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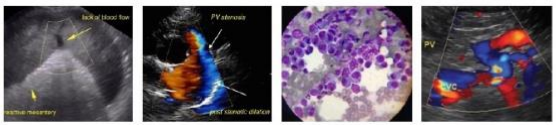


THE FOCAL ZONE
IMAGING PERFORMED BY
289-808-2608 info@thefocalzone.com

PATIENT

Jake Alonso

SPECIES

Canine

BREED

JackxChi

SEX

Neutered Male

AGE

5yr

WEIGHT

6.9 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Beatties Burlington PH

REFERRING VET

Dr. Ruggieri

INVOICE

10099

DATE

12/31/21

PRESENTING CLINICAL SIGNS

History: Chronic Diarrhea, intermittent vomiting R/O primary GI disease Anorexia (at time of exam 48hrs without eating) Went to MOVEH, maybe he had a reaction to metronidazole, was put on gastric feeding tube which he sneezed out. Went home and ate again for a few days. Went off food again this week on Wednesday. Has been on Raw diet for life. Switched this week to a Hypo diet as a trial, added Mirtazipine today and Tylosin.

Abnormal PE/Chem/CBC/UA Results: TP/BG -WNL, Complete blood count (12/24) -mild leukocytosis characterized by mild neutrophilia, mild monocytosis and mild basophilia (r/o acute on chronic inflammation vs infection vs other) • Serum biochemistry (12/24) -NSF Unremarkable except for evidence of infection. December 9th: CBC: Leukocytosis (21.59), Neutrophilia (17.96), Monocytosis (1.41), Basophilia (0.15) Electrolytes, Chem: Hypoproteinemia (48), Hypoalbuminemia (22) cPLI: Normal Urine analysis: WNL

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 mostly anechoic with no evidence of debris. Cystic calculi and discrete masses are not observed. The region of the trigone is normal.

The left kidney presented normal size (4.31 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. Hyperechoic no mineralized speckling is observed within the medulla. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney presented normal size (4.38 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. Hyperechoic to mineralized speckling is observed within the medulla. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The prostate is not definitively visualized due to its pelvic location.

Adrenal Glands

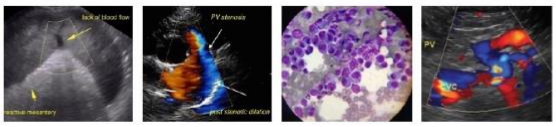
The left adrenal gland is normal size (0.56 cm at cranial pole) (0.50 cm at caudal pole) (1.74 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.98 cm at cranial pole) (0.53 cm at caudal pole) (1.38 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 (1.17 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



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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 gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal.

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 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. The colonic lumen is diffusely distended with liquid-appearing fecal material. There is no obvious evidence of an obstructive pattern.

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. A 1.19 cm lymph node is observed in the right cranial quadrant.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The prominent lymph node in the right cranial quadrant is likely reactive.
- Pinpoint mineralizations in the renal medulla bilaterally, likely incidental.
- The remainder of the abdomen is unremarkable. An obvious cause for the patient's clinical signs is not identified in this study. Differentials include primary gastrointestinal disease (i.e., infectious/parasitic, food allergy, intestinal dysbiosis, inflammatory bowel disease), low-grade pancreatitis, underlying metabolic issue, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Fecal evaluation for ova and Giardia
- Prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.
- Malabsorption panel including serum cobalamin, folate, TLI and PLI
- A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended.

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

- To further evaluate for concurrent causes of hypoalbuminemia, consider the following:

  1. UPC (if proteinuria is present)
  2. Pre- and post-prandial serum bile acids

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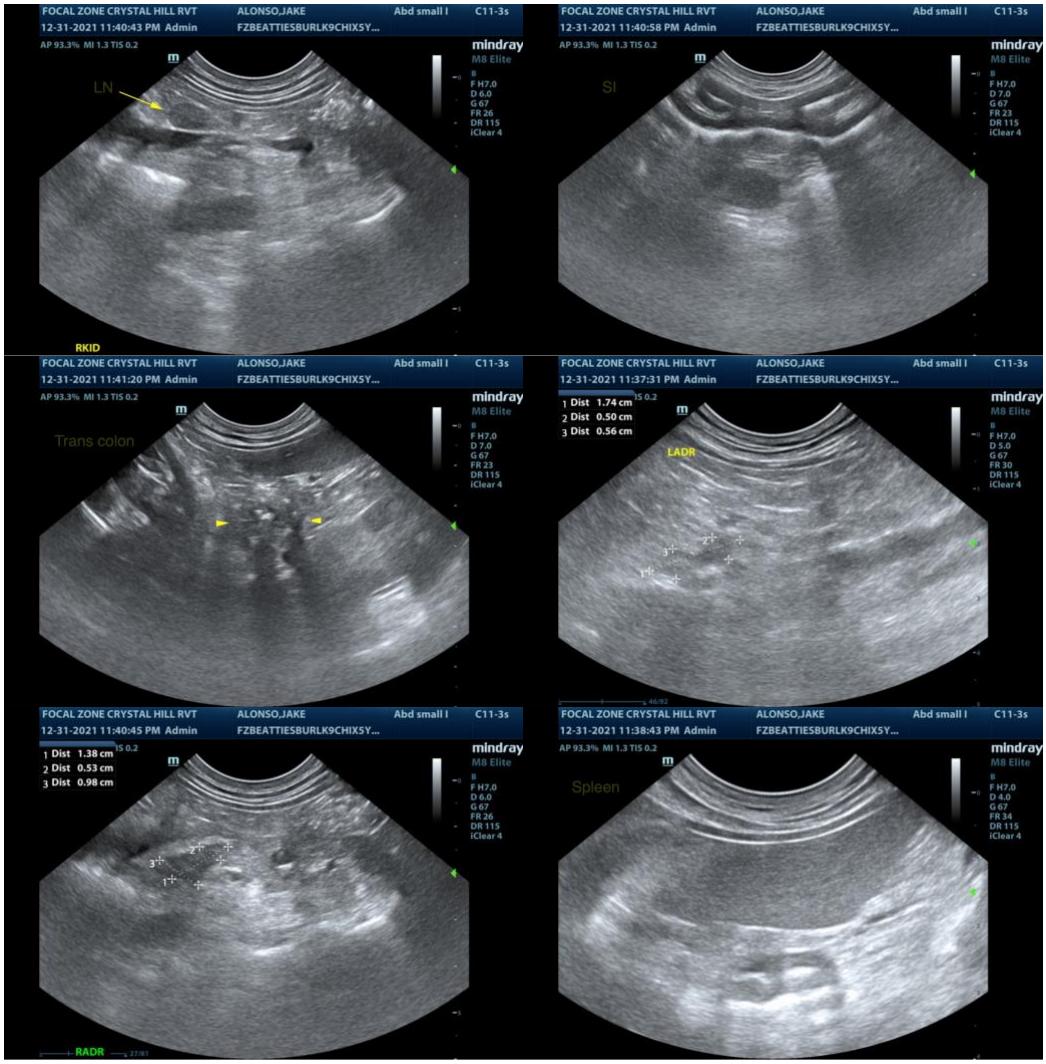

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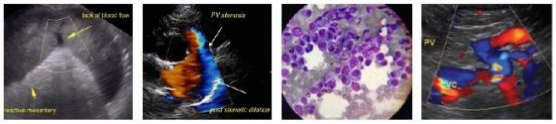

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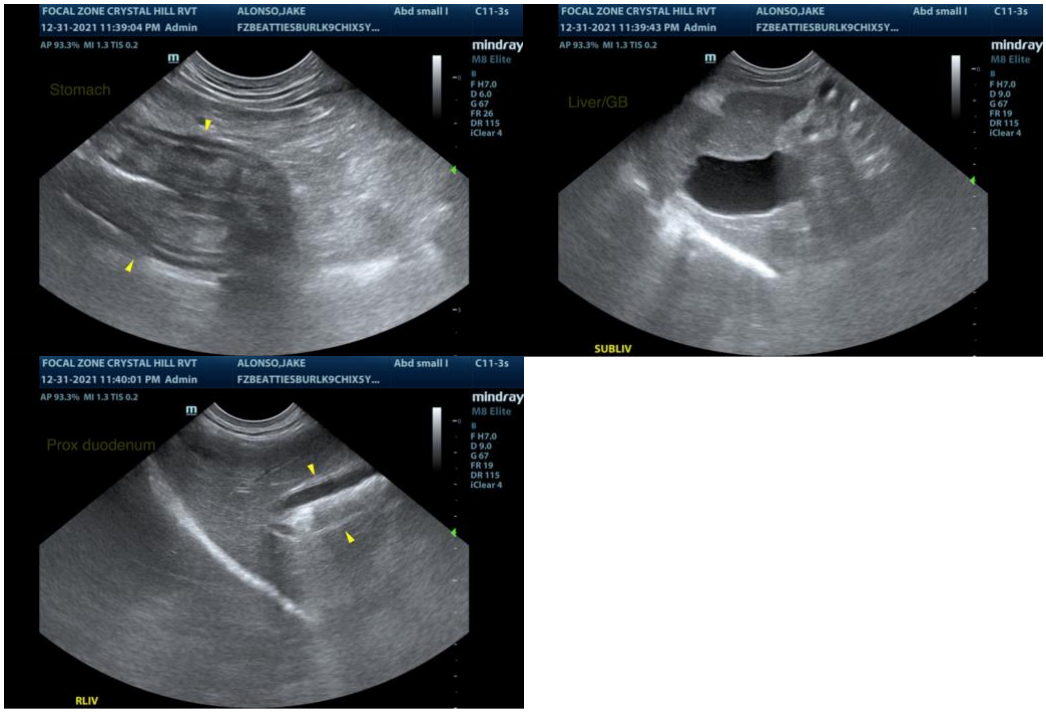

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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