



**PATIENT**

Tessa Kolar

**SPECIES**

Canine

**BREED**

German Shepherd

**SEX**

Female

**AGE**

5 Yrs. 8 months

**WEIGHT**

63.7 lbs.

**INTERPRETED BY**

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

**IMAGING  
PERFORMED BY**

Dr. Katie Buss

**HOSPITAL NAME**

Kings VH

**REFERRING VET**

Dr. Ellen Putoff

**INVOICE**

12451

**DATE**

**PRESENTING CLINICAL SIGNS**

History: 1. Eye - Owner seeing bright red in the right eye and says it 'goes crazy'. Doesn't seem bothered by her eyes, only small amount of discharge that is always present. 2. Bumps on feet - noticed her feet seeming tender and irritated-bumps that may have burst- on the tops of her feet. Some of them have been bleeding. Mostly seems to be affecting her right front foot - she is now limping on this foot and licking at it. 3. Gait issues - Concern since Tessa was adopted. Breeder had a history of hip dysplasia, so she is concerned that Tessa's gait could be displaying some signs. 4. Diarrhea - Tessa has had chronic diarrhea since adoption. It cleared up on the course of medications from Dr. Thomas but returned as soon as she was off of it. She is getting a probiotic twice daily producing stools that are better (mashed-potato texture) compared to the liquid before. Eating and drinking great but did receive some CBD oil last night and ended up having softer stools this morning.

**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 left kidney is subjectively normal size; 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 (7.35 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 region of the left adrenal gland is evaluated. No obvious pathology is observed.

The right adrenal gland is normal size (0.73 cm at cranial pole) (0.51 cm at caudal pole) (2.33 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 (2.21 cm in width 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**



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The liver is not visualized in its entirety. In the visualized portions, the size and peripheral margins are normal and the parenchyma is homogeneous. Vascular and biliary tracts are of normal volume with no evidence of congestion. No images were provided for the gallbladder.

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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. Discreet masses are not identified. The colonic wall is normal. No obstructive disease is noted.

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**Pancreas**

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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.

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**Free Abdomen**

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. A few prominent lymph nodes are observed at the aortic trifurcation, the largest measuring 2.43 cm.

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**ULTRASONOGRAPHIC FINDINGS**

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- 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).
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

\*An obvious cause for the patient's clinical signs is not identified in this study.

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

- Regarding the diarrhea, consider the following recommendations:
  1. CBC chemistry panel, urinalysis and T4 is recommended to assess overall metabolic function, if not already performed.
  2. Serum cobalamin, folate, PLI and TLI
  3. A fecal evaluation for ova/Giardia
  4. Prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.
  5. A 6-week limited antigen diet trial to assess for food allergies.

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6. Consider a 4-week course of Tylosin as empirical treatment for small intestinal bacterial overgrowth.
  7. A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended.
  8. Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be warranted.
  9. Three-view thoracic radiographs should be performed prior to any anesthetic event.
- Regarding the redness in the eye, consider a PT/PTT to assess for coagulopathy as well as a Schirmer tear test, tonometry, and fundic and neurologic examinations are recommended.. Referral to a board-certified veterinary ophthalmologist may be warranted.
  - Additional sonographic images of the liver and gallbladder would be useful to rule out pathology in these organs.





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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.

**IMAGING PERFORMED BY**

Dr. Katie Buss

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