

PATIENT PRESENTING CLINICAL SIGNS

Ruby DeVre
SPECIES Canine
BREED German Shorthair
SEX Female, spayed
AGE 8 Yrs.
WEIGHT 71 lbs.

History: Chronic diarrhea started on 11/25/22. Initially responsive to bland diet/Provable/metronidazole. Recurred after ceasing metronidazole. GI parasite PCR panel negative. HP diet initiated. O did not notice much response. BW on 1/2/23 revealed PLE. P started on Vit B12 injections once weekly. + Prednisone/metronidazole and responded well for 4 days then appetite decreased and d recurred. Initially v bile 2-3 times a week but no further v over past few weeks. P has lost 7 lbs in last 2 weeks (11/22-12/22 wt stable)
Abnormal PE/Chem/CBC/UA Results: Total Protein 3.4 g/dL 5.0 - 7.4 Albumin 2.1 g/dL 2.7 - 4.4 Globulin 1.3 g/dL 1.6 - 3.6 with HCT 65%

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is 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. The region of the trigone is normal.

The left kidney is normal size (6.66 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 is normal size (7.05 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 length (0.54 cm at cranial pole) (0.60 cm at caudal pole) with slightly flattened contour. 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 length (0.41 cm at cranial pole) (0.53 cm at caudal pole) with slightly flattened contour. 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 overall subjectively normal in size. A 2.32 x 1.68 cm irregular hypoechoic nodule/mass is observed at the tip of the caudal pole. In the remainder of the spleen, the margins are curvilinear. The parenchyma is slightly mottled. Splenic vasculature appears normal with no evidence of thrombosis.

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

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REFERRING VET

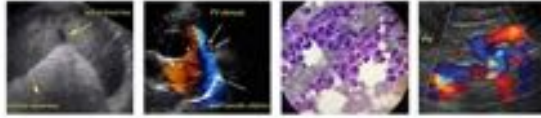
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distended. The wall is thin and smooth. A moderate amount of echogenic to mineralized mostly gravity-dependent debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

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 segmentally dilated with fluid and chyme. The small intestinal wall is mildly thickened (up to 0.52 cm) with retention of the normal layering pattern. There is evidence of mucosal fogging and striations in some segments. Discreet masses are not identified. The colonic wall is normal. No obvious obstructive disease is noted.

Pancreas

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is slightly hypoechoic 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 mesentery throughout the abdomen is mildly hyperechoic. Trace free fluid is observed. The abdominal lymph nodes are normal/not visible.

Other

A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.

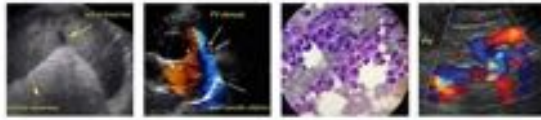
ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The patient's clinical history, in conjunction with the sonographic changes, are most consistent with a protein losing enteropathy. Top differentials include lymphangiectasia, inflammatory bowel disease, Infectious/parasitic disease or infiltrative neoplasia (i.e., lymphoma).
- The mild diffuse peritonitis is likely secondary to bowel pathology.
- The splenic lesion could be consistent with an emerging tumor, focus of lymphoid hyperplasia or similar, area of infarction, other.

Secondary Findings:

- The flattened adrenal glands bilaterally may be due to atrophy (secondary to recent steroid administration) or may be a normal variant for this patient.
- The pancreatic changes are suggestive of age-related remodeling +/- mild chronic inflammation.



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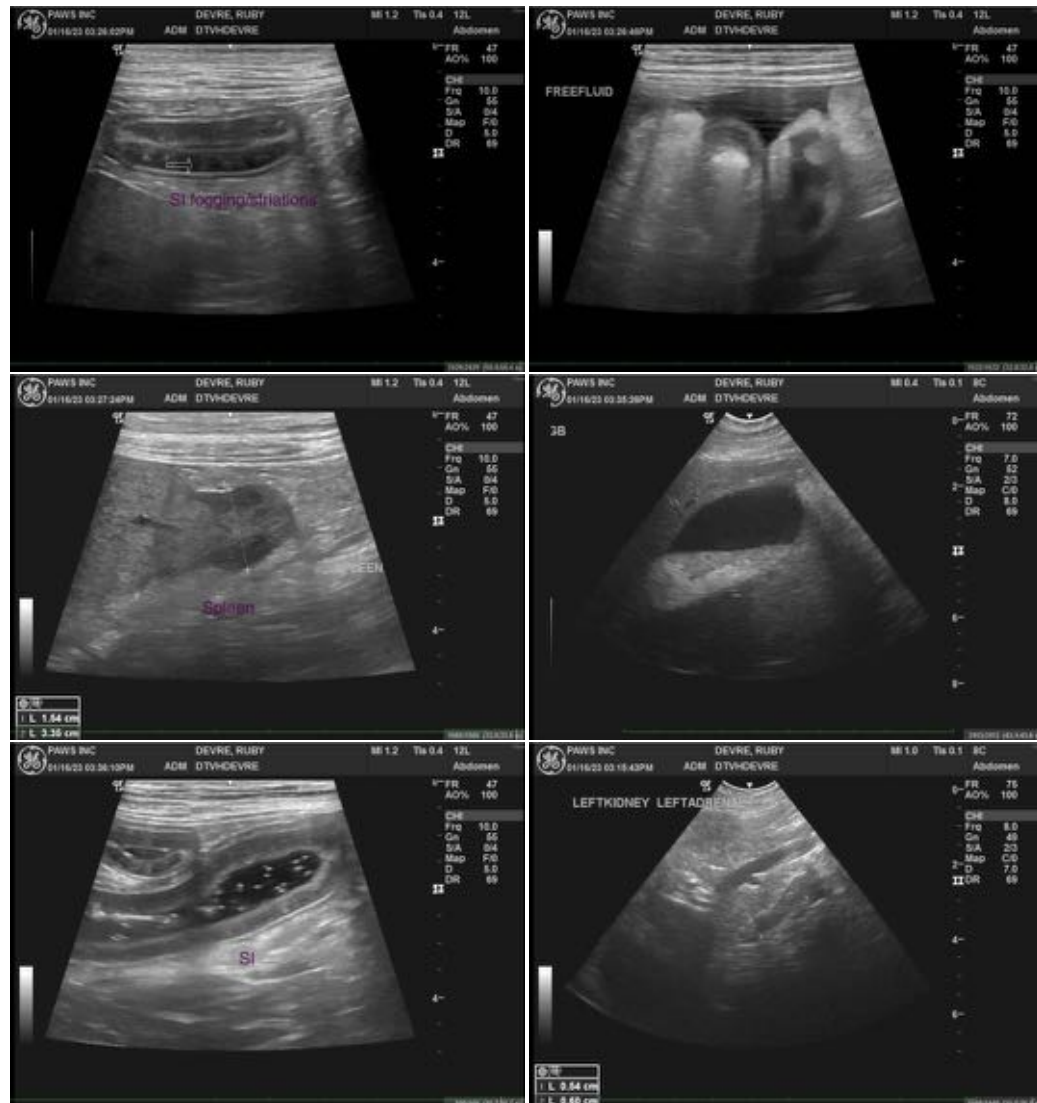
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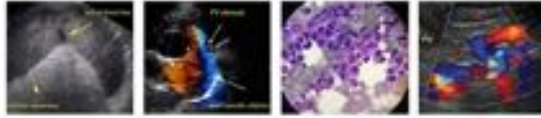
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

In order to get a definitive diagnosis, endoscopic or surgical GI biopsies would be necessary. In the meantime, consider the following:

1. Initiation of a fiber supplement (i.e., Metamucil or Konsyl).
2. Initiation of a low fat, limited antigen diet as empirical treatment for lymphangiectasia and inflammatory bowel disease.
3. If the patient fails to respond to corticosteroids, additional immunosuppressive therapy may be warranted. It should be noted, however that dogs with protein losing enteropathies often have a guarded prognosis with regard to response to therapy.
4. Consider a fine needle aspirate of the splenic nodule if clotting status is appropriate.





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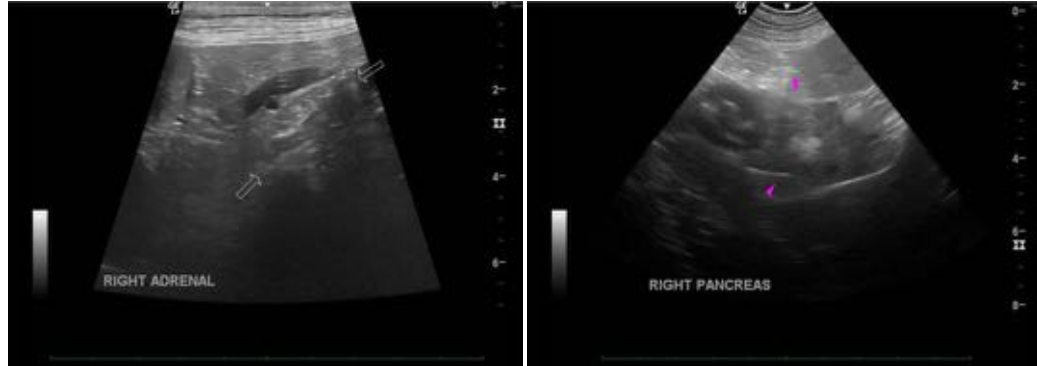
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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