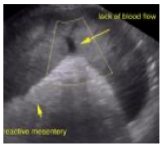
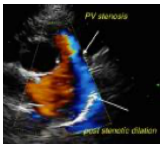
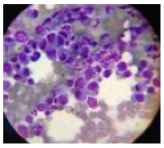
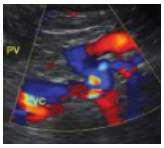
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT
Kota Standifer

SPECIES
Canine

BREED
Labrador Retr

SEX
Spayed Female

AGE
12 years

WEIGHT
34.7 kg

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

IMAGING PERFORMED BY
Dr. Peterson

HOSPITAL NAME
Wilvet Salem

REFERRING VET
Dr. Kristin Peterson

INVOICE
11928

DATE
10.31.22

PRESENTING CLINICAL SIGNS

History: P presents for v+/d+ since 10/29, with no eating for 24+ hours. Moderate dental disease, round pink mass (approx 1.5cm) at left lateral edge of tongue. LN appear enlarged but due to copious subcutaneous masses in LN region difficult to determine LN vs lipomatous/other mass. several firm to fluctuant subcutaneous masses throughout body. Large firm non-moveable mass in left inguinal region, firm moveable SQ mass right lateral neck caudal to mandibular LN, several small SQ masses at thoracic inlet. Vomiting, diarrhea, inappetence - r/o GI (infectious, inflammatory, dietary indiscretion, cancer, pancreatitis, obstruction, SPD, etc) vs extra gi (toxin, metabolic, systemic illness, cancer)

Vomiting, diarrhea, inappetence - r/o GI (infectious, inflammatory, dietary indiscretion, cancer, pancreatitis, obstruction, SPD, etc) vs extra gi (toxin, metabolic, systemic illness, cancer)

Abnormal PE/Chem/CBC/UA Results:
CBC - HCT 43%, WBC 15.89, Neut 12.6, Mono 1.21, PLT 251
Chem 10 - Glu 113, Creat 0.9, BUN 24, TP 6.6, ALB 3, Glob 3.6, ALT 114, ALP 489*
CPL - 123 - normal
EPOC - ph 7.380, BE -11.5*, Na 145, K 3.7, Cl 116, Ca 1.2, Lact 6.75*, BUN 22, Creat 0.8, Glu 103, HCT 45%

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. The region of the trigone is normal.

The left kidney is normal size (7.02 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 (6.75 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of 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 (0.70 cm at cranial pole) (0.68 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 region of the right adrenal gland is evaluated. No obvious pathology is observed.

Spleen
The spleen is normal in size (2.15 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 hypoechoic relative to the spleen and diffusely heterogenous, with several, small, ill-defined hypoechoic nodules. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The gall bladder is of normal contours and contains some 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 **gastric lumen** is minimally fluid-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 segmentally fluid-distended (minimal). The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. Bowel segments in the cranial to midabdomen, which are thought to be colon, are moderately fluid and gas-distended. The colonic wall is normal.

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

Primary Findings

- There is no obvious evidence of GI foreign body/obstruction. The fluid-dilated bowel loops are thought to be colon with diarrheic stool. A partial GI obstruction, however, cannot be completely excluded.

Secondary Findings

- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory and infiltrative disease are considered less likely.

  *An obvious cause for the patient's clinical signs is not identified in this study. Considerations include primary gastrointestinal disease (i.e., acute gastroenteritis, infectious/parasitic disease, food allergy/intolerance, dietary indiscretion) underlying metabolic issue, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A fecal evaluation for ova and Giardia is recommended.

Consider prophylactic deworming with Fenbendazole

Supportive care for acute gastroenteritis is recommended. If the patient's clinical status does not improve within 48-72 hours of medical management, consider repeat abdominal imaging +/- a more advanced GI work-up.

Given the patient's age and history of vomiting, three-view thoracic radiographs are recommended to assess for occult aspiration pneumonia.


Lt adr - caudal


Spleen
Stomach


GB


Liver


GDJ


Colon


SI

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