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Clinical Sonography & Telecytology
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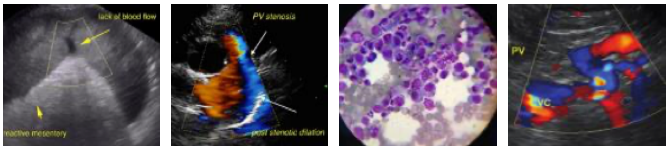


PATIENT
Noelle Bellairs

SPECIES
Canine

BREED
Welsh corgi

SEX
Female, spayed

AGE
10 Yrs.

WEIGHT
35 lbs.

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

IMAGING PERFORMED BY
Amy Mayhew

HOSPITAL NAME
SVS Imaging Michigan

REFERRING VET
Oxford VH

INVOICE
14284

DATE
11/28/22

PRESENTING CLINICAL SIGNS

History: Started having diarrhea on 11/14. Has gotten bad, and she is going out several times. Eating dinner but hasn't been eating breakfast. Drinking less than normal
Abnormal PE/Chem/CBC/UA Results: Open dx for diarrhea - concern for possible Addison's disease as chronic GI issues seem to be happening With Noelle's history of acute onset of diarrhea, I am concerned about pancreatitis vs. general enteritis vs endocrinopathy. Noelle's blood work revealed cPL of 892, consistent with pancreatitis. She also has a decrease in Albumin along with increased Creatinine (1.7) and SDMA (26). Albumin 2.4, normal T4, unremarkable CBC, normal resting cortisol level.

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. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal in size (5.56 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal size (6.05 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.78 cm at cranial pole) (0.66 cm at caudal pole) with a slightly irregular shape. A 0.93 x 0.57 cm hyperechoic nodule is observed at the cranial pole. The glandular echogenicity and detail at the caudal pole are unremarkable. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is prominent in size (0.87 cm at cranial pole) (0.72 cm at caudal pole) with a slightly irregular shape. The parenchyma is heterogeneous with some loss of glandular detail. Surrounding vasculature appears normal.

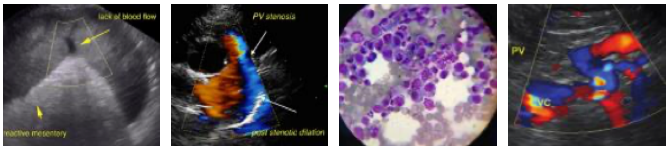
Spleen

The spleen is normal in size (1.42 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 with minor changes consistent with age-related remodeling. No focal lesions are observed. Hepatic vasculature 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 small to moderate amount of gravity-dependent echogenic debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal



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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.

Pancreas

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. A 0.68 cm cystic medial iliac lymph node is visualized.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- An obvious cause for the patient's diarrhea is not definitively identified in this study. Top differentials include primary gastrointestinal disease (i.e., dietary indiscretion, food allergy/intolerance, infectious/parasitic disease, inflammatory bowel disease), underlying metabolic issue, other.

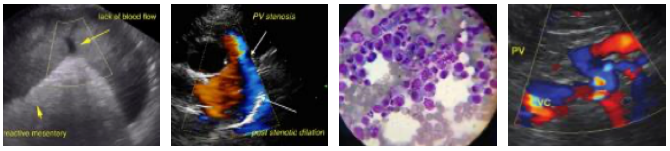
Secondary Findings:

- Minor, bilateral, age-related renal changes with dystrophic mineralization.
- The bilateral adrenal changes are most consistent with benign hyperplasia. However, an emerging tumor cannot be excluded in the left adrenal gland.
- Minor, age-related hepatic and pancreatic changes.
- The cystic medial iliac lymph node is likely a benign incidental finding. However, emerging neoplasia cannot be completely excluded.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Fecal evaluation for ova and Giardia is recommended (if not already performed). Also consider a fecal PCR infectious disease panel.
- Prophylactic deworming with Fenbendazole should also be considered along with initiation of a probiotic, fiber supplement and a bland diet.
- If the patient's clinical signs do not improve with the above diagnostics, a more comprehensive GI workup (i.e., hypoallergenic diet trial, GI panel, gastrointestinal biopsies) may be necessary to get a definitive diagnosis.
- Regarding the azotemia, consider the following:

    1. Urinalysis with culture and sensitivity



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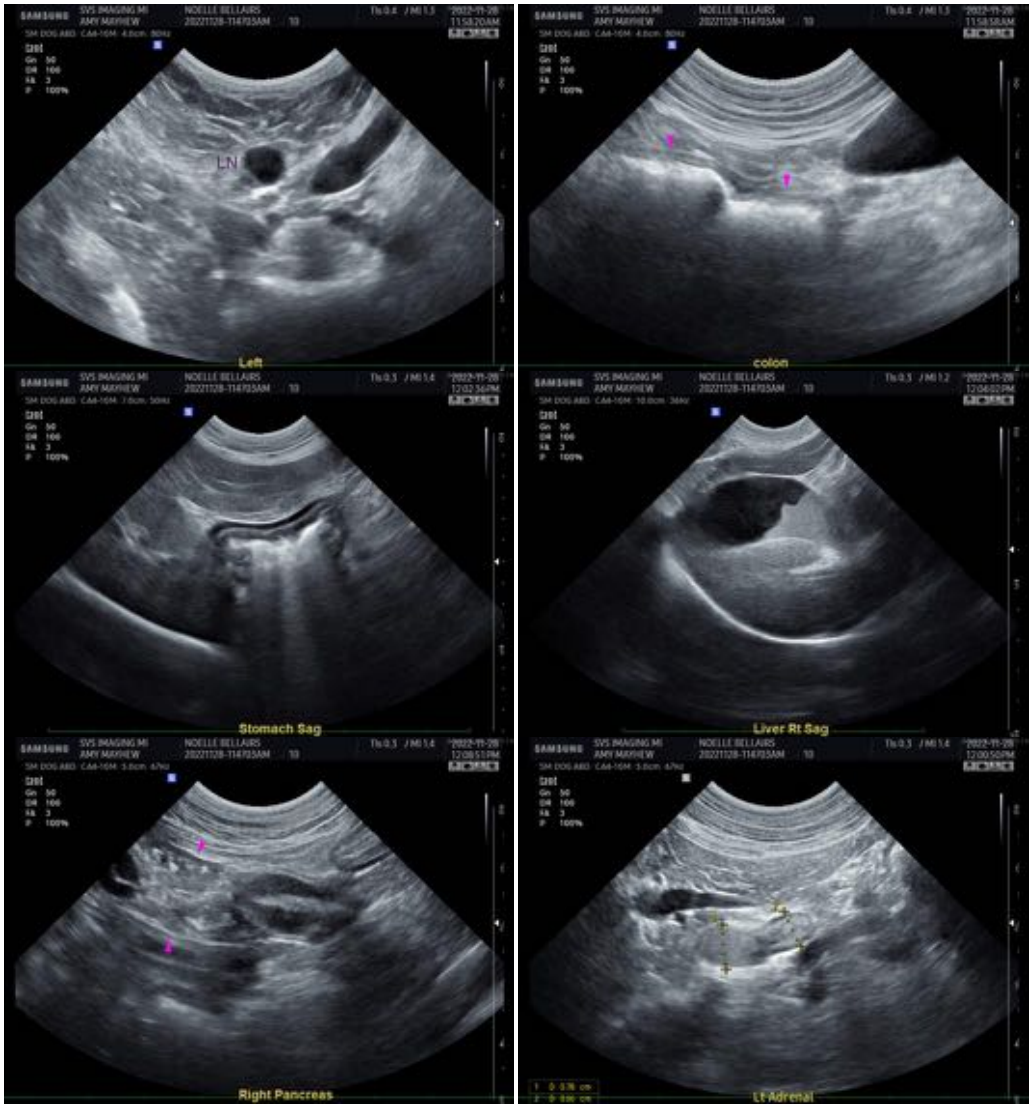
2. UPC (if proteinuria is present in the absence of infection)
3. Baseline blood pressure measurement

- Regarding the hypoalbuminemia, consider pre and post prandial serum bile acids to assess for occult hepatic dysfunction, although a GI protein loss is considered more likely.



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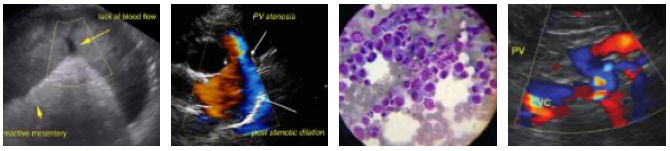

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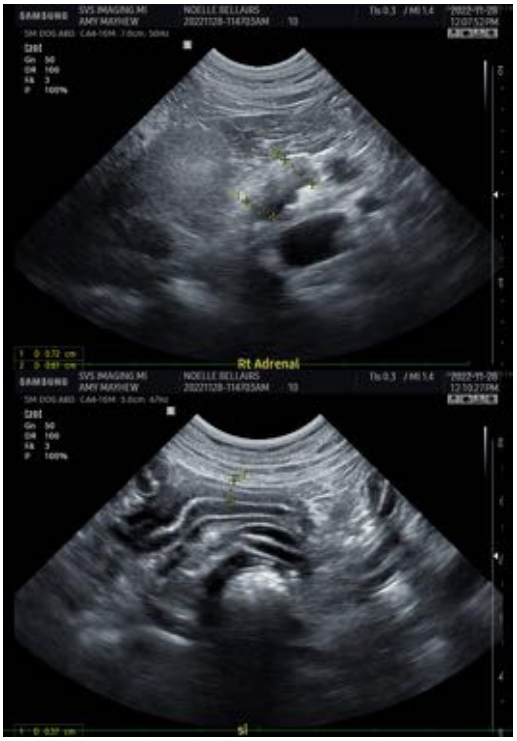

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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