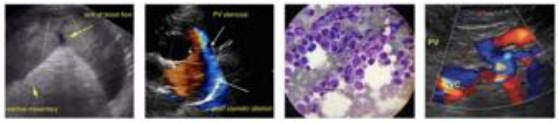


PATIENT

Rocky Chionchio

SPECIES

Canine

BREED

Maltese

SEX

Neutered Male

AGE

12/12/2007

WEIGHT

8 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

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

HOSPITAL NAME

Sun Dog Cat Moon VC

REFERRING VET

Shelley Fetterolf

INVOICE

11915

DATE

10.28.22

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: P presents for ongoing diarrhea. Has had nonstop diarrhea since 10-12. O states no form to stool. Completely liquid. Straining to go.
Current Medications: Metronidazole, Pawfy Probiotic, Interceptor Plus

Bloodwork done in September was unremarkable per rDVM.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** wall is 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. The region of the trigone and the visible portion of the proximal urethra are normal.

The **prostate** is normal in size (0.81 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 (3.54 cm in length); with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild to moderate loss of corticomedullary distinction. A few, small cortical cysts are seen. Several hyperechoic shadowing diverticular foci are observed. Trace pyelectasia is present. There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

The **right kidney** is normal size (4.02 cm in length); with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild to moderate loss of corticomedullary distinction. A few, small cortical cysts are seen. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The **left adrenal gland** is normal size (0.49 cm at cranial pole) (0.39 cm at caudal pole); 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 (0.41 cm at cranial pole) (0.43 cm at caudal pole) (1.77 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.

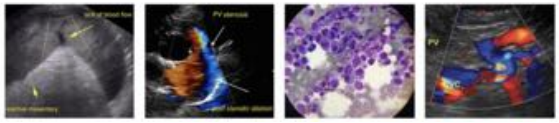
Spleen

The **spleen** is normal in size (0.64 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 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 moderately distended. The wall is thin and smooth. A small amount of aggregated, partially dependent to suspended, debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.



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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 pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal to mildly thickened (up to 0.42 cm) with retention of the normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

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

Trace ascites is present. One to two prominent mesenteric **lymph nodes** are visualized, the largest measuring 1.41 cm in length. The nodes are normal in size and echogenicity.

Other

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Mild small intestinal wall thickening. This finding is most consistent with an inflammatory process (i.e., inflammatory bowel disease). No obvious evidence of neoplasia or obstruction.
- Trace ascites which may be secondary to bowel inflammation or other etiology (i.e., increased hydrostatic pressure, vasculitis, low oncotic pressure, other.

Secondary Findings

- Bilateral degenerative renal changes with dystrophic mineralization
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recheck baseline blood work including a CBC, chemistry panel, urinalysis and T4, would be ideal to assess overall metabolic function.

Consider empirical treatment for small intestinal bacterial overgrowth with a 2-4-week course of Tylosin. Also consider supplementation with fiber (i.e., Metamucil or Konsyl).

A malabsorption panel, including serum cobalamin and folate, TLI and PLI, would be ideal. However, if this is not performed, consider initiation of B12 supplementation.

If the patient does not respond to the above therapeutics, consider transitioning to a limited antigen or hydrolyzed protein diet.

Ultimately, GI biopsies (i.e., endoscopic or surgical) would be necessary to get a definitive diagnosis. If pursued, three-view thoracic radiographs are recommended prior to anesthesia.

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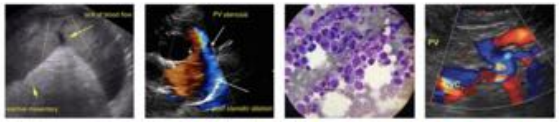

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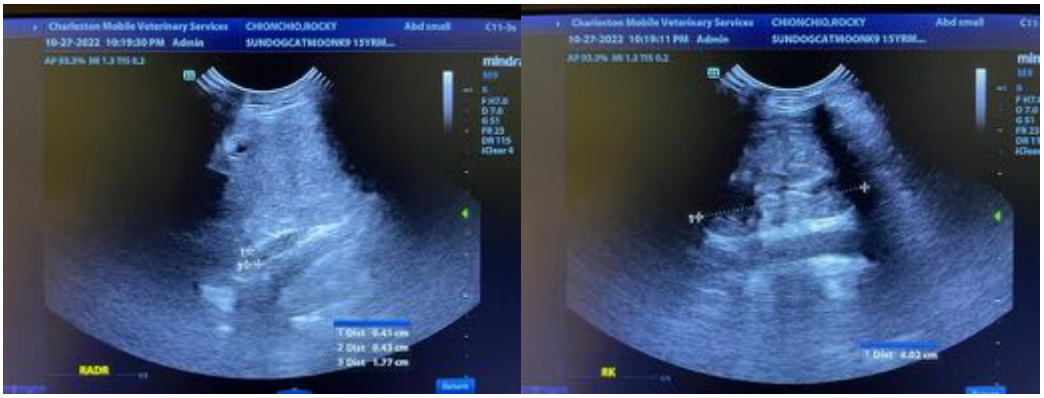

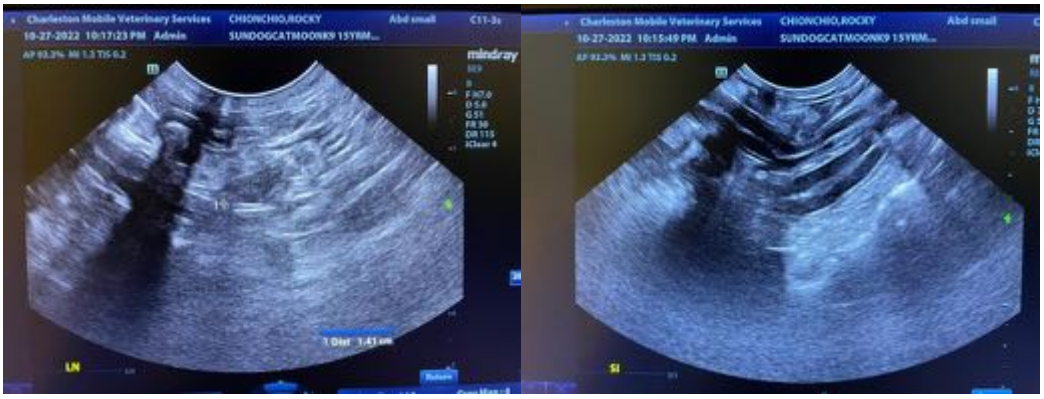

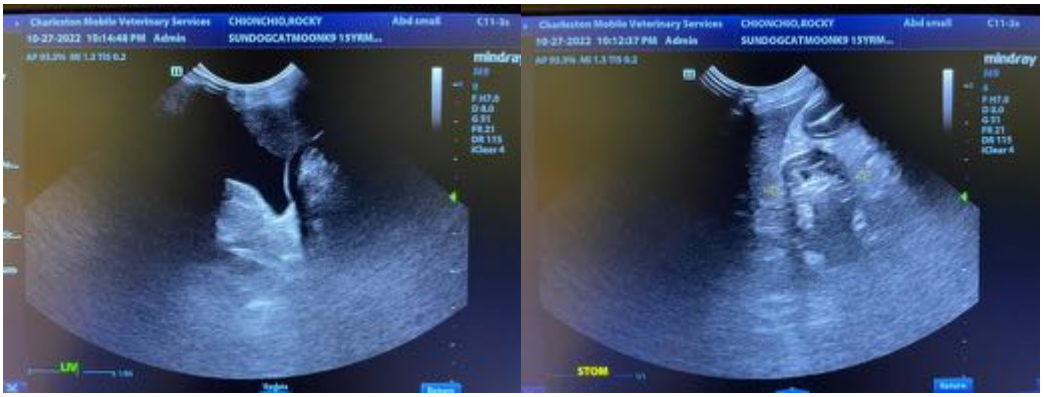

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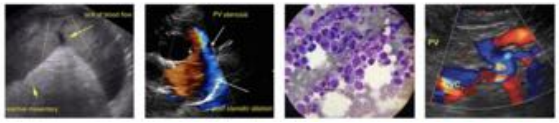

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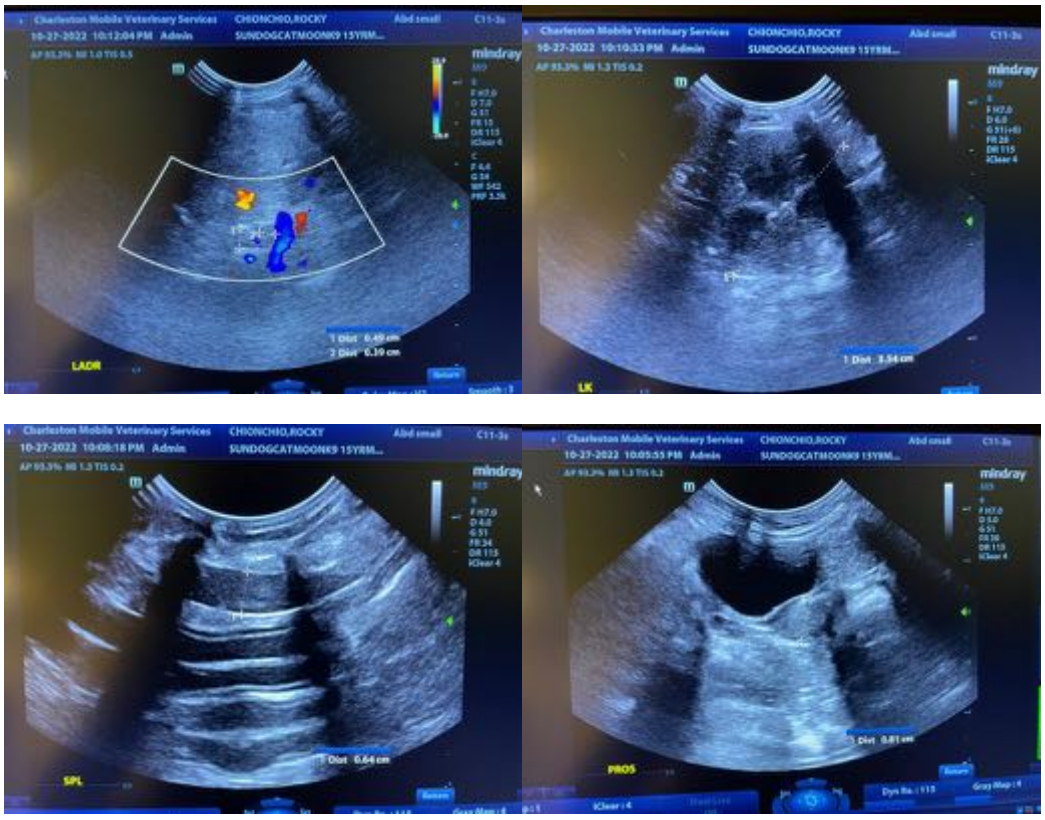

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com