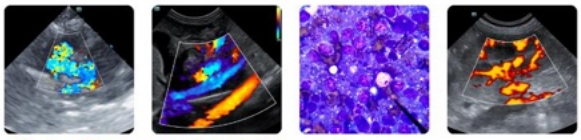


DATE

1/19/26

PATIENT

Carmen Buchdahl

SPECIES

Canine

BREED

Labrador Retriever

SEX

Female, spayed

AGE

3/6/2016

WEIGHT

66 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Jacksonville VH

REFERRING VET

Dr. Coll

INVOICE

13395

PRESENTING CLINICAL SIGNS

Patient History: Patient has been having on and off again diarrhea with vomiting sometimes. Has been going on for about a year with an increase in frequency starting in November. Marginally elevated ALT, only concern on bloodwork. eats i/d dry twice daily. On proviable and endosorb for diarrhea.

Current Medications: Proviable 1 cap over food SID, Endosorb give 2 tabs BID for 2-3 days then PRN for diarrhea, Hills I/d dry
Labwork Results: Labwork not attached, reported as: Marginally elevated ALT (203)
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed by: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and 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 the visible portion of the proximal urethra are normal.

The left kidney is normal in size (6.98 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (6.56 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.69 cm at cranial pole) (0.65 cm at caudal pole) with a normal shape. A 1.12 x 0.64 cm ill-defined hyperechoic area/nodule is observed approximately mid-gland. The remaining glandular echogenicity and detail are unremarkable. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.67 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.

Spleen

The spleen is normal in size (1.79 cm in width at the level of the hilus) with a normal capsular contour. The parenchyma is subtly mottled in appearance. At least 2 small ill-defined hypoechoic nodules are observed. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and slightly mottled in appearance. No distinct focal lesions are observed. 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 scant amount of echogenic 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 is normal in thickness with a normal layering pattern. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. There is no 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
A 0.55 x 0.41 cm sublumbar lymph node is visualized.

Free Abdomen
The mesentery surrounding the fundus of the stomach is hyperechoic. There is no obvious evidence of free fluid.

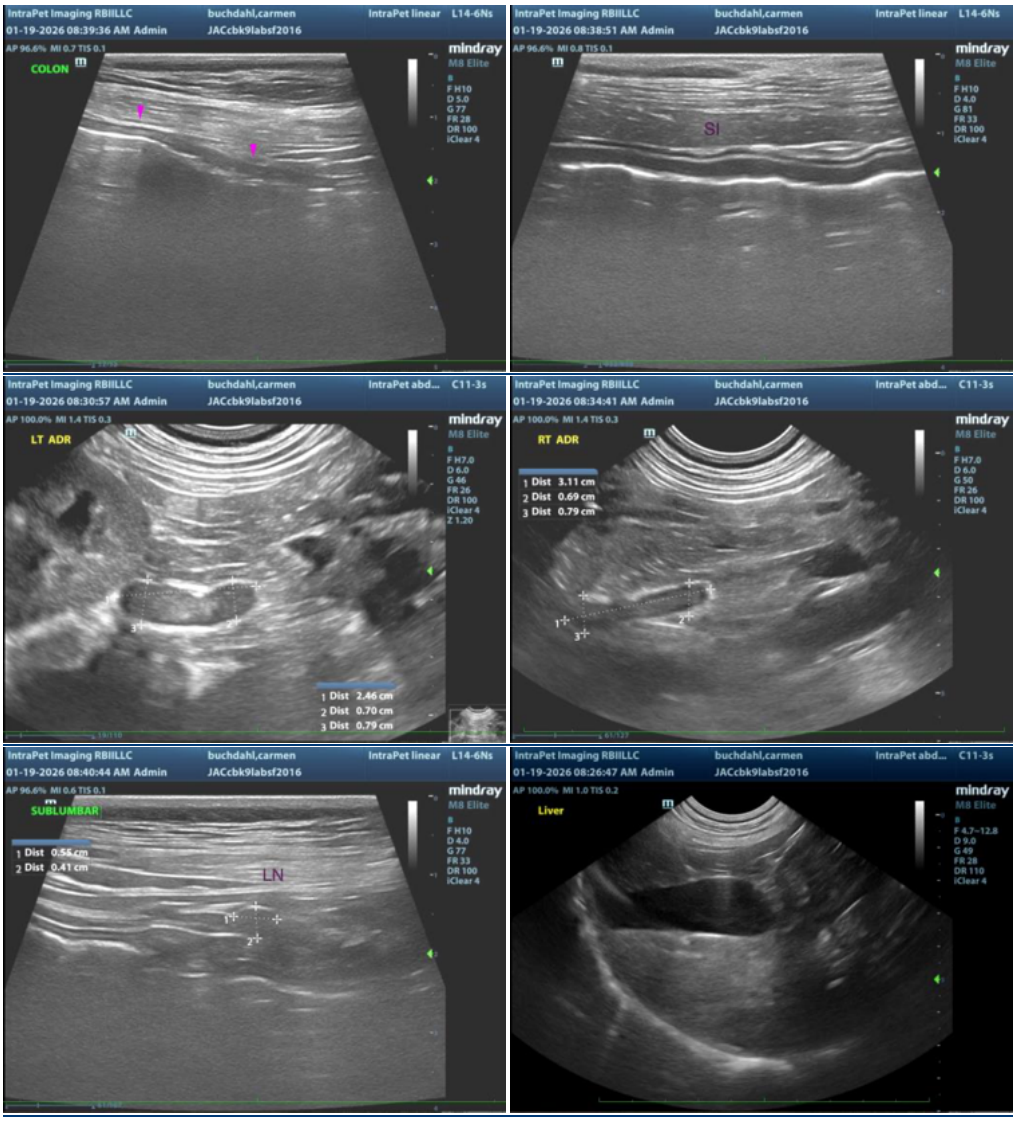
Other
A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.

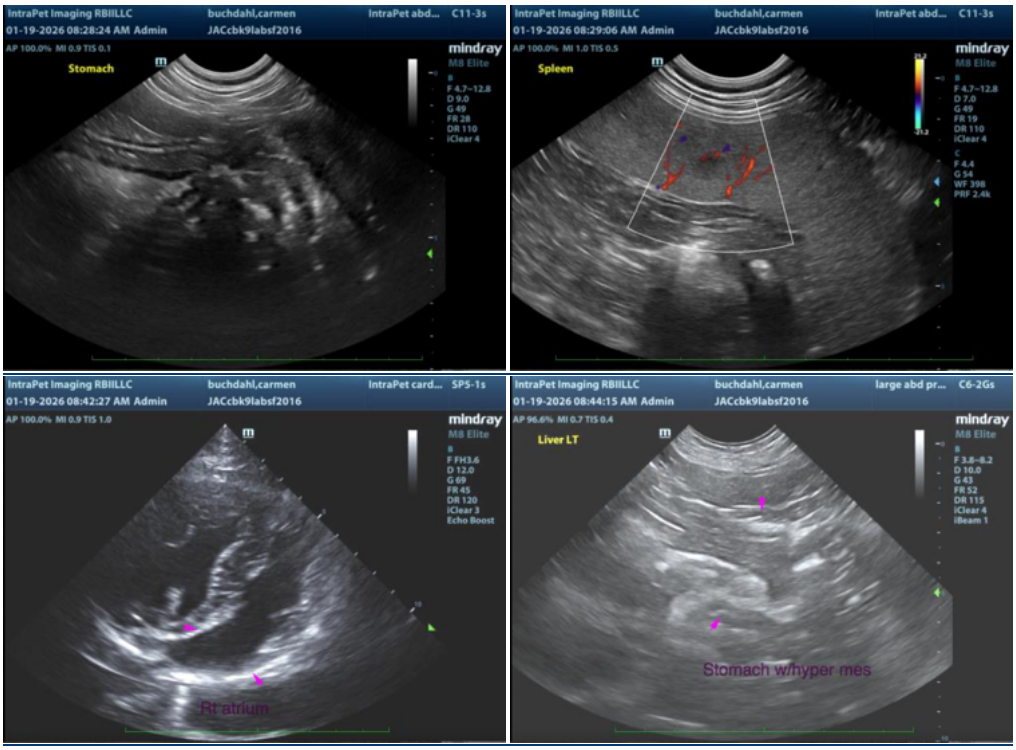
ULTRASONOGRAPHIC FINDINGS
- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or antigenic stimulation with a lower possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).
- The hepatic changes are non-specific and could be secondary to benign age-related parenchymal remodeling, reactive hepatopathy, regenerative nodular hyperplasia, inflammatory disease (i.e., cholangiohepatitis, chronic hepatitis), hepatotoxicosis (i.e., copper), fibrosis, infiltrative neoplasia (less likely) and/or other hepatopathy.
- The left adrenal nodule could be consistent with focal nodular hyperplasia, adenoma, emerging adenocarcinoma, pheochromocytoma, other.
- Mild peritonitis adjacent to the stomach
- The prominent sublumbar lymph node is likely reactive with a lower possibility of emerging neoplasia.

*An obvious cause for the patient's clinical signs is not definitively identified in this study. Considerations include a microscopic enteropathy (i.e., food allergy/intolerance, inflammatory bowel disease, infectious/parasitic disease), underlying metabolic issue, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS
- The following diagnostics/treatment recommendations can be considered:
    1. Texas GI panel including serum cobalamin, folate, PLI, TLI and resting cortisol level
    2. Fecal evaluation for ova/Giardia
    3. Prophylactic deworming with Fenbendazole.
    4. 3-4 week hypoallergenic or hydrolyzed protein diet trial
    5. Initiation of a probiotic with a high colony count +/- fiber supplement (i.e., psyllium).
    6. Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be warranted. Three-view thoracic radiographs should be performed prior to any anesthetic event.

- Regarding the elevated ALT, consider pre and post prandial serum bile acids +/- hepatic tissue sampling for further evaluation.





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