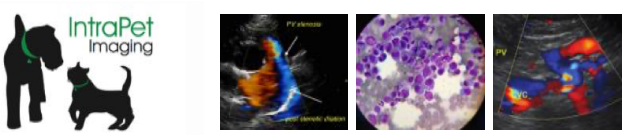
IMAGING PERFORMED BY

IntraPet.com



SonoPath
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DATE

10/25/21

PATIENT

Moose Bowers

SPECIES

Canine

BREED

Pitbull Mixed breed

SEX

Male, neutered

AGE

3/7/2010

WEIGHT

44 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Fullerton AH

REFERRING VET

Dr. Levine

INVOICE

12406

PRESENTING CLINICAL SIGNS

History: Progressive weight loss. Cutaneous mast cell tumors identified, but recent thoracic and abdominal radiographs and blood work were unremarkable.

Current Medications: Should have recently finished 150mg sid Cefpodoxime started following a laceration.
Lab Results: ALT 135, T4 and 4DX negative.
Radiographs: Not provided by the veterinarian.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: Sedation not required for scan.
Stat Report: STAT report not requested by the veterinarian.

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 prostate is normal in size (1.37 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal size (5.84 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.

The right kidney is normal size (6.64 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.

Adrenal Glands

The left adrenal gland is normal size (0.62 cm at cranial pole) (0.54 cm at caudal pole) (2.36 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 (0.51 cm at cranial pole) (0.53 cm at caudal pole) (2.53 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 (1.85 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A few small hyperechoic nodules/areas are observed. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and subtly heterogeneous 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 moderate amount of aggregated echogenic partially dependent to suspended sludge 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 mildly distended with ingesta and gas. 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 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. A 1.67 cm jejunal lymph node is observed medial to the spleen. In addition, a 1.59 x 0.59 cm sublumbar lymph node is visualized.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The hepatic parenchymal changes are most consistent with benign age-related pathology. However, low-grade inflammatory disease cannot be excluded. Infiltrative neoplasia is considered unlikely.
- Gallbladder sludge. Differentials include cholestasis, fasting or early mucocele formation.

Secondary Findings:

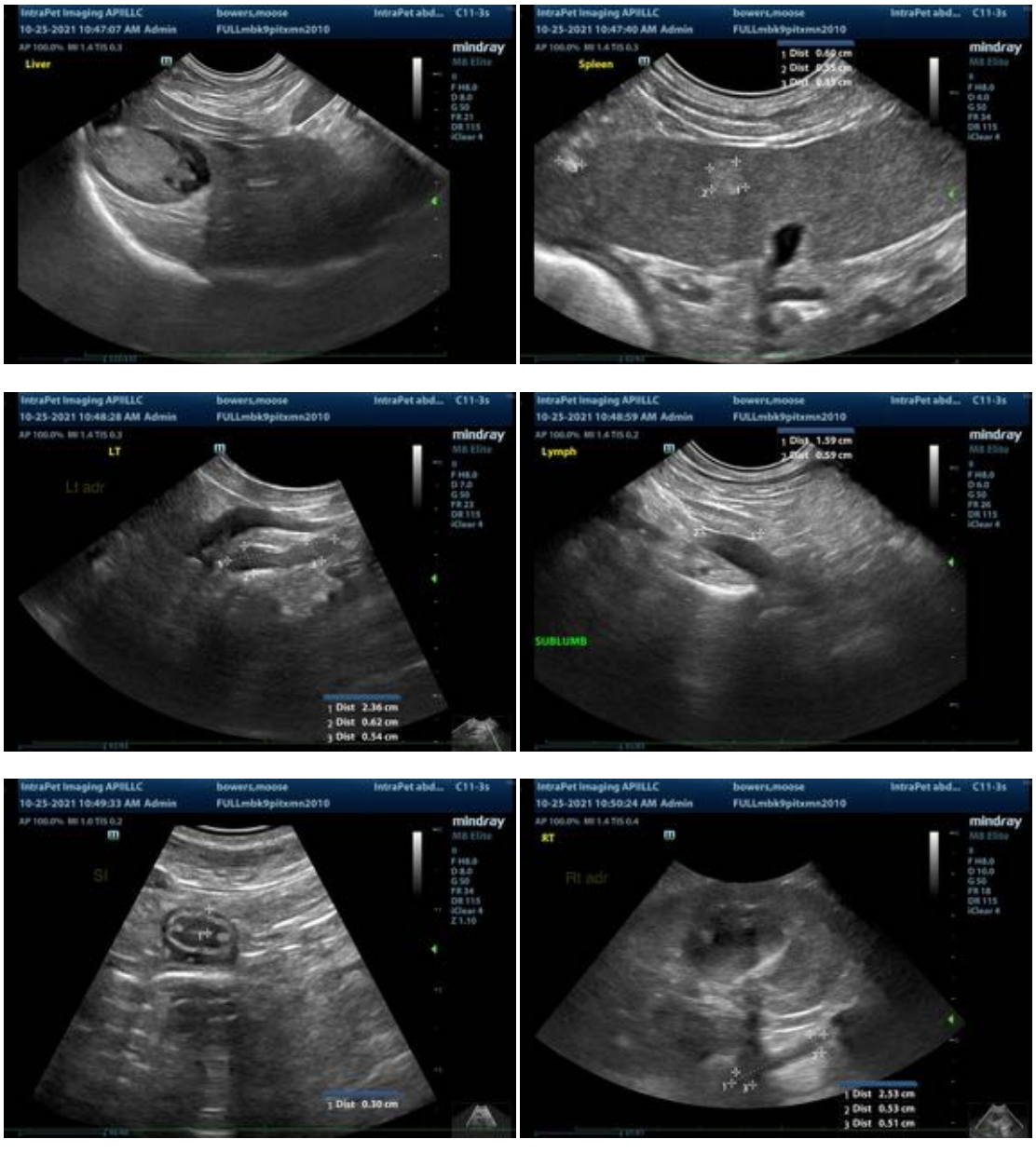
- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.
- The hyperechoic lesions adjacent to the splenic vessels are most consistent with myelolipomas. Although a neoplastic process within the spleen cannot be excluded, it is considered unlikely in this patient.

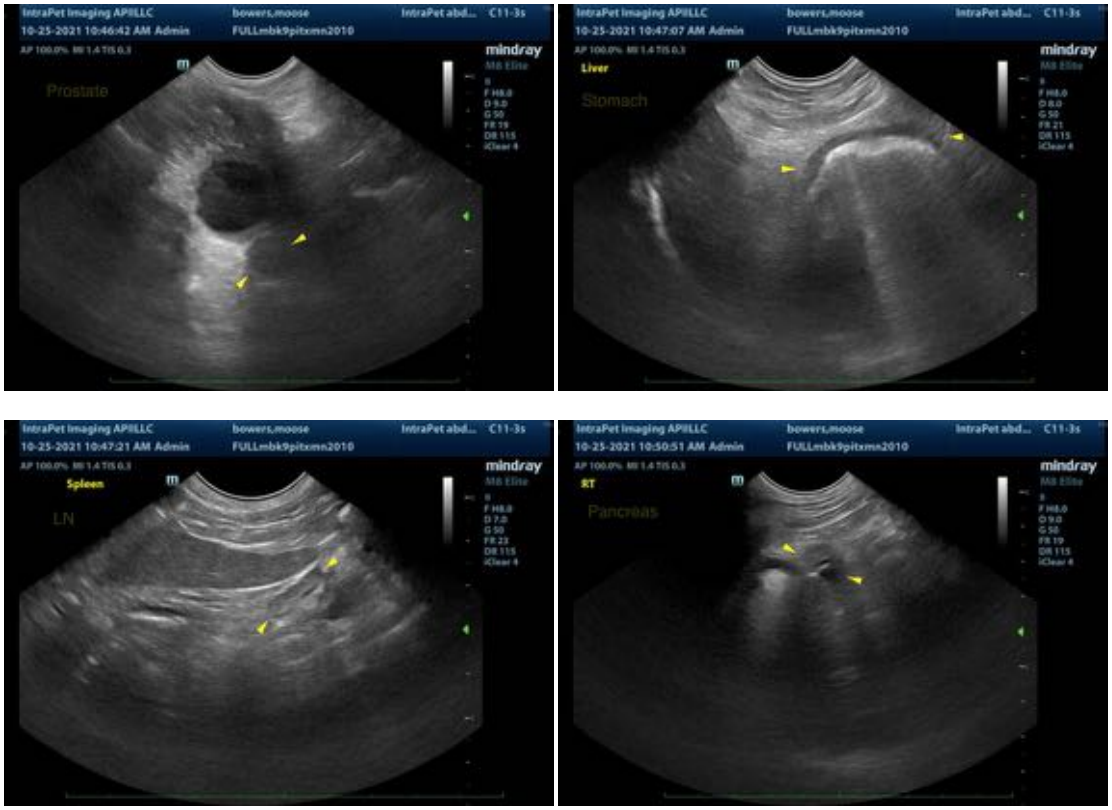
*An obvious cause for the patient's weight loss is not identified in this study. Considerations include gastrointestinal maldigestion/malabsorption, primary neurologic disease, underlying metabolic issue, occult neoplasia, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A GI panel including serum cobalamin, folate, TLI and PLI is recommended to assess for maldigestion/malabsorption.
- A fecal evaluation for ova/Giardia
- A thorough neurologic examination is recommended as brain tumors can sometimes present with weight loss as the sole clinical sign.
- Depending on the results of the above diagnostics, endoscopic or surgical gastrointestinal biopsies may be necessary to get a definitive diagnosis.

- Given the gallbladder changes, consider a recheck ultrasound in 2-3 weeks, preferably 2 hours post small meal. If the changes are similar to the current scan, consider initiation of Ursodiol.





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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