



PATIENT PRESENTING CLINICAL SIGNS

Paula Berg
 History: Diarrhea on and off for about 2 months, occasional vomiting, no appetite, lethargic. Patient was fasted prior to scan.
 Abnormal PE/Chem/CBC/UA Results: Chems done 10/31/22 ALKP <10 all others WNL, CBC WNL, cPLI Normal 12/14/22

SPECIES

Canine

BREED

Pub mix

SEX

Female, spayed

AGE

11 Yrs.

WEIGHT

20 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Sarah Pender

HOSPITAL NAME

SVS Imaging

REFERRING VET

Dr. Mike White

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DATE
12/19/22

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 size (4.99 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. Trace pyelectasia is present. There is no evidence of nephroliths, infarcts or hydronephrosis.

The right kidney is normal size (5.34 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. Trace pyelectasia is present. There is no evidence of nephroliths, infarcts or hydronephrosis.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.54 cm at cranial pole) (0.63 cm at caudal pole) (1.95 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 right adrenal gland is mildly enlarged (1.79 cm at cranial pole) (0.70 cm at caudal pole) (2.62 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 (1.30 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 gallbladder 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.

Gastrointestinal



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The gastric lumen is moderately fluid distended and hypomotile. 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 ileocecolic junction and colonic wall are normal. No obstructive disease is noted.

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Pancreas

The base and limbs of the pancreas is normal in size 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.

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Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

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ULTRASONOGRAPHIC FINDINGS

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Primary Findings:

- Suspected gastric ileus without evidence of an outflow tract obstruction. This may be secondary to a primary gastrointestinal motility disorder, inflammatory bowel disease, food allergy/intolerance, infectious/parasitic disease, underlying metabolic issue, low-grade pancreatitis, other.

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Diplomate ACVIM
(Small Animal Internal
Medicine)

Secondary Findings:

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Mild bilateral adrenomegaly.

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Sarah Pender

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The following diagnostics/treatment recommendations can be considered:

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1. GI Panel: serum cobalamin, folate, PLI and TLI
2. A fecal evaluation for ova/Giardia
3. Prophylactic deworming with Fenbendazole
4. A 6-week limited antigen diet trial to assess for food allergies.
5. Consider a 4-week course of Tylosin as empirical treatment for small intestinal bacterial overgrowth.
6. Also consider initiation of a probiotic as well as a fiber supplement.



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- Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be warranted. Three-view thoracic radiographs should be performed prior to any anesthetic event.

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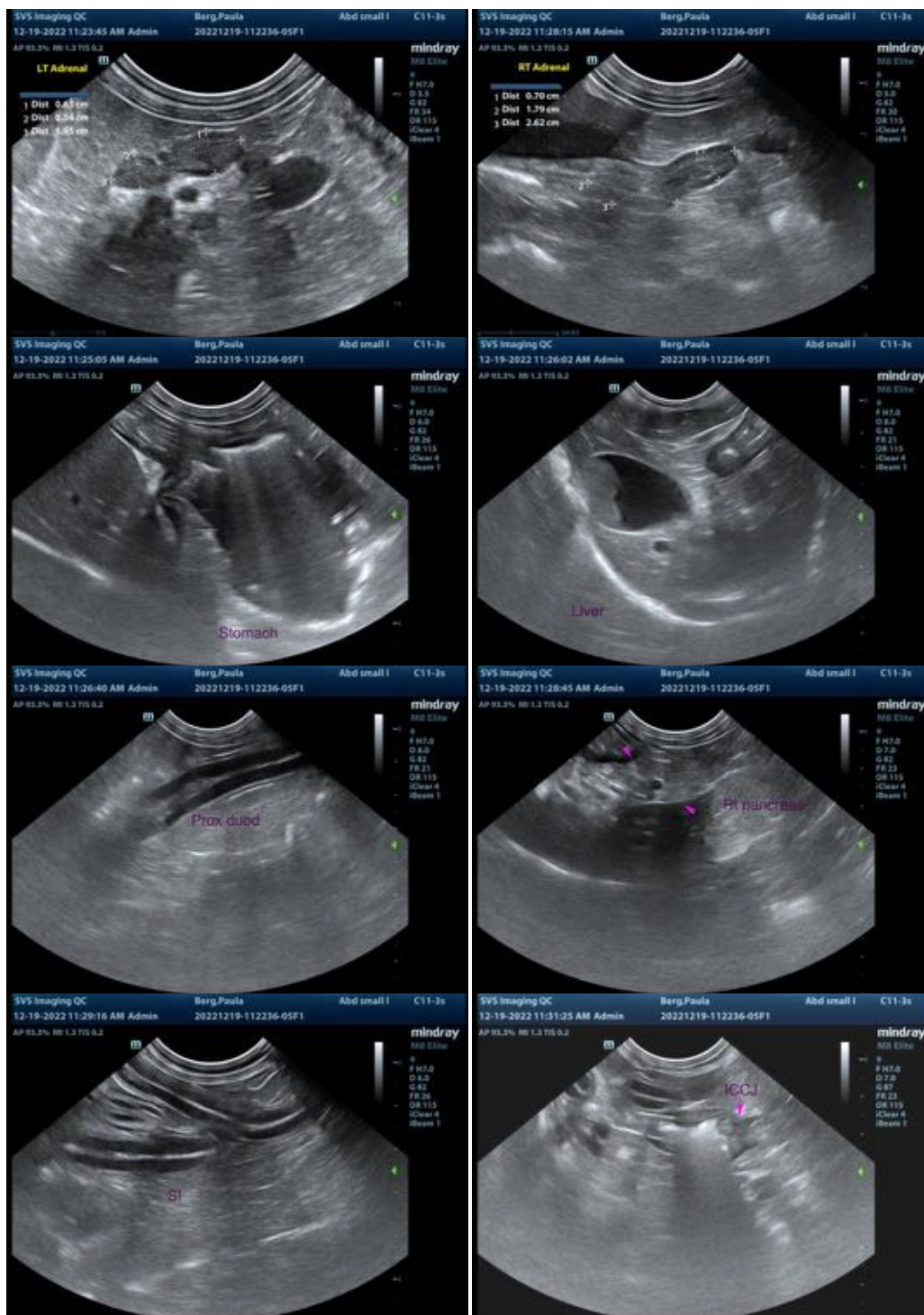
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The information and recommendations provided are based on the images presented by the referring



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veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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info@SonoPath.com

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