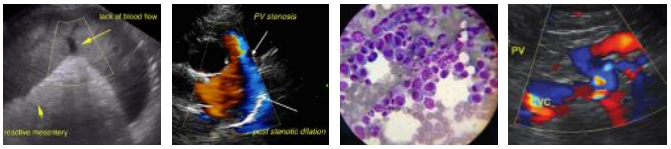
Spleen

The spleen is normal in size (1.01 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. Several irregular hyperechoic nodules are observed along the medial aspect in the region of the hilus, the largest measuring 1.47 cm in length. Splenic vasculature is normal.

Liver

The liver is subjectively prominent in size with slightly swollen peripheral contours. The parenchyma is isoechoic relative to the spleen and subtly heterogenous in appearance with a few small ill-defined hypoechoic nodules/areas. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A moderated amount of



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aggregated echogenic to mineralized mostly gravity dependent debris/sludge is observed within the lumen. The cystic and common bile ducts are normal.

Gastrointestinal

The gastric lumen is not distended. 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 not dilated. The small intestinal wall thickness is normal with a normal layering pattern. There is subtly mucosal fogging in the proximal duodenal mucosa. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. No obstructive or overt infiltrative disease is noted.

Pancreas

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic 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

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. One to two prominent mesenteric lymph nodes are visualized, the largest measuring 0.91 cm in length. In addition, a few lymph nodes in the caudal abdomen are seen, but are not overtly enlarged.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The subtly fogging in the proximal duodenal mucosa may be a normal variant for this patient or may be secondary to an inflammatory process or dilated lacteals.

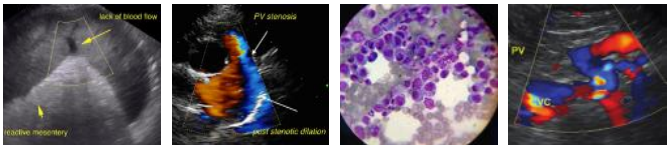
Secondary Findings

- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory and infiltrative disease are considered less likely.
- Age-related pancreatic remodeling
- The hyperechoic lesions adjacent to the splenic vessels are most consistent with myelolipomas. Although a neoplastic process within the spleen cannot be excluded, it is considered unlikely in this patient.
- Bilateral degenerative renal changes with dystrophic mineralization and nonobstructive nephrolithiasis
- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- To further investigate for causes of diarrhea in this patient, consider the following:

  1. Despite the negative fecal evaluation, prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.



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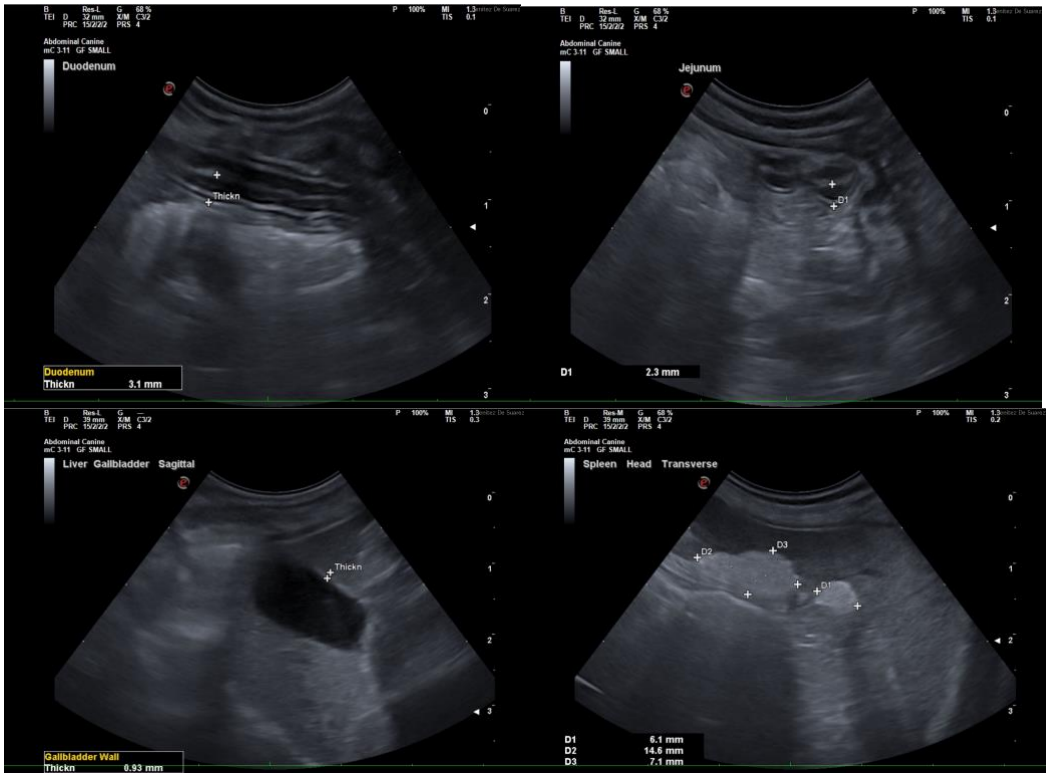
2. GI Panel (Send to Texas A&M)
3. Consider a fecal PCR infectious disease panel
4. A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended
5. Consider empirical treatment for small intestinal bacterial overgrowth with a 4-week course of Tylosin as well as supplementation with a probiotic with a high colony count such as Visbiome or Probiable Forte.
6. Continue the hypoallergenic diet trial for at least 6 weeks to help rule out food allergies.
7. Depending on the results of the above diagnostics/treatments, GI biopsies (i.e., endoscopic or surgical), may be necessary to get a definitive diagnosis.



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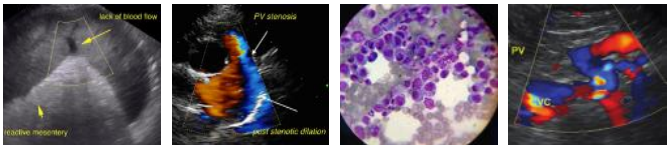

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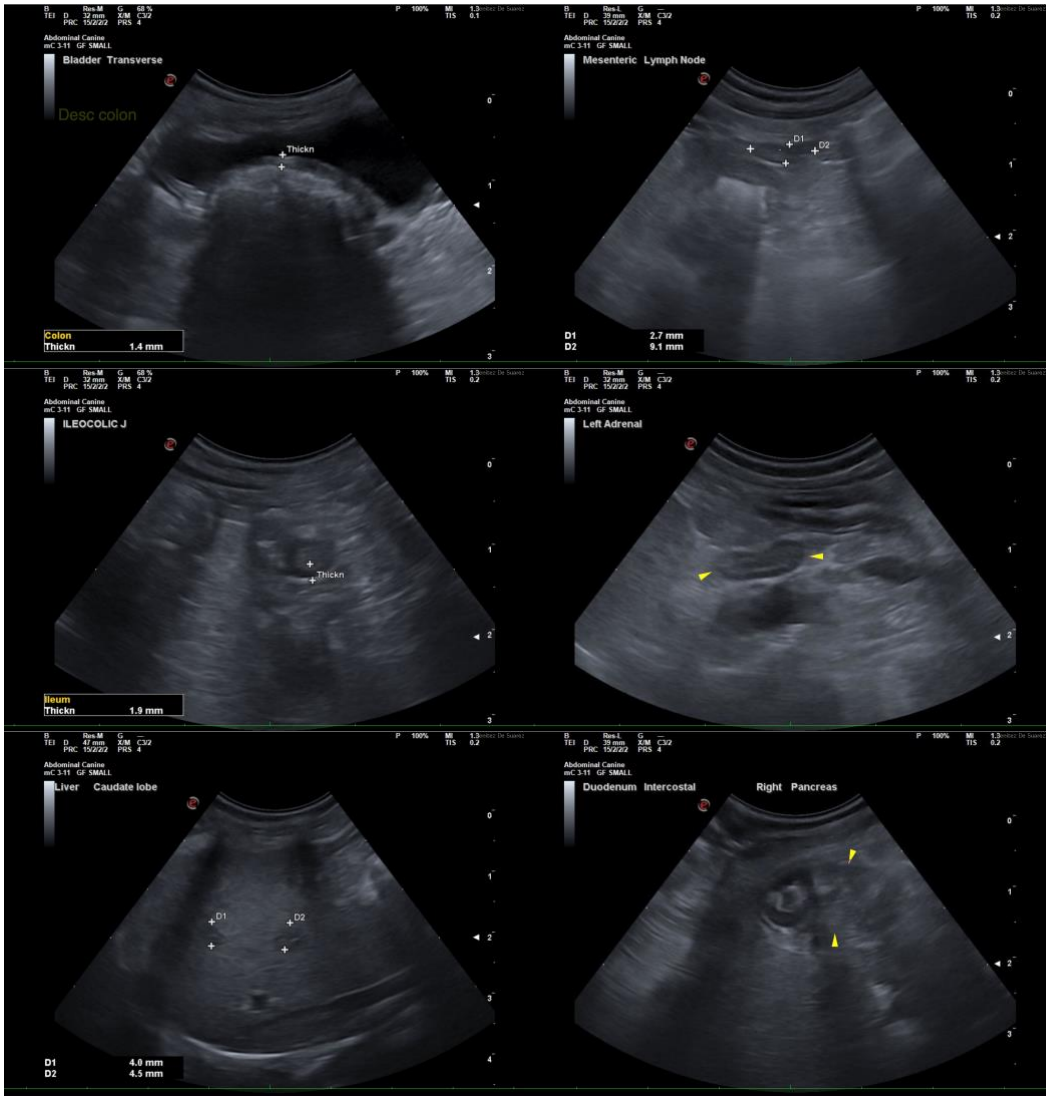

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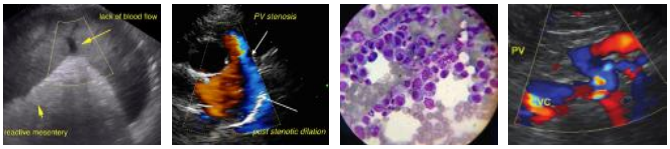

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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