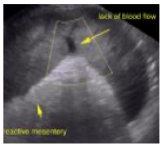
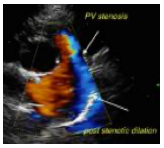
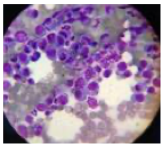
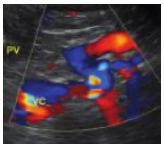
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT

Mandy Mayer

SPECIES

Canine

BREED

Maltese

SEX

Spayed Female

AGE

15 years

WEIGHT

6.24 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Sheldon

HOSPITAL NAME

Advanced PC of Oakland

REFERRING VET

Dr. Sheldon

INVOICE

11967

DATE

11.3.22

PRESENTING CLINICAL SIGNS

History: Pet has a 2-week history of anorexia. She is regurgitating and vomiting 1-2 times a day. She has a history of vestibular symptoms pet takes meclizine and cerenia PRN and has been on these medications. Pet is also on EOD pred for stomatitis from a previous vet. Pet is also on entyce. Drinking a ton of water.

Abnormal PE/Chem/CBC/UA Results: Pet is slightly ataxic. No head tilt or nystagmus. Very anxious. Possible pain with palpation of abdomen but could be anxiety. CBC/chemistry/chest radiographs: no significant findings.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder and visible portion of the pelvic urethra are normal for the degree of luminal distension. The urine is anechoic with no evidence of debris. Cystic calculi and discrete masses are not observed. The region of the trigone is normal.

The left kidney is normal size (3.41 cm in length); with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild loss of corticomedullary distinction. A small cortical cyst is observed at the caudal aspect. Several hyperechoic shadowing diverticular foci are observed. A few, small, nonobstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (3.58 cm in length); with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild loss of corticomedullary distinction. A small cortical cyst is observed at the caudal aspect. Several hyperechoic shadowing diverticular foci are observed. A few, small, nonobstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.52 cm at cranial pole) (0.33 cm at caudal pole) (1.31 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 region of the right adrenal gland is evaluated. No obvious pathology is observed.

Spleen

The spleen is normal in size (1.04 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A 0.71 cm hypoechoic nodule is observed at the medial aspect, near the hilus. Splenic vasculature is normal.

Liver

The liver is subjectively prominent to enlarged with swollen peripheral contours. The parenchyma is hyperechoic relative to the spleen with ill-defined hypoechoic areas. Hepatic vasculature and intrahepatic 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 amount of aggregated, echogenic, partially dependent debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is mildly to moderately distended with echogenic fluid. 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 dilated with chyme. 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

There is no evidence of free fluid. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Mild gastric ileus

Secondary Findings

- Bilateral degenerative renal changes with nonobstructive nephrolithiasis
- The splenic nodule could be consistent with an emerging tumor or a benign process (i.e., focus of lymphoid hyperplasia, extramedullary hematopoiesis, or similar).
- 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.
- Gall bladder debris/sludge, non-mucocele
- Age-related pancreatic remodeling

*An obvious cause for the patient's clinical signs is not identified in this study. Considerations include primary gastrointestinal disease (i.e., motility disorder, food allergy/intolerance, inflammatory bowel disease, infectious/parasitic disease, esophageal dysfunction), underlying metabolic issue, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

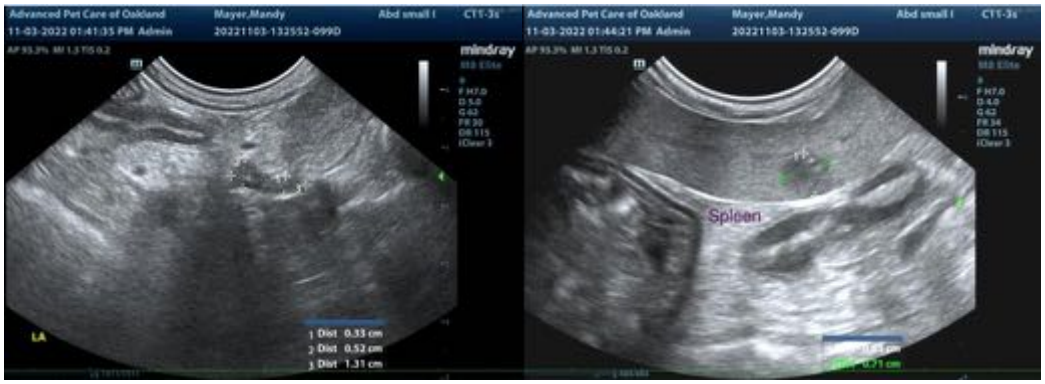
Consider a barium esophagram, preferably via fluoroscopy, to assess for esophageal dysfunction.

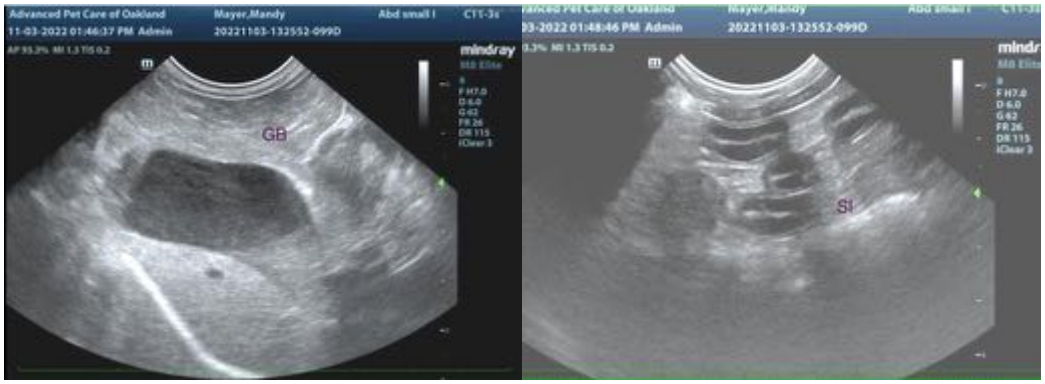
Other diagnostic/therapeutic considerations include the following:

1. A fecal evaluation for ova and Giardia is recommended.
2. A malabsorption panel, including serum cobalamin and folate, TLI and PLI, is also recommended (send to Texas A&M).
3. Empirical treatment with a promotility agent (i.e., metoclopramide). If no improvement in the patient's clinical signs is seen within 5-7 days of initiating therapy, the medication should be discontinued.
4. A resting cortisol level to screen for atypical hypoadrenocorticism is recommended.

5. Depending on the results of the above diagnostics, endoscopic or surgical biopsies may be necessary to get a definitive diagnosis.

Regarding the splenic nodule, a fine-needle aspirate may be considered, if clotting status is appropriate. A 25-gauge needle should be used.





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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