PATIENT

Lucy Nazzaro

SPECIES

Canine

BREED

Beagle Mix

SEX

Female Spayed

AGE

10

WEIGHT

21.4

INTERPRETED BY

Andrea Nicastro DVM
Diplomate ACVIM

(Sm Animal Internal Med)

IMAGING PERFORMED BY

Pamela Harrigan, RDCS,
Cert Vet Sonog (IVUSS)

HOSPITAL NAME

Catherine Caffarella BVSc

REFERRING VET

Chase VC

INVOICE

22399

DATE

1-17-26

PRESENTING CLINICAL SIGNS

History: Chronic diarrhea, periodic vomiting and inappetence. GI protein loss. Grade III/VI heart murmur; no coughing. Elevated proBNP (1273), decreased total protein (4.3), decreased albumin (1.9), decreased calcium (8). On Metronidazole 250 mg, 1/2 tab BID, Cerenia 24 mg SID, Probiotic SID. Plan to start Prednisone (please advise). BP: 120-125 mmHg.
*Having bi-cavity ultrasound exam:

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The left kidney is normal in size (4.40 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild-to-moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. Trace pyelectasia is present (0.18 cm in the transverse plane). There is no evidence of infarcts or hydroureter.

The right kidney is normal in size (5.04 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild- loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis.

Adrenal Glands

The left adrenal gland is borderline enlarged (0.40 cm at cranial pole) (0.56 cm at caudal pole) with a normal shape and 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 borderline enlarged (0.41 cm at cranial pole) (0.55 cm at caudal pole) with a normal shape and 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 (1.04 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 prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits mild heterogeneity. No distinct focal lesions are observed. Hepatic vasculature and biliary tracts are of normal volume with no evidence of congestion.

The gallbladder lumen is moderately distended. The wall is thin and smooth. A small amount of suspended echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

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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 is normal-to-mildly-thickened (up to 0.46 cm) with retention of the normal layering pattern. Ther is suspected mild mucosal fogging in some segments. Discreet masses are not identified. The colonic wall is normal. The colonic lumen contains some liquid-appearing fecal material. There is no obvious evidence of an obstructive pattern.

Pancreas

The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

Lymph Nodes

The abdominal lymph nodes are normal/not visible.

Free Abdomen

The mesentery throughout the abdomen is mildly hyperechoic. Trace free fluid is observed.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The sonographic changes, in conjunction with the patient's clinical history, are consistent with a protein-losing enteropathy. Top differentials include inflammatory bowel disease, lymphangiectasia, infectious/parasitic disease, or emerging neoplasia (i.e., lymphoma). Diarrheic stool is present.
- Trace ascites, likely secondary to hypoalbuminemia.
- Mild peritonitis, likely sterile.

Secondary Findings

- Bilateral nonspecific age-related renal changes with dystrophic mineralization and trace left pyelectasia. The pyelectasia may be secondary to pyelonephritis, parenchymal remodeling, PU/PD (if applicable), or some combination thereof.
- The diffuse hepatic changes are nonspecific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory disease, infiltrative neoplasia and other hepatopathies are considered less likely.
- Gallbladder debris, non-mucocele
- The pancreatic changes are most consistent with age-related parenchymal remodeling, pancreatic potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the patient's clinical history, consider the following:

    1. Fecal evaluation for ova and Giardia, along with a fecal PCR infectious disease panel

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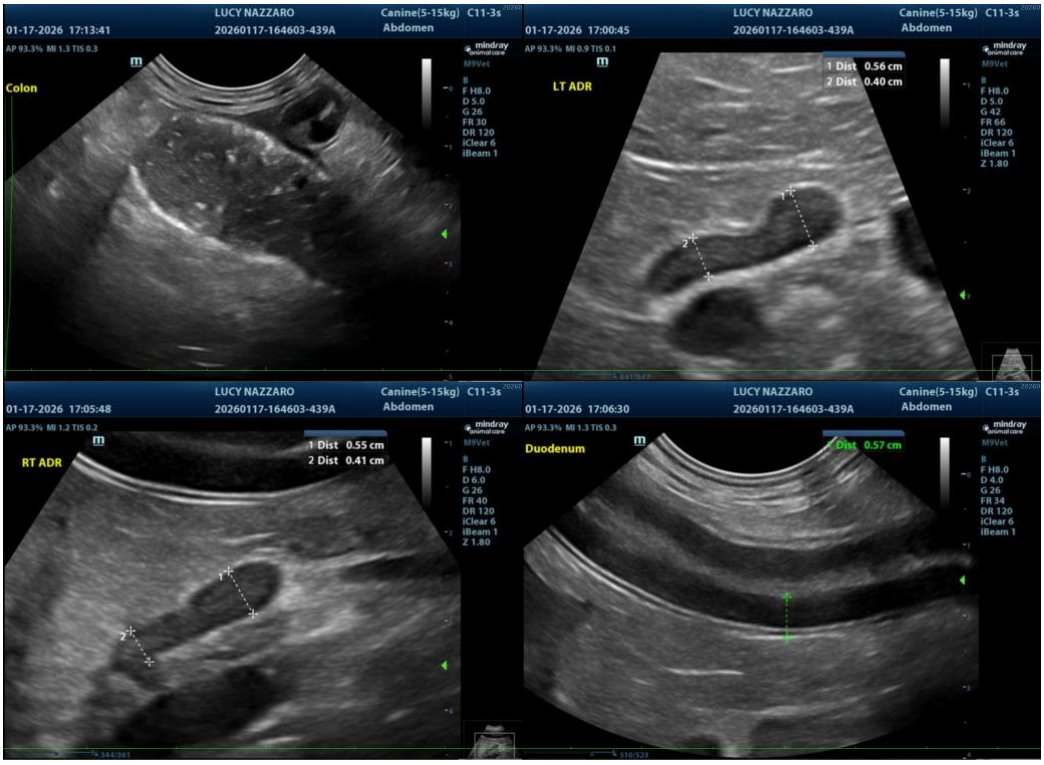
2. Prophylactic deworming with fenbendazole
3. GI panel including serum cobalamin and folate, TLI, PLI and resting cortisol level
4. Transition to a low-fat limited antigen diet
5. Ultimately, endoscopic or surgical GI biopsies may be necessary to get a definitive diagnosis. Three-view thoracic radiographs are recommended prior to any anesthetic event. If biopsies are not pursued at this time, empirical treatment for inflammatory bowel disease (corticosteroids, low-fat limited antigen diet) can be considered as long as the as long as the client understands the risks of treatment without a definitive diagnosis.

- To further evaluate for other causes of hypoalbuminemia, consider the following:

1. Pre- and postprandial serum bile acids
2. UPC if proteinuria is present in the absence of infection
3. A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended.



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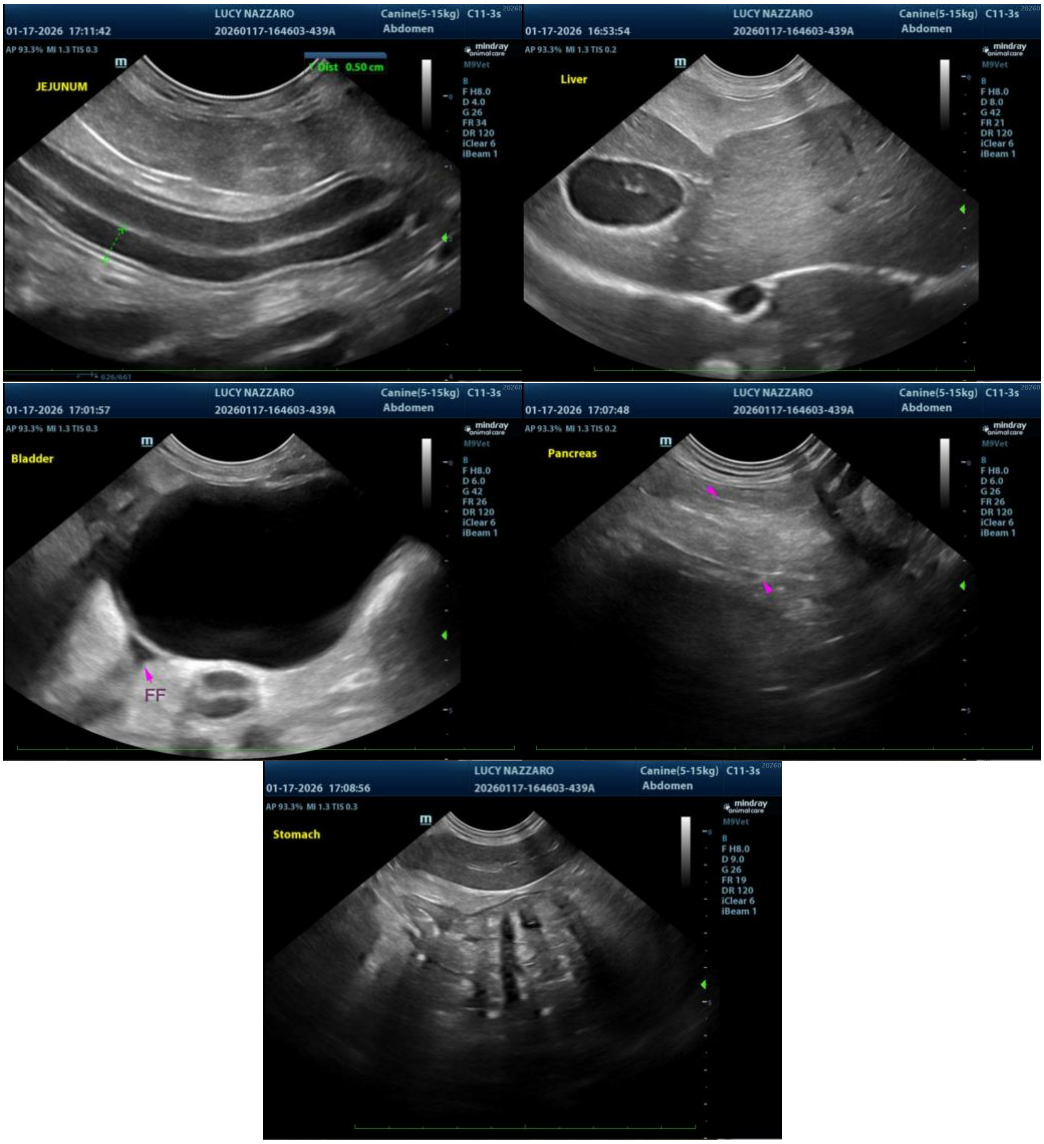

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com