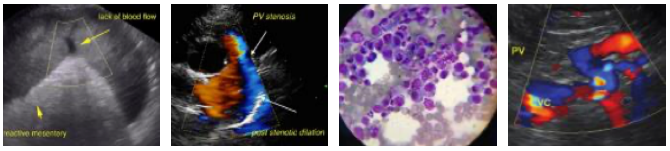
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Bounty Chappo

SPECIES
Canine

BREED
Boxer

SEX
Male, neutered

AGE
8 Yrs.

WEIGHT
67.2 lbs.

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

IMAGING PERFORMED BY
Amy Mayhew

HOSPITAL NAME
SVS Imaging Michigan

REFERRING VET
Town Center VA

INVOICE
14531

DATE
1/31/23

PRESENTING CLINICAL SIGNS

History: Presenting Complaint: Possible UTI, vomiting, PU/PD History: O notes pt has been urinating in house since around end of November, very PU/PD. O fills water bowl multiple times a day and will catch pt drinking from toilet. O also notes it seems she is feeding pt less, is free fed and does not seem to be eating as much. O also notes she hears pt vomiting outside sometimes, usually not in the house. Pt does have a history of 2 previous sx's - 1 foreign body and 1 scar tissue revision.
Abnormal PE/Chem/CBC/UA Results: Diagnostics: Total Body Function- pending results Urinalysis: USG- 1.035; trace protein, pH 7.0; fat droplets, 0-2 cocci/hpf

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly to moderately distended with anechoic urine. The wall is of appropriate thickness for the level of repletion. The mucosal surface in the region of the apex is slightly irregular. No cystic calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The prostate is normal in size (0.89 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal size (5.43 cm in length); normal shape and architecture with 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 size (6.38 cm in length); normal shape and architecture with 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.

Adrenal Glands

The left adrenal gland is normal size (0.50 cm at cranial pole) (0.68 cm at caudal pole); 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.

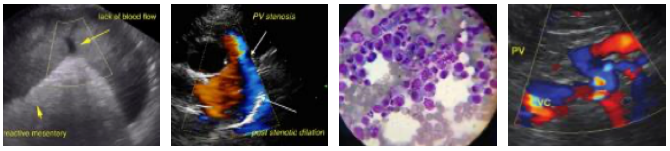
The right adrenal gland is normal size (1.12 cm at cranial pole) (0.47 cm at caudal pole); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (2.03 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. 2-3 small (up to 1.25 cm) ill-defined hypoechoic nodules/areas 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 congestion. No pathological hepatic lymphadenopathy observed. The gall bladder lumen is moderately



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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 moderately distended with ingesta. The gastric wall is normal in thickness with a normal layering pattern. The small intestinal lumen is segmentally dilated with gas and chyme (mild). 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. No obstructive disease is noted.

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.

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- If the patient was fasted for the study, the presence of ingesta in the gastric lumen could suggest delayed gastric emptying.

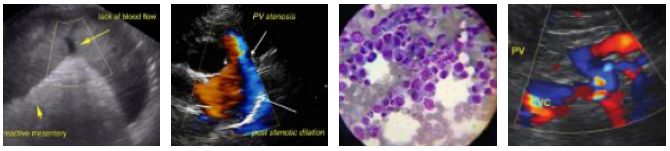
Secondary Findings:

- The hypoechoic splenic nodules/areas trend toward the benign (i.e., foci of lymphoid hyperplasia, extramedullary hematopoiesis or similar) with a lower possibility of emerging neoplasia.
- The mild urinary bladder wall thickening could be consistent with cystitis or may be artifactual due to lack of full repletion.

*An obvious cause for the patient's PU/PD is not identified in this study. Importantly, the patient is still concentrating his urine. Differentials in this patient include occult urinary tract infection, underlying metabolic issue, Leptospirosis, psychogenic polydipsia, occult hepatic dysfunction, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the PU/PD, consider the following:
  1. Urine culture and sensitivity
  2. Leptospirosis testing (i.e., blood and urine PCR, serology)
  3. Pre- and post-prandial serum bile acids to assess for occult hepatic dysfunction



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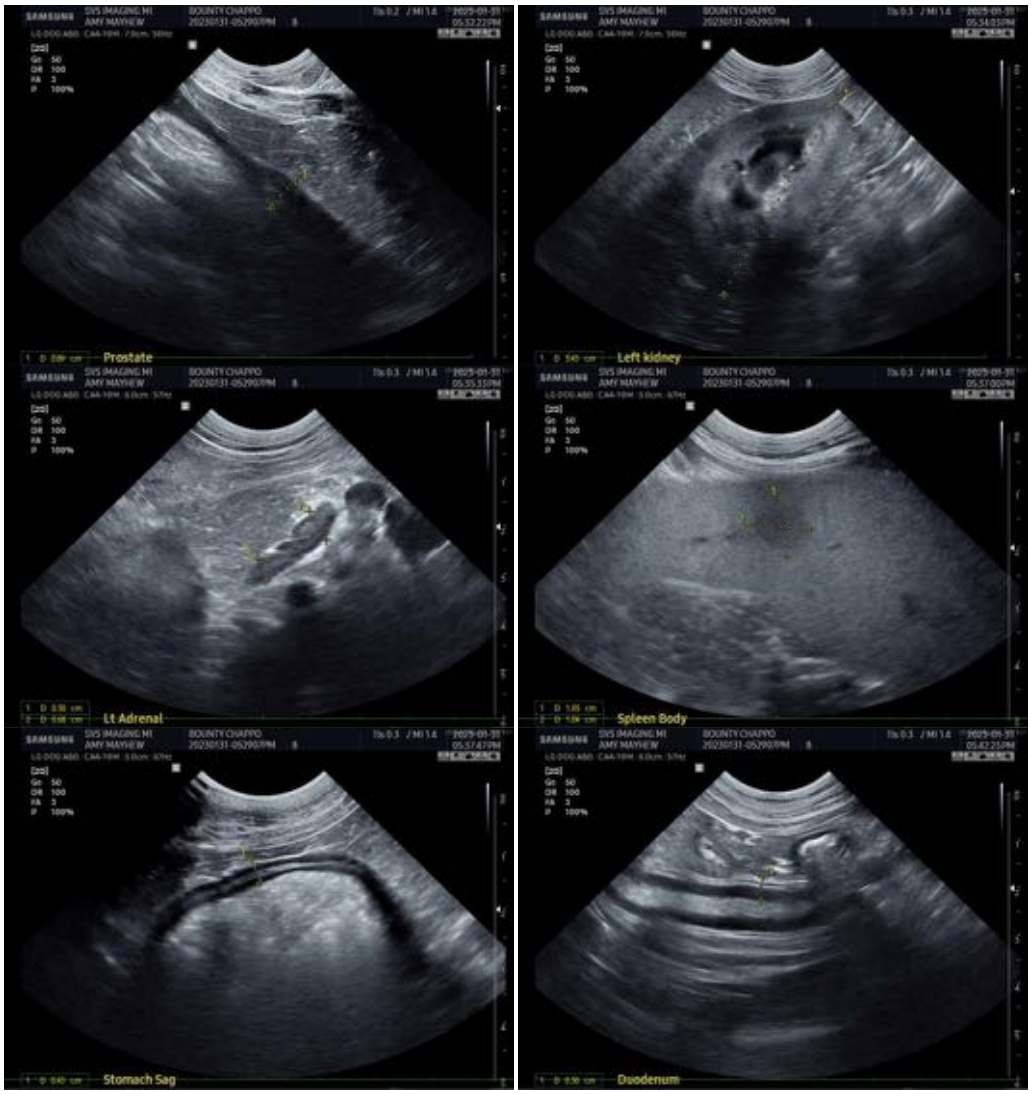
4. Depending on the results of the above diagnostics and the baseline lab work results, a modified water deprivation test may be warranted to assess for psychogenic polydipsia.

- Regarding the vomiting, consider the following:

1. A fecal evaluation for ova/Giardia
2. Texas GI panel including serum cobalamin, folate, TLI, PLI and resting cortisol level
3. 6-week limited antigen or hydrolyzed protein diet trial
4. Consider initiation of a probiotic
5. Thoracic radiographs are recommended to assess for occult esophageal disease.
6. Depending on the results of the above diagnostics, endoscopic or surgical GI biopsies may be warranted.



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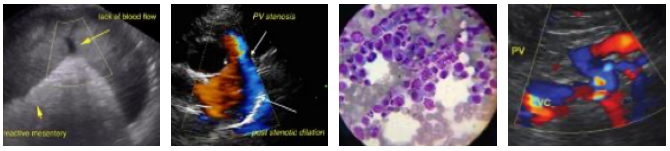

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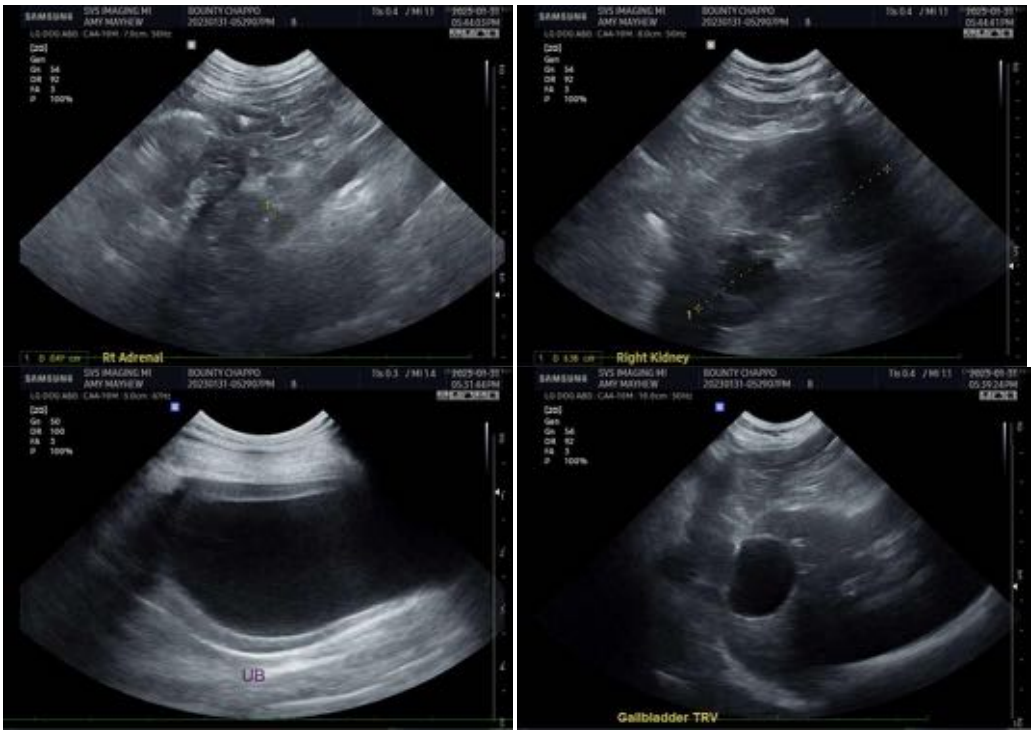

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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