IMAGING PERFORMED BY

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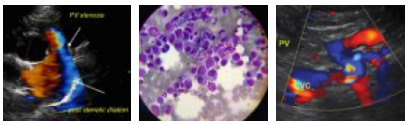

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Clinical Sonography & Telecytology
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DATE

10/18/2021

PATIENT

Dottie Lou Lieber

SPECIES

Canine

BREED

Toy poodle

SEX

Female, spayed

AGE

10/6/2017

WEIGHT

7.7 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Eastern Animal Hospital

REFERRING VET

Dr. Cusack

INVOICE

12365

PRESENTING CLINICAL SIGNS

History: Dottie Lou has chronic hx of periods of inappetence, vomiting and diarrhea every 10 days. PE unremarkable except for moderate-severe dental tartar and tear staining.
Current Medications: Cerenia 8mg q24 when needed during episodes, Entyce 3 mg/kg as needed during episodes, Visbiome 1 packet SID.
Lab Results: CBC/Chem - thrombocytopathy and lymphocytosis, remainder WNL; Urinalysis - SG 1.045, pH 7, protein 2+, wbc 2-3, remainder unremarkable; baseline cortisol - 2.7; Negative fecal. Attached separately.

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, 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 (4.05 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 (3.89 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 (0.34 cm at cranial pole) (0.38 cm at caudal pole) (1.70 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 (0.42 cm at cranial pole) (0.44 cm at caudal pole) (1.42 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 (0.86 cm in width at the level of the hilus) with normal curvilinear peripheral contours. At least 2 small ill-defined hypoechoic nodules, the largest measuring 0.56 cm in diameter, are observed in the parenchyma. The remaining parenchyma is homogeneous in appearance. Splenic vasculature is normal with no evidence of thrombosis.

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 mildly distended. The wall is normal in thickness. Luminal contents are anechoic. A very small polypoid like lesion (0.43 cm in diameter) is arising from the luminal surface near the gallbladder neck. 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 ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

Pancreas
The pancreas is normal in size with normal peripheral contours. The pancreatic duct is normal. The base and limbs of the pancreas are isoechoic to surrounding omental fat. No focal lesions are observed. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen
The peritoneal cavity is normal. There is no evidence of inflammation or effusion. A few prominent lymph nodes are observed adjacent to the ileocecal colic junction, the largest measuring 0.87 cm in width.

Other
A uterine stump is visible (0.33 cm in width). No obvious pathology is seen.

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

ULTRASONOGRAPHIC FINDINGS
Primary Findings:

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

Secondary Findings:

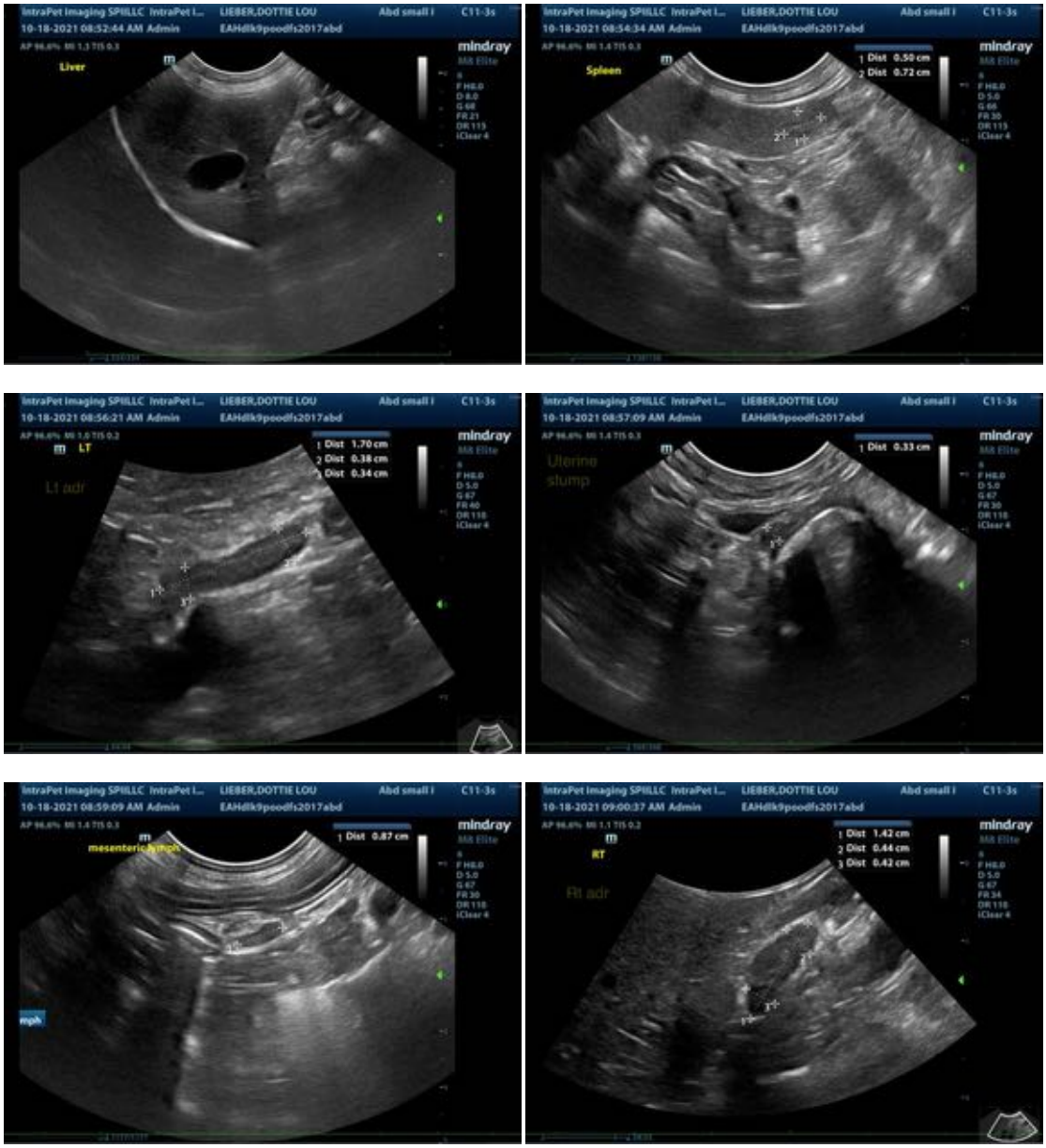
- The splenic nodules trend toward the benign (i.e., foci of lymphoid hyperplasia or extramedullary hematopoiesis) with a lower possibility of emerging neoplasia.
- Gallbladder neck polyp like lesion.
- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.
- Visible uterine stump- incidental.

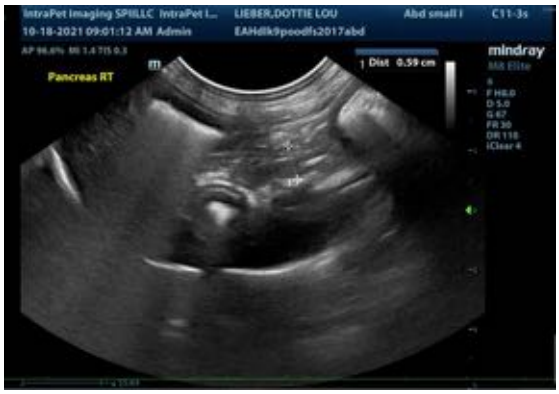
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the GI signs, consider the following:

1. GI panel including serum cobalamin, folate, TLI and PLI.
2. Despite the negative fecal evaluation, prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.
3. Limited antigen diet trial.

4. +/- endoscopic or surgical gastrointestinal biopsies.
5. Three-view thoracic radiographs should be performed prior to any anesthetic event.
6. Given the proteinuria, a UPC is recommended.

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Pancreas RT
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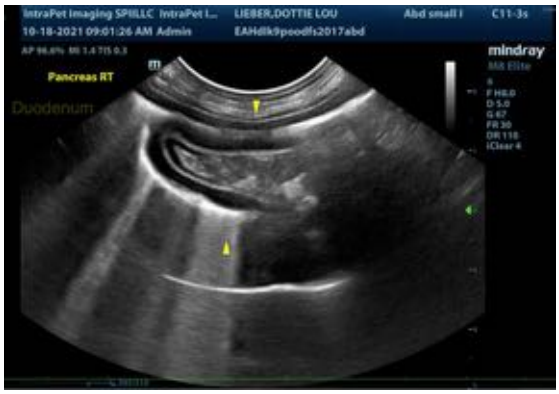
mindray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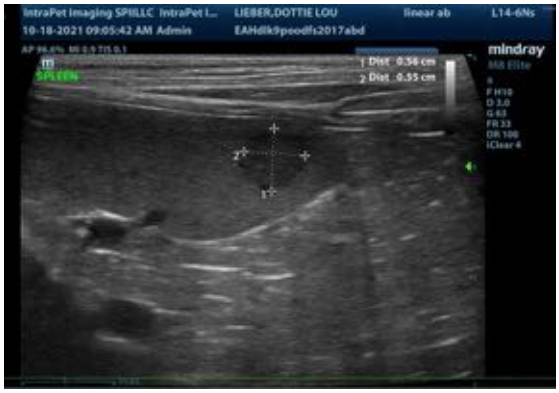
Pancreas RT
Duodenum
mindray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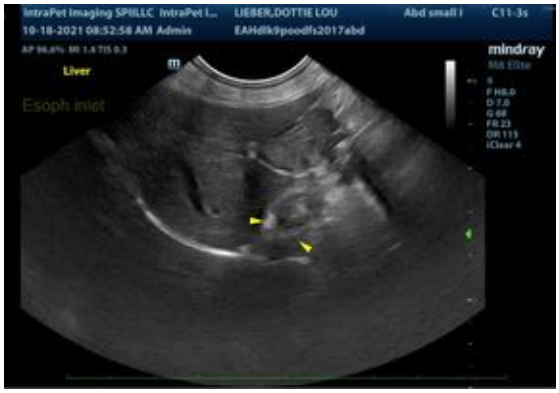
SPLEEN
1 Dist 0.58 cm
2 Dist 0.55 cm
mindray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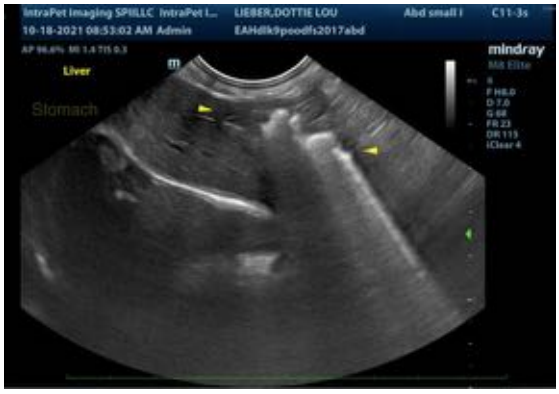
Liver
Esoph inlet
mindray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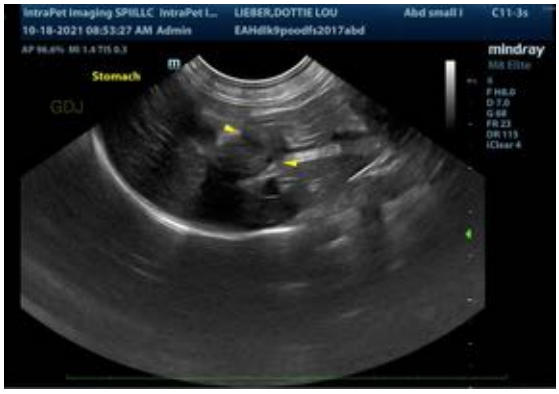
Liver
Stomach
mindray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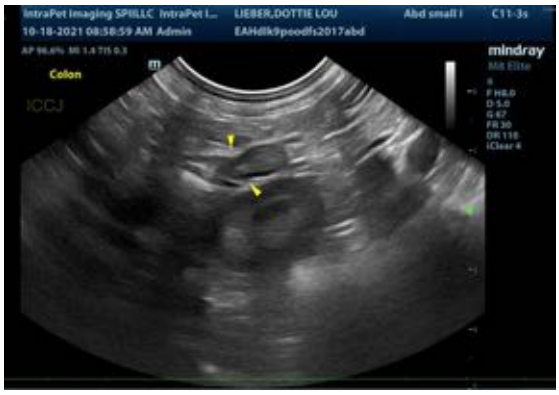
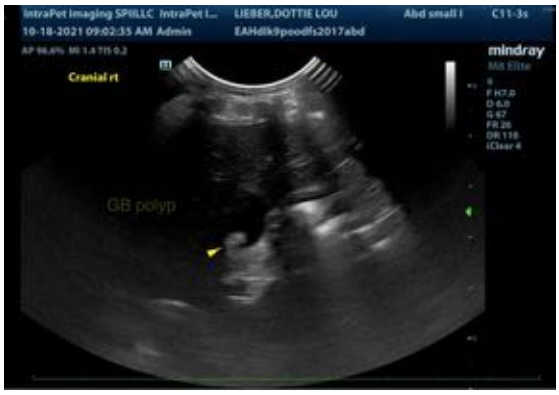
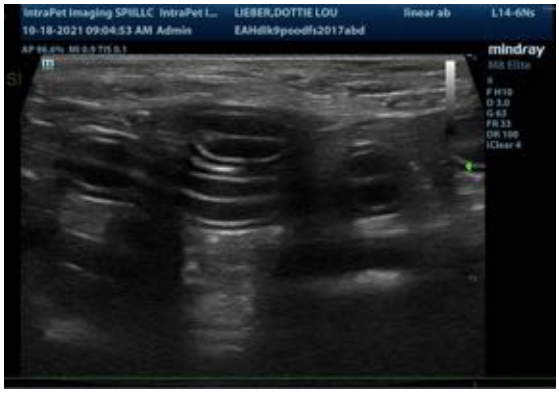
Stomach
GDJ
mindray







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