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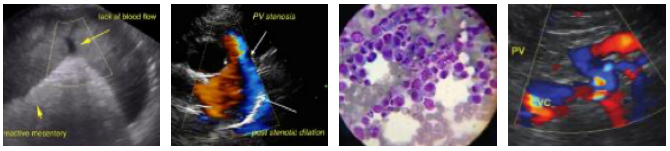


SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Jiren Santana Ruiz

SPECIES
Canine

BREED
Pitbull

SEX
Male, neutered

AGE
4 Yrs.

WEIGHT
42.6 lbs.

INTERPRETED BY
Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)

IMAGING PERFORMED BY
Dr. Gabriel Ferrer

HOSPITAL NAME
Pasesos VC

REFERRING VET
Dr. Carabello

INVOICE
12877

DATE
1/18/22

PRESENTING CLINICAL SIGNS

History: Jiren presented as a referral for an abdominal ultrasound. Patient has been having diarrhea that has not been responsive to treatment. Treatment was Metronidazole 250mg: 1 tab PO BID x14 days and it was done at the previous veterinarian.
Abnormal PE/Chem/CBC/UA Results: Bloodwork CHEM: CA: 7.2 (7.9-12) TP: 3.9 (5.2-8.2) ALB: 1.5 (2.3-4) GLOB: 2.4 (2.3-4.5) ALPK: <10 (23-312) CHOL: 77 (110-320) CBC: Leuk: 17.3 (5-16) NEU: 12.83 2-11.64) EOS: 1.48 (0.6-1.23) Platelets: 624 (148-484)

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 prominent to mildly enlarged (1.60 cm in width) with a normal shape and smooth peripheral contours. The parenchyma is mildly heterogeneous. The prostatic urethra is not overtly dilated.

The left kidney is normal size (5.50 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 (5.60 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.

Adrenal Glands

The left adrenal gland is normal size (0.54 cm at cranial pole) (0.66 cm at caudal pole) (2.47 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.

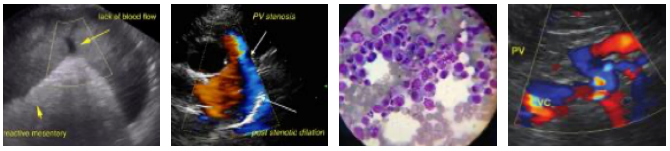
The right adrenal gland is normal size (1.48 cm at cranial pole) (0.65 cm at caudal pole) (2.51 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.41 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



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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/not seen.

Gastrointestinal

The gastric lumen is mildly gas distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The small intestinal lumen is not dilated. The small intestinal wall is diffusely thickened (up to 0.50 cm) with a normal layering pattern. There is evidence of mucosal fogging in several segments. Discreet masses are not identified. The colonic wall is normal. The colonic lumen contains granular appearing fecal material. No obstructive disease is noted.

Pancreas

The right limb of the pancreas is visible/prominent with slightly irregular peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and mottled in appearance. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated.

Free Abdomen

A moderate amount of anechoic free fluid is present. The mesentery throughout the abdomen is hyperechoic. A prominent caudal abdominal lymph node is visualized (2.60 x 0.97 cm). In addition, a 1.21 cm mesenteric node is visualized.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Given the sonographic bowel changes and clinical history, a protein-losing enteropathy (i.e., inflammatory bowel disease, lymphangiectasia, infectious/parasitic disease), infiltrative neoplasia (i.e., lymphoma)) is considered likely.
- The ascites and diffuse peritonitis is likely secondary to low oncotic pressure +/- increased vascular permeability due to bowel pathology.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

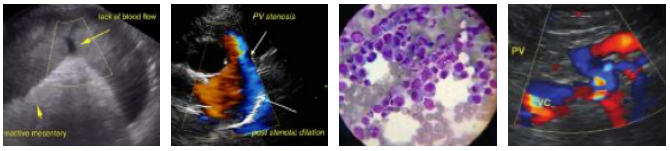
Secondary Findings:

- The pancreatic changes are suggestive of low-grade pancreatitis, which may be chronic.
- The prostate changes could be consistent with recent neutering, hyperplastic change, inflammation, or less likely, infiltrative neoplasia. Correlation with clinical findings is recommended.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the likelihood of a protein losing enteropathy, the following diagnostics/therapeutics are recommended:

1. Malabsorption panel including serum cobalamin, folate, TLI and PLI.



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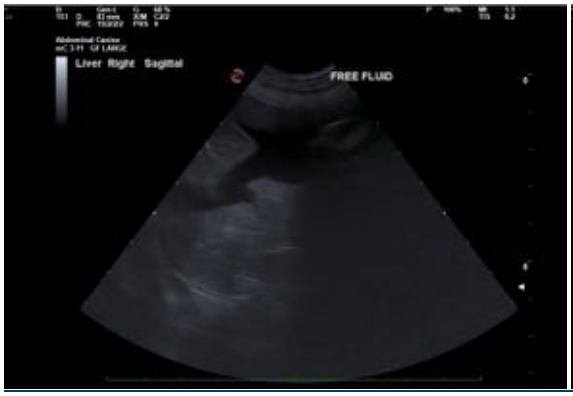
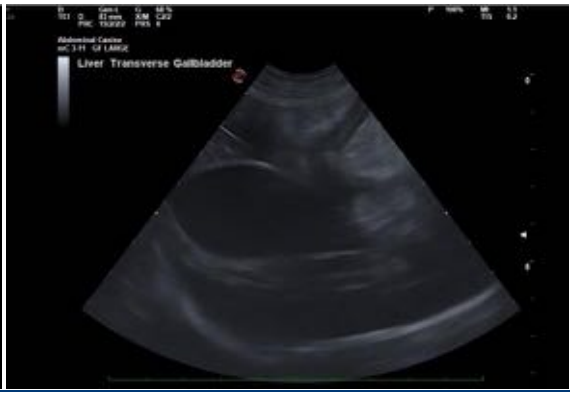
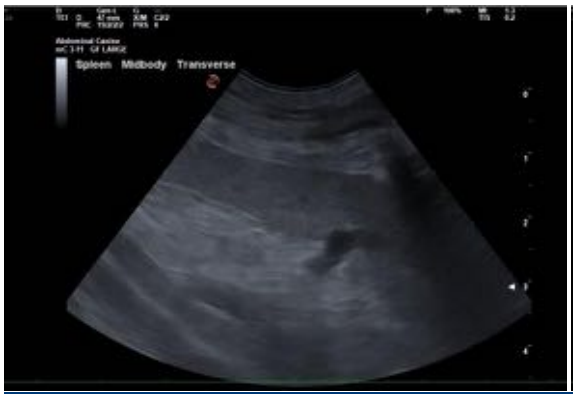
2. A fecal evaluation for ova/Giardia
3. Prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.
4. A low-fat hypoallergenic diet trial.
5. Ultimately, however endoscopic or surgical gastrointestinal biopsies would be necessary to get a definitive diagnosis. Surgical biopsies would be ideal in that all areas of bowel can be sampled.
6. Three-view thoracic radiographs should be performed prior to anesthesia, particularly given the concern for third spacing of fluids due to the hypoalbuminemia.

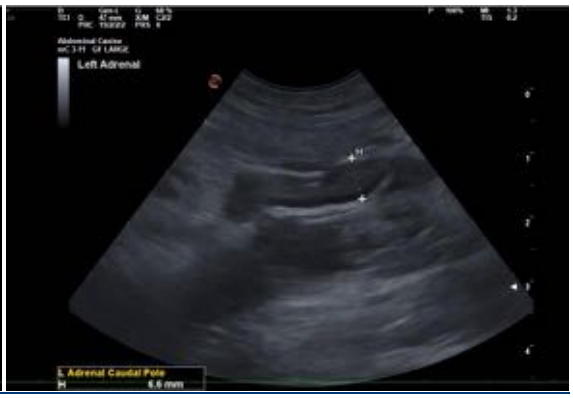
To further assess for concurrent causes of hypoalbuminemia, consider the following:

1. Pre- and post-prandial serum bile acids
2. UPC (if proteinuria is present)
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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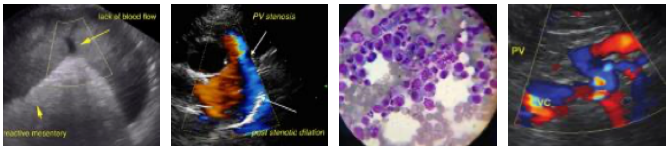

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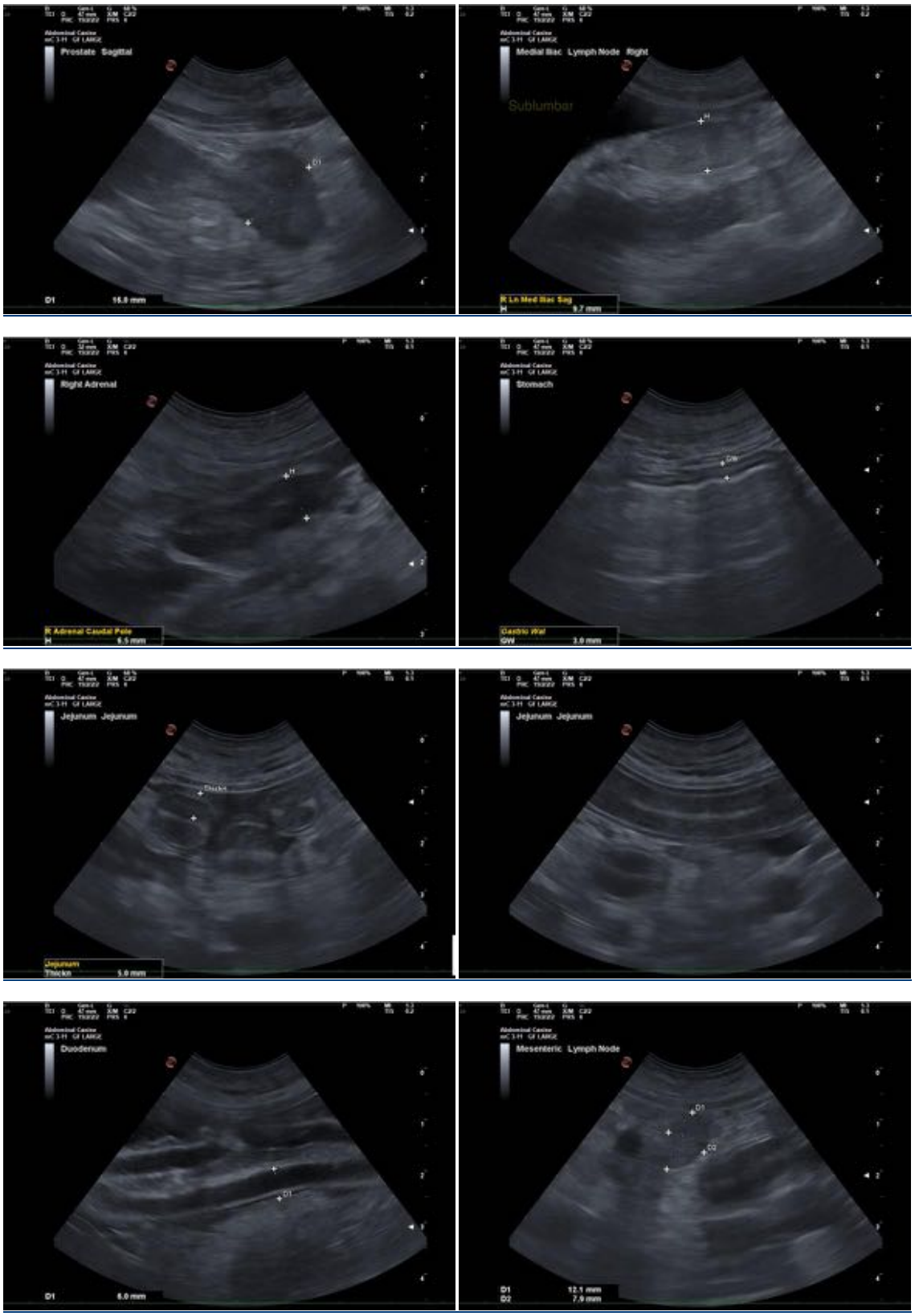

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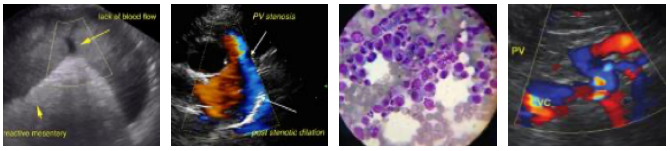

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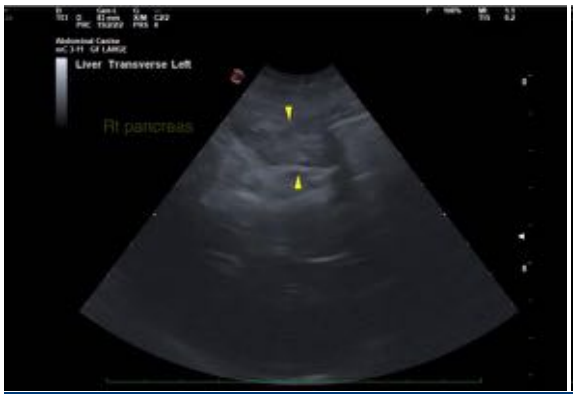

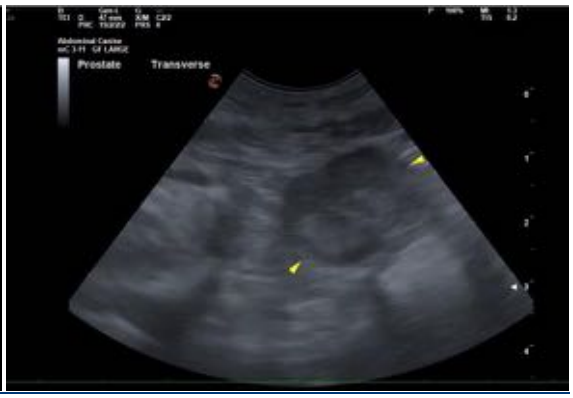

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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