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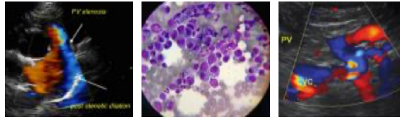

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DATE

10/12/21

PATIENT

Quigley Lomax

SPECIES

Canine

BREED

Golden retriever

SEX

Male, neutered

AGE

10/4/2009

WEIGHT

94.8 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Festival VC

REFERRING VET

Dr. Lomax

INVOICE

12345

PRESENTING CLINICAL SIGNS

History: Chronic diarrhea for 30 days. Progressive weight loss (19lbs) for 5 months associated with a reduced appetite. Diet - Proplan chicken and Beneful chicken. No vomiting. Clinical improvement in stool quality and appetite since medications and transition to Purina EN.

Current Medications: Deramaxx 100mg 1/4 PO QD, Metronidazole 1250mg SID for 5 days (10/5-10/9/2021, Proviable started on 10/9/2021.
Lab Results: CBC chem WNL. USG 1.013. No proteinuria, inactive sediment. T4 normal.
Radiographs: Not provided by the veterinarian.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: not needed
Stat Report: not requested

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder and visible portion of the pelvic urethra are normal for the degree of luminal distension. The urine is anechoic with no evidence of debris. Cystic calculi and discrete masses are not observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The prostate is not definitively visualized due to its pelvic location.

The left kidney is normal size (7.45 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 (7.48 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.

Adrenal Glands

The left adrenal gland is normal size (0.88 cm at cranial pole) (0.58 cm at caudal pole) (3.60 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 (0.86 cm at cranial pole) (0.75 cm at caudal pole) (3.37 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 subjectively normal in size (2.21 cm in width at the level of the hilus) with normal curvilinear peripheral contours. The parenchyma is subtly mottled in appearance. 2 hypoechoic nodules are seen, one measuring 1.30 cm and the other measuring 0.85 cm. Splenic vasculature is normal with no evidence of thrombosis.

Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and is mottled in appearance. No distinct focal lesions are observed. Vascular and 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 small amount of echogenic debris 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 with normal curvilinear peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen

There is no evidence of free fluid. Several prominent hypoechoic to slightly heterogeneous mesenteric lymph nodes are visualized, the largest measuring 2.54 cm in length. Surrounding mesentery is hyperechoic.

Other

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The abdominal lymphadenopathy could be consistent with lymphoid hyperplasia, reactive lymphadenitis, or infiltrative neoplasia (i.e., lymphoma).

Secondary Findings:

- The splenic parenchyma changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis or splenitis with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

*An obvious cause for the patient's clinical signs is not identified in this study. Considerations include microscopic gastrointestinal disease (i.e., inflammatory bowel disease, food allergy, lymphoma, infectious/parasitic), low-grade pancreatitis, underlying metabolic issue, other.

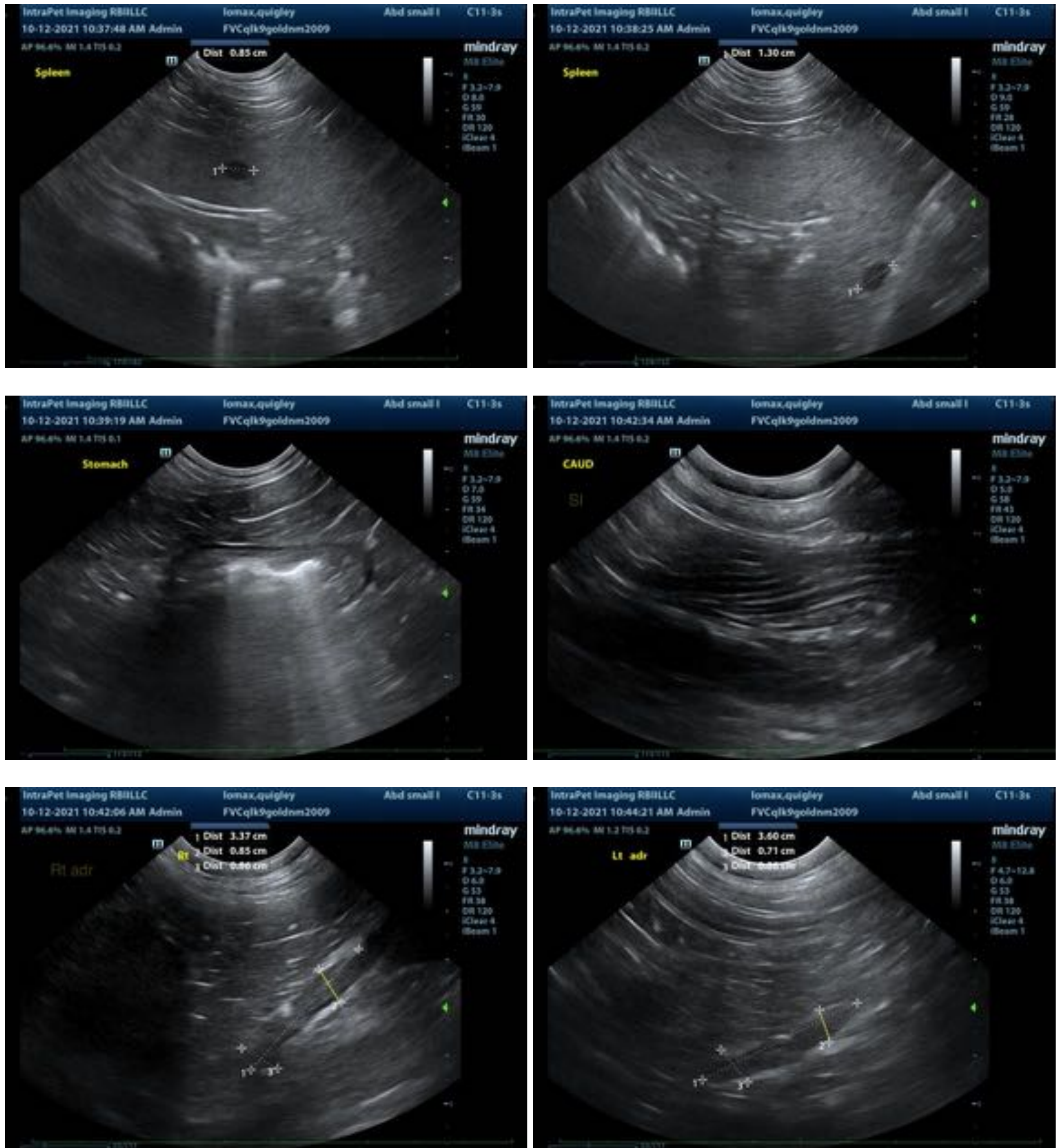
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

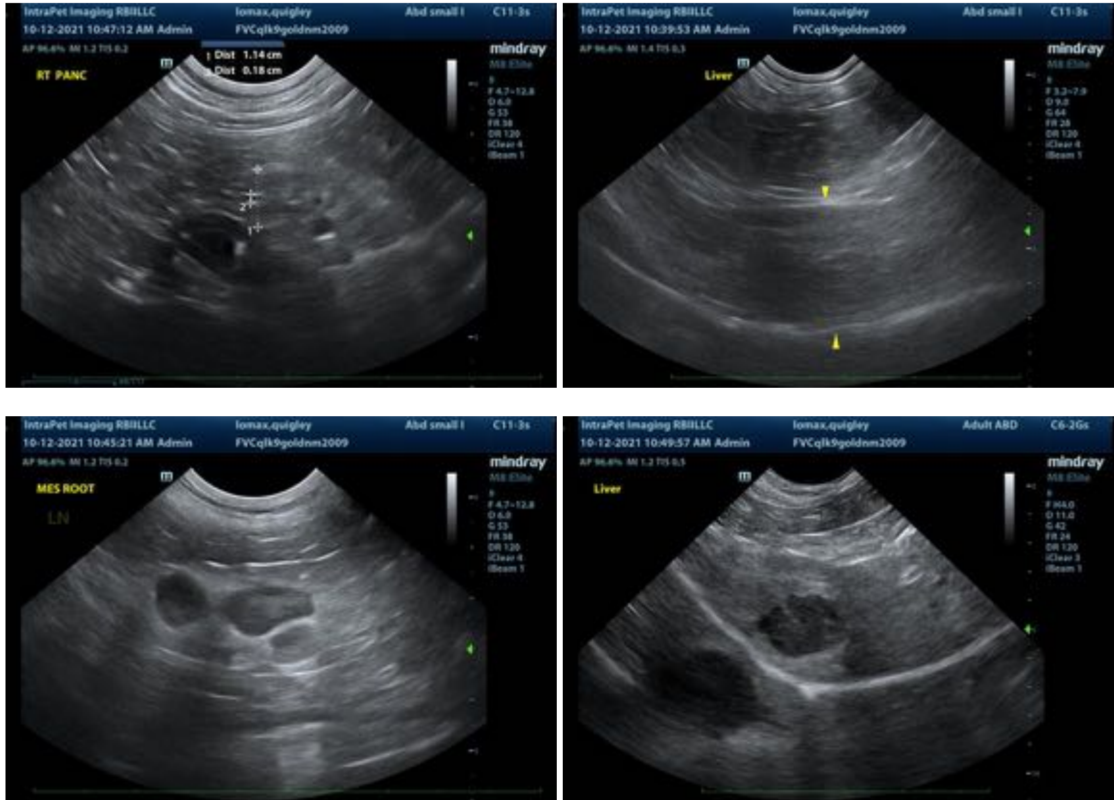
- If accessible, a fine needle aspirate of one of the enlarged mesenteric lymph nodes is recommended (if clotting status is normal). 25-gauge needle should be used.

- Other diagnostic considerations include the following:

  1. Three-view thoracic radiographs to assess for occult neoplasia
  2. GI panel including serum cobalamin, folate, TLI and PLI
  3. Fecal evaluation for ova and Giardia
  4. Fecal PCR infectious disease panel
  5. 6-week hypoallergenic diet trial

6. Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be necessary to get a definitive diagnosis. Surgical biopsies may be preferable to access all portions of the GI tract as well as abdominal lymph nodes.





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*)
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