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Clinical Sonography & Telecytology
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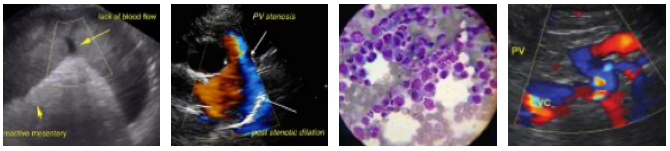


SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Aston Laas

SPECIES

Canine

BREED

Schnoodle

SEX

Male, neutered

AGE

9 years 10 months

WEIGHT

27 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Potomac Mobile Veterinary Ultrasound

HOSPITAL NAME

Heritage AH

REFERRING VET

Dr. Jarrett

INVOICE

12663

DATE

PRESENTING CLINICAL SIGNS

History: Elevated liver enzymes and history of chronic vomiting off and on, concern for possible pancreatitis.
Abnormal PE/Chem/CBC/UA Results: ALP 789. ALT 126. Neutrophills 23.55.

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. A small amount of suspended echogenic debris is observed within the lumen. 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 prostate is not definitively visualized due to its pelvic location.

The left kidney is normal size (4.59 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is slightly heterogeneous in appearance. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (4.64 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.44 cm at cranial pole) (0.48 cm at caudal pole) (1.85 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.

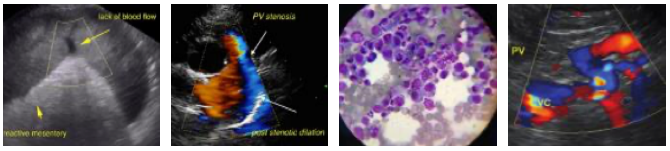
The right adrenal gland is normal size (0.39 cm at cranial pole) (0.45 cm at caudal pole) (1.77 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.98 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A 0.37 cm hypoechoic nodule is observed within the parenchyma. Splenic vasculature is normal.

Liver

The liver is subjectively prominent in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen with a coarse echotexture and a heterogeneous appearance throughout the organ. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gallbladder is of normal contours and contains some



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dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. 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 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 hyperechoic 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

Trace free fluid is observed adjacent to the urinary bladder. The abdominal lymph nodes are normal/not visible.

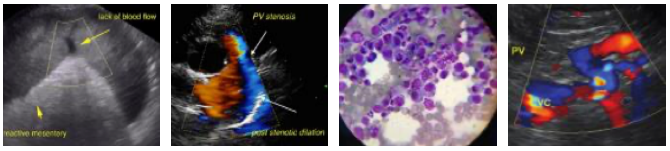
ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- 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.
- Gallbladder debris, non-mucocele.
- The significance of the trace ascites is unclear. It may represent increased vascular permeability, increased hydrostatic pressure or low oncotic pressure. Correlation with clinical findings is recommended.

Secondary Findings:

- Minor age-related renal changes.
- Age-related pancreatic remodeling/fibrosis. Low-grade pancreatitis may be present, particularly if the patient exhibits discomfort on abdominal palpation.
- The splenic nodule trends toward the benign (i.e., a focus of lymphoid hyperplasia or extramedullary hematopoiesis) with lower potential for emerging neoplasia.



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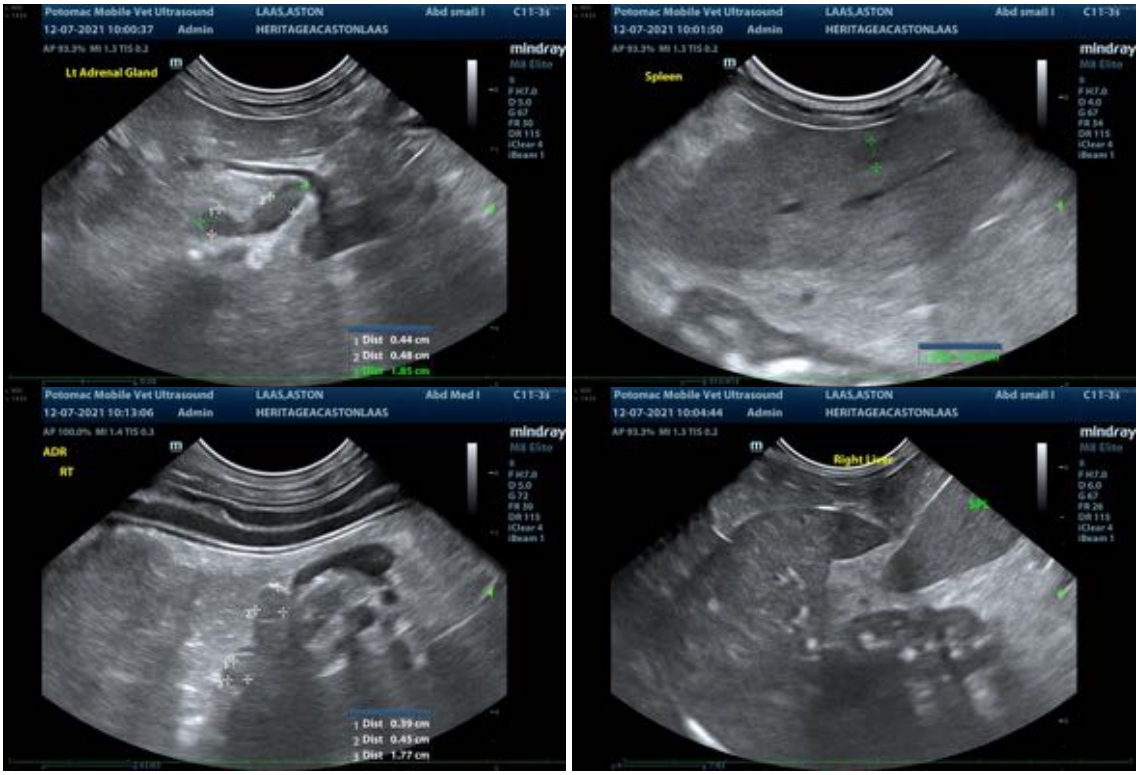
*An obvious cause for the chronic intermittent vomiting is not identified in this study. Considerations include microscopic gastrointestinal disease (i.e., food allergy, intestinal dysbiosis, inflammatory bowel disease, infectious/parasitic disease), low-grade pancreatitis, underlying metabolic issue, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Regarding the chronic vomiting, consider the following:

1. A fecal evaluation for ova/Giardia.
2. Malabsorption panel (sent to Texas A&M).
3. A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended
4. 6-week limited antigen diet trial.
5. Three-view thoracic radiographs are recommended to assess for occult esophageal disease.
6. Depending on the results of the above diagnostics, endoscopic or surgical gastrointestinal biopsies may be necessary to get a definitive diagnosis. If surgical biopsies are pursued, a liver biopsy should also be obtained.



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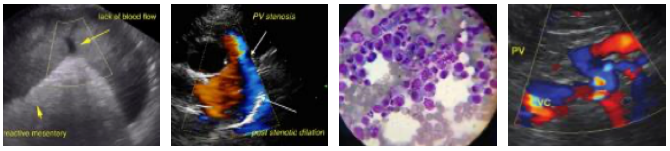

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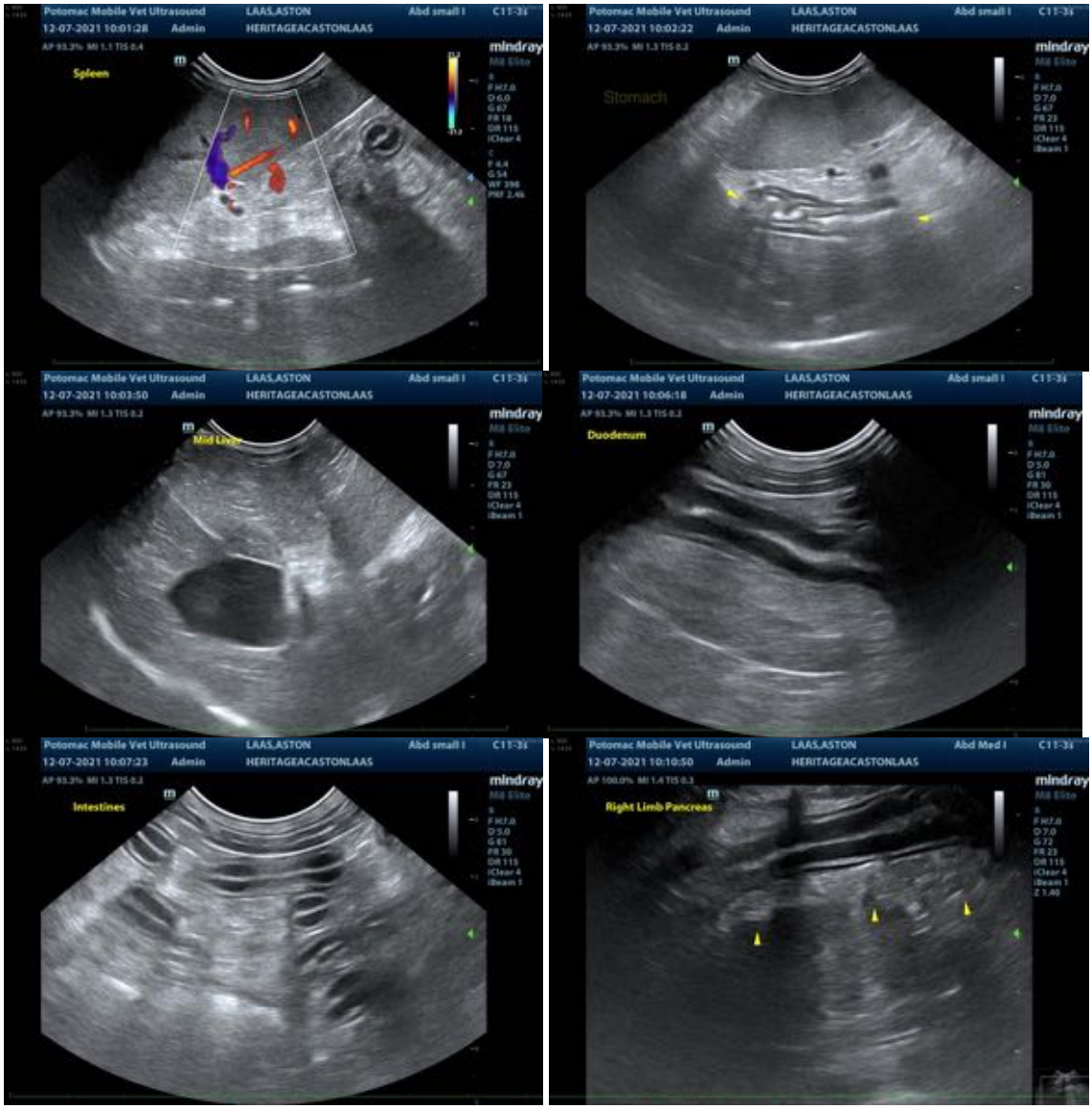

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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 ACVIM (*Small Animal Internal Medicine*)

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