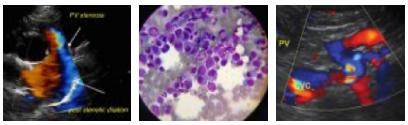
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

DATE

1/4/2022

PATIENT

Bella Chambers

SPECIES

Canine

BREED

Cockapoo

SEX

Female, spayed

AGE

2/9/2009

WEIGHT

17.4 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Fallston VC

REFERRING VET

Dr. Cianelli

INVOICE

12776

PRESENTING CLINICAL SIGNS

History: Recheck AUS - developing mucocele on AUS 11/23/21. Has been on Ursodiol since 12/1/2021. Vomiting started again mid-December. Owner modified diet to ProPlan Chicken and rice. No vomiting since 12/26/2021.

Current Medications: Omeprazole 20mg tabs, Ursodiol 100mg tabs 1 tab PO QD.
Lab Results: Pending.
Date of Previous IntraPet Ultrasound: 11-23-2021.
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, 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 left kidney is normal size (4.77 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. Several non-obstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (4.18 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. Several non-obstructive nephroliths are visualized. There is a questionable infarct at the caudal pole. There is no evidence of pyelectasia or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is upper limits of normal size (0.56 cm at cranial pole) (0.55 cm at caudal pole) (2.07 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 upper limits of normal size (0.62 cm at cranial pole) (0.57 cm at caudal pole) (1.86 cm in length) with a normal shape. A 0.33 x 0.30 cm irregular hyperechoic nodule is observed approximately mid gland. The remaining glandular echogenicity and detail are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

Previously splenectomized. The region of the splenic fossa is unremarkable.

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

gall bladder lumen is distended. The wall is normal in thickness. An excessive amount of aggregated echogenic to mineralized suspended sludge in a partially stellate pattern is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. 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 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 right limb of the pancreas is visible/prominent with slightly irregular peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and subtly mottled in appearance. The pancreatic duct is not overtly dilated

Free Abdomen

There is no evidence of free fluid. A 1.54 x 0.75 cm irregular, hypoechoic lymph node is observed in the right cranial quadrant.

Other

A uterine stump is visible (0.42 cm in width). No obvious pathology is observed.

A brief echocardiogram reveals no evidence of pericardial effusion.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Given the history, the pancreatic changes in the right limb are suggestive of resolving pancreatitis.
- Gallbladder changes are consistent with a developing mucocele. Changes are similar to the previous sonogram.

Secondary Findings:

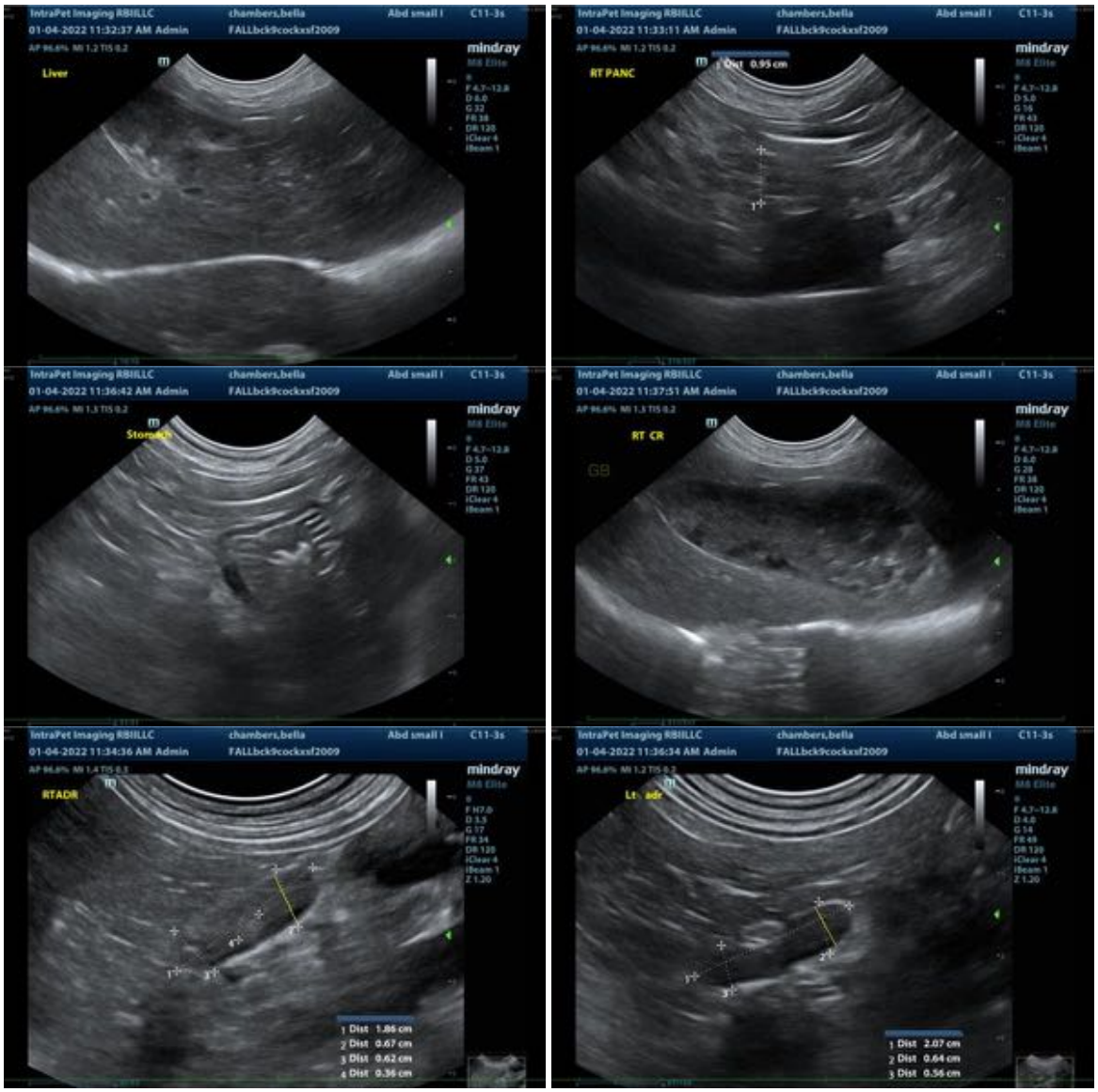
- Minor bilateral age-related renal changes with non-obstructive nephrolithiasis.
- The right adrenal nodule is most consistent with regenerative nodular hyperplasia. However, emerging neoplasia cannot be excluded.
- Uterine stump, incidental finding.
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory and infiltrative disease are considered less likely.
- The prominent lymph node in the right cranial quadrant could be consistent with lymphoid hyperplasia, reactive lymphadenitis, or less likely, infiltrative neoplasia.

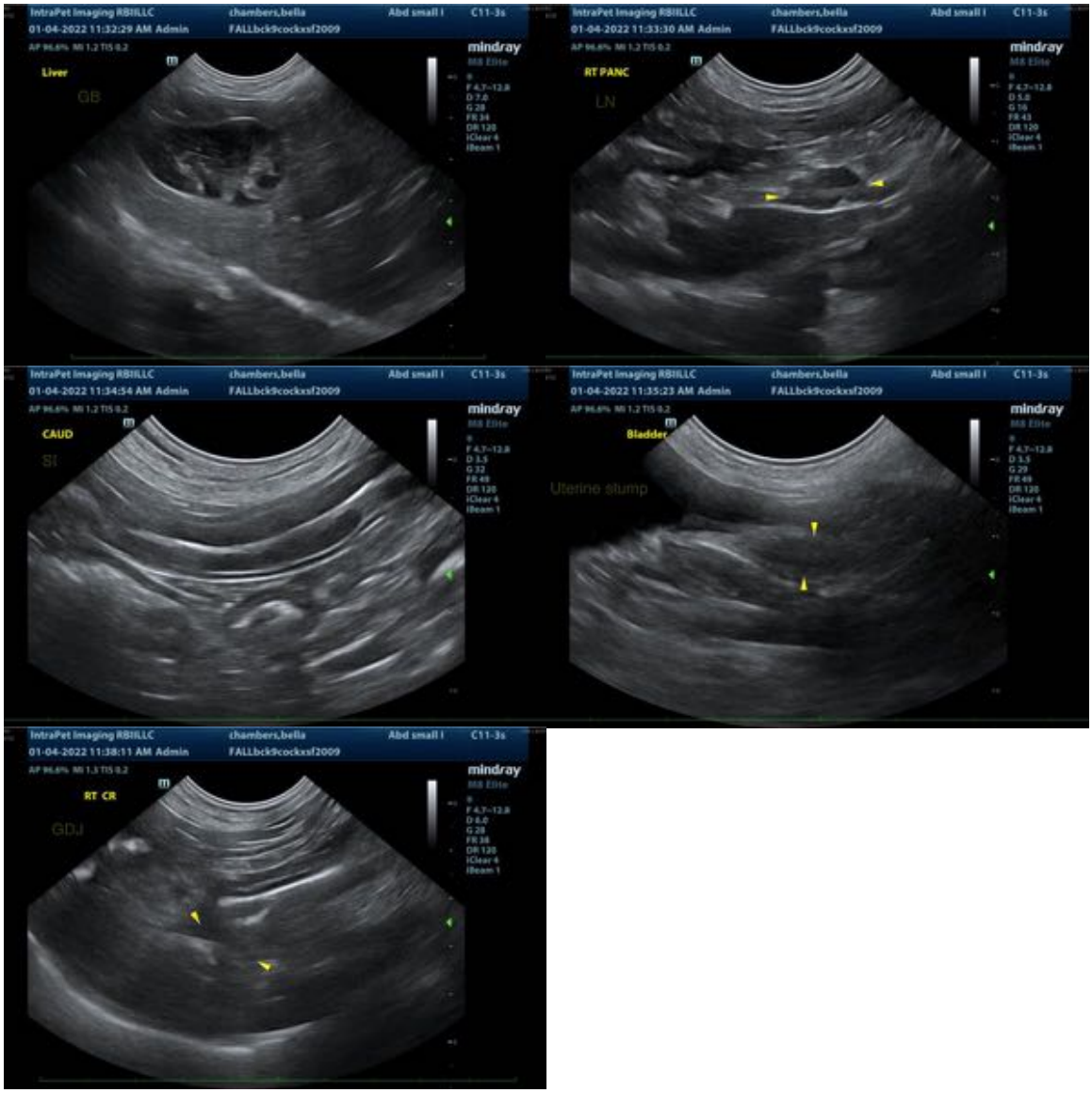
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Baseline labwork including a CBC chemistry panel, urinalysis and T4 is recommended if not already performed.

- Regarding the gallbladder, if a continued conservative approach is desired, Ursodiol therapy should be continued. If a more aggressive approach is desired, a cholecystectomy with submission of the gallbladder for histopathology is an option. If surgery is pursued, referral to a board-certified surgeon is recommended due to the potential for perioperative complications.

- Consider a malabsorption panel including serum cobalamin, folate, TLI and PLI given the intermittent GI signs.





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.

Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)
Andrea.nicastro@sonopath.com