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Clinical Sonography & Telecytology
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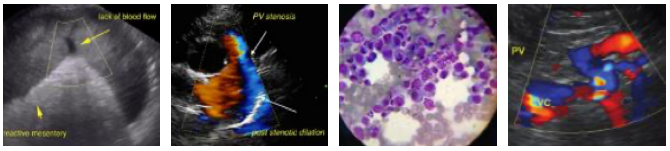

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1-800-838-4268 info@sonopath.com

PATIENT
Tika Agius

SPECIES
Canine

BREED
Chihuahua

SEX
Female, spayed

AGE
10 Yrs. 10 months

WEIGHT
1.81 kg

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

IMAGING PERFORMED BY
Dr. Brian Barnes

HOSPITAL NAME
Westview VH

REFERRING VET
Dr. Brian Barnes

INVOICE
12379

DATE
10/19/20

PRESENTING CLINICAL SIGNS

History: History of weekly vomiting +/- loose stools over years. Had elevated BNP on work up . Had Double cavity exam in March 2021 . Noted CDVD with mild to moderate MR and mild TR
Abnormal PE/Chem/CBC/UA Results: BNP was 1230 (N 0-900) , Still having GIT issues Had positive Stool CPA (C. Perfringens Alpha toxin) Has been on Tylosin having GIT issues

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. A small amount of suspended echogenic debris is observed within the lumen. 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 in size (2.79 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is mild loss of corticomedullary distinction. Hyperechoic shadowing diverticular foci +/- small nephroliths are visualized. Several hyperechoic shadowing diverticular foci are observed. Trace pyelectasia is present. There is no evidence of hydroureter. Renal vasculature is normal.

The right kidney is normal size (2.98 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is mild loss of corticomedullary distinction. Hyperechoic shadowing diverticular foci +/- small nephroliths are visualized. Several hyperechoic shadowing diverticular foci are observed. Trace pyelectasia is present. There is no evidence of hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.33 cm at cranial pole) (0.35 cm at caudal pole) (1.31 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 (0.71 cm at cranial pole) (0.34 cm at caudal pole) (1.20 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 normal in size (0.74 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and mottled in appearance. In the parenchyma adjacent to the diaphragm ill-defined hypoechoic areas with foci of mineralization 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 moderate to large amount of echogenic to mineralized debris is observed within the lumen, most of which is gravity dependent and some of which is suspended. The cystic and common bile ducts are normal/not seen.

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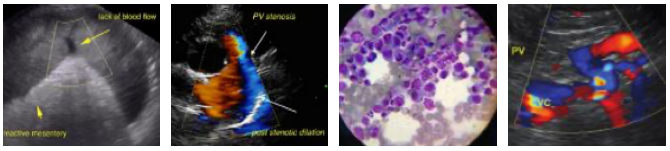

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Gastrointestinal

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. There is disruption in the normal 1:3 muscularis: mucosal ratio in most segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are 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.

Other

The caudal vena cava: aortic ratio is approximately 1:1.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

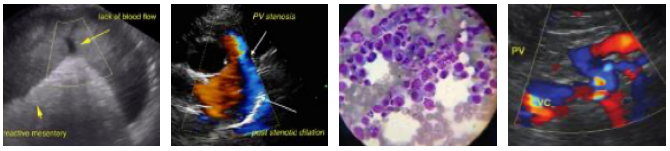
- Bowel pattern consistent with inflammatory bowel disease with potential for emerging lymphoma.
- The hypoechoic mineralized hepatic nodules/areas could be consistent with inflammatory foci (i.e., suppurative), regenerative nodular hyperplasia with dystrophic mineralization, emerging neoplasia, other.

Secondary Findings:

- Gallbladder debris, non-mucocele.
- Bilateral age-related renal changes with dystrophic mineralization +/- small amount of obstructive nephrolithiasis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the GI signs, consider the following diagnostics:
  1. GI panel including serum cobalamin, folate, TLI and PLI.
  2. Prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended if not already performed.
  3. Limited antigen diet trial.
  4. +/- endoscopic or surgical gastrointestinal biopsies.



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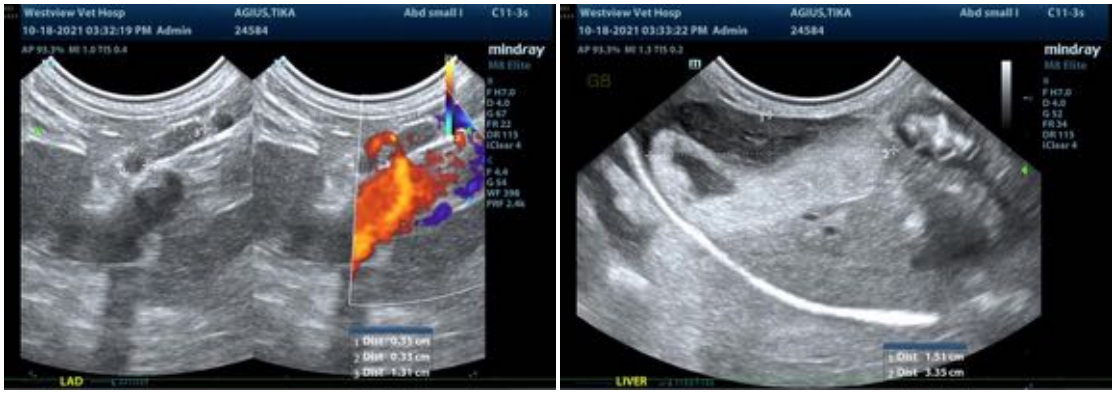
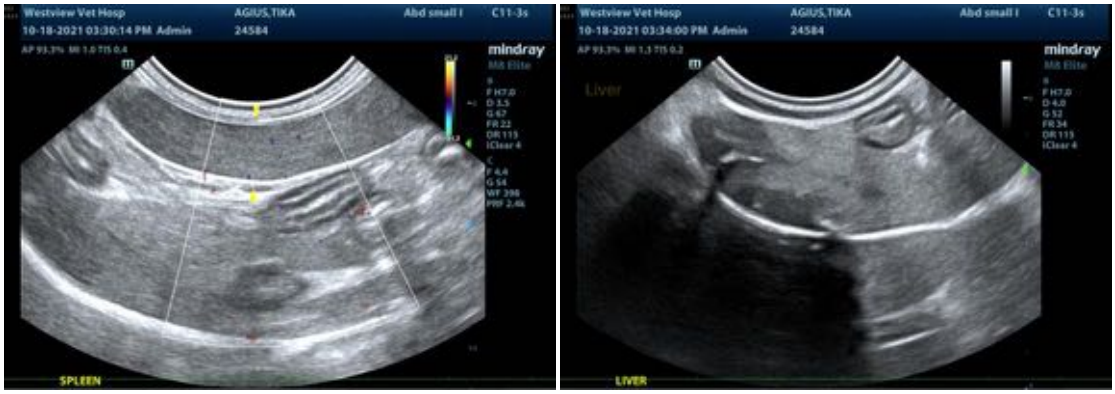
- Regarding the hepatic lesions, fine needle aspiration for cytology and aerobic/anaerobic cultures would be ideal, if accessible and if clotting status is appropriate. A 25-gauge needle should be used. If the regions are not accessible, consider a repeat ultrasound in 3-4 weeks to assess for progression. A surgical biopsy can also be considered.
- Given the history of heart disease, three-view thoracic radiographs are recommended if not already performed.





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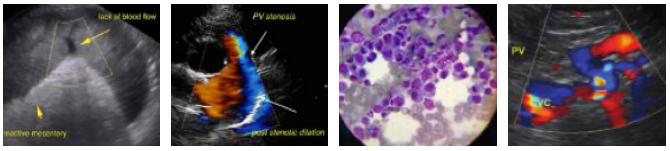

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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