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Clinical Sonography & Telecytology
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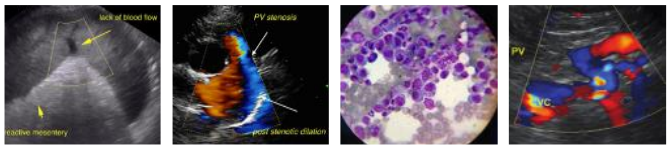


SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Junie Stegemoller

SPECIES

Canine

BREED

Hound Mix

SEX

Spayed Female

AGE

10 Years

WEIGHT

19.2 kg

INTERPRETED BY

Andrea Nicastro, DMV, Diplomate DACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Jolee Stegemoller, DVM

HOSPITAL NAME

North Idaho AH

REFERRING VET

Jolee Stegemoller, DVM

INVOICE

13924

DATE

10/21/21

PRESENTING CLINICAL SIGNS

History: Patient had dental cleaning, bloodwork, and senior wellness work up 9/25/21. Following anesthesia, became inappetent for 3 days, but returned to normal. Developed anal gland abscess 10/2 and needed sedation for treatment. Was inappetent for 5 days, so during this time, performed barrage of other tests to look for underlying causes; arrived at pancreatitis likely induced from reduced splanchnic blood flow during anesthesia as a trigger. Patient was treated for a presumed soft tissue lameness starting 10/6 and was started on gabapentin/carprofen/omeprazole given history of pancreatitis. On 10/17 and 10/18 patient vomited in the morning (while I was traveling home from SDEP Echo Lab) but was BAR and was happily eating food. 10/20/21 was completely inappetent and uncomfortable/restless. Hospitalized today on IV fluids and continued supportive care. Current medications: Gabapentin 100mg BID, carprofen (2.2mg/kg BID but discontinued this morning), Omeprazole 20mg BID, ElleVet CBD BID, Dasuquin, Dermaquin, Apoquel 8mg 3 times per week. Currently eating a commercially prepared, fresh, low-fat diet (<8%) as she had been a very picky eating before starting this diet in July and now loves food, so when her appetite is now a little "off", I've become hypersensitive as her owner. This afternoon has responded to fluid therapy and gastroprotectants and is eating.

Abnormal PE/Chem/CBC/UA Results: 9/25/21: Neu 2.86, Plt 119, TP 5.4, specCpl 131, USG 1.055, 1+ proteinuria, 1+ bilirubinuria (voided), cortisol 0.9 10/7/21: No CBC, Ca 8.2, TP 4.7, Alb 2.5, Glob 2.2, specCPL 509, Normal ACTH stimulation tests (pre-2.2, post-5.2), Cobalamin 619, Folate 5.6, USG 1.035, wbc 4/hpf, rbc 2/hpf, negative proteinuria (voided) 10/20/21:CBC WNL, Alb 2.5, ALP 21, Lipase 1929, specCPL pending, USG > 1.040, urine protein 30mg/dL, quiet sediment

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is contracted. The bladder wall is of appropriate thickness for the level of repletion. The mucosal surface is slightly irregular. Luminal contents are anechoic. No cystic calculi are observed.

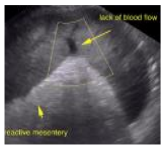
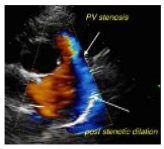
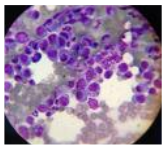
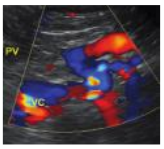
The left kidney presented normal size (5.76 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney presented normal size (5.69 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 in size (0.51 cm at cranial pole) (0.51 cm at caudal pole) (2.52 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 (0.83 cm at cranial pole) (0.39 cm at caudal pole) (2.35 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are

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unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (2.36 cm at the level of the hilus) with a normal capsular contour. The parenchyma is subtly mottled in appearance. No focal lesions 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 is of normal contours and contains some gravity dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. 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 mildly distended with ingesta. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal (xxx cm) with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. No obstructive or overt infiltrative 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

- 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).

*An obvious cause for the patients' clinical signs is not identified in the study. Considerations include primary gastrointestinal disease (i.e., food allergy, inflammatory bowel disease, infectious/parasitic), low-grade pancreatitis, underlying, metabolic issue, other. The patient's lab work revealed chronic mild hypoalbuminemia, which could be secondary to GI or renal loss or hepatic dysfunction.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for occult esophageal disease.
- Given the history of inappetence and hypoalbuminemia, also consider the following:

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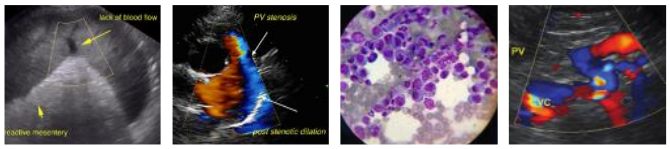

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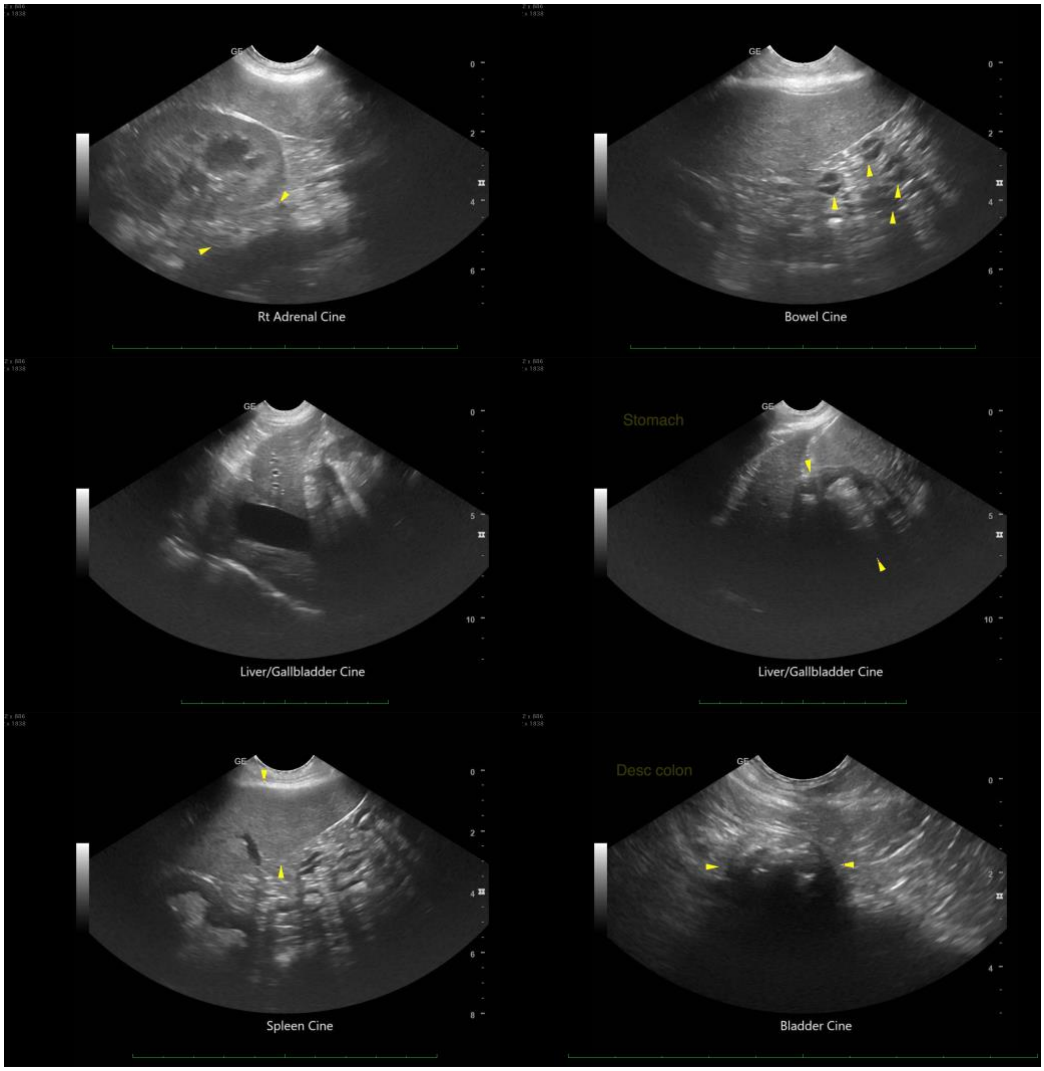
1. Fecal evaluation for ova and Giardia
2. Limited antigen, low-fat diet trial (if patient will eat it). Consider consultation with a nutritionist at the University of Tennessee. https://vetmed.tennessee.edu/vmc/smallanimalhospital/small-animal-nutrition/.
3. Pre- and postprandial serum bile acids
4. UPC
5. +/- endoscopic or surgical gastrointestinal biopsies



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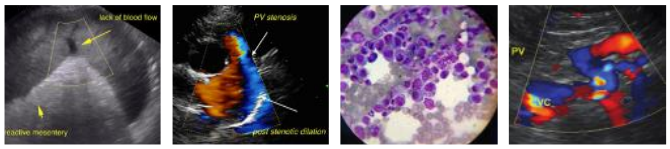

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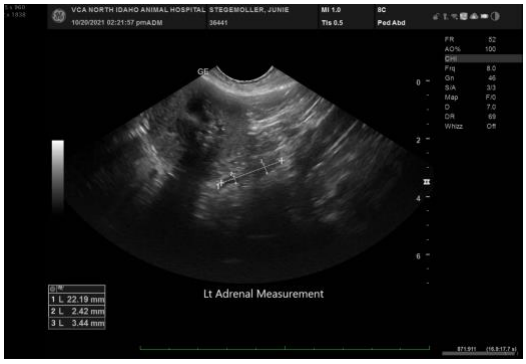

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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