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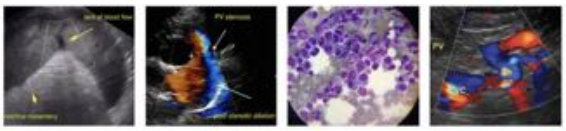


Charleston Mobile Veterinary Services
IMAGING PERFORMED BY
CharlestonMobile.Net 800.403.5408

PATIENT

Mookie Sama

SPECIES

Canine

BREED

Bichon Poodle Mix

SEX

Neutered Male

AGE

3/10/2009

WEIGHT

5.98 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

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

HOSPITAL NAME

Sun Dog Cat Moon

REFERRING VET

Dr. Clayton

INVOICE

12213

DATE

2.13.23

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Anorexia and vomiting starting 2/10. The dog has been progressively hyporexic for the past 2 weeks and got acutely worse this past Friday. Polydipsia is suspected.

Abnormal lab-work values: CBC chemistry unremarkable. USG 1.028

Current Medications: Dasuquin Advanced/Advantage Multi

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 prostate is normal in size (0.57 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal in size (4.28 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. A small cortical cyst is observed at the medial aspect. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (4.26 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. A small cortical cyst is observed at the medial aspect. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.55 cm at cranial pole) (0.46 cm at caudal pole) with a normal shape and 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 in normal size (0.70 cm at cranial pole) (0.33 cm at caudal pole with a normal shape and 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 (1.27 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 normal to slightly prominent in size with normal curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and diffusely homogeneous in appearance. A small hypoechoic nodule/area (1.60 cm in diameter) is observed on the left side. Vascular 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 amount of aggregated, echogenic-to-mineralized debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

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. There is no evidence of an obstructive pattern.

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 0.83 cm medial iliac lymph node is visualized. The node is normal in shape and echogenicity.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- An obvious cause for the patient's GI signs is not definitively identified in this study. Considerations include microscopic gastrointestinal disease (i.e., food allergy/intolerance, inflammatory bowel disease, infectious/parasitic disease), mild pancreatitis, underlying metabolic issue, other.

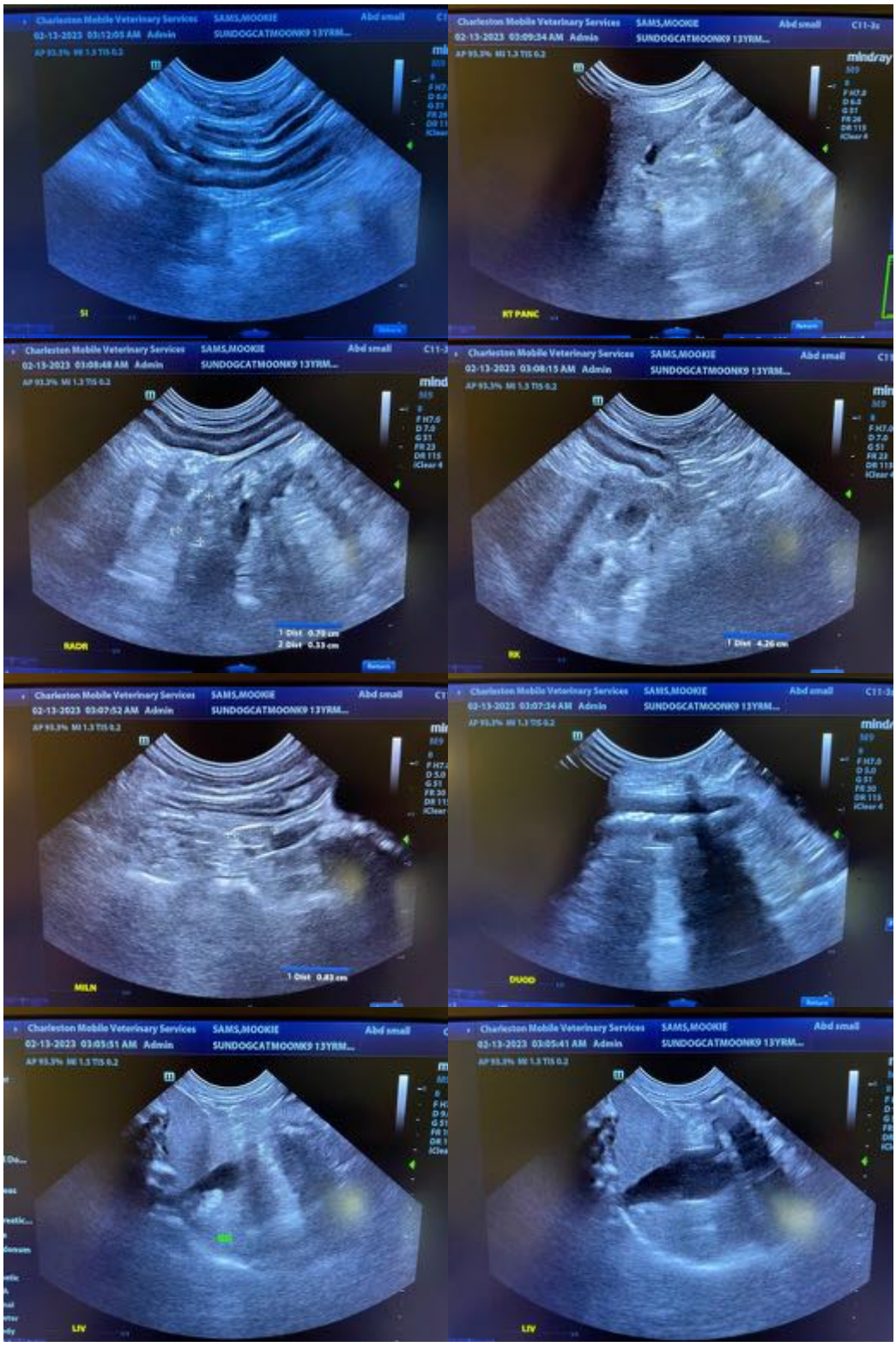
Secondary Findings

- Minor bilateral age-related renal changes
- The pancreatic changes are most consistent with age- related remodeling +/- mild fibrosis. Mild chronic pancreatitis or a prior episode of pancreatitis also cannot be excluded.
- The hepatic parenchymal changes are most consistent with a benign hepatopathy, such as vacuolar hepatopathy (i.e., idiopathic/endocrine), particularly in light of the normal liver enzymes. The hypoechoic hepatic nodule trends toward the benign (i.e., regenerative nodule) with a lower possibility of an inflammatory focus or an emerging tumor.
- The prominent medial iliac lymph node is likely reactive.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Further diagnostics/treatment recommendations could include the following:

    1. Fecal evaluation for ova and Giardia
    2. GI panel including serum cobalamin and folate, TLI, PLI, and resting cortisol level
    3. Symptomatic care along with initiation of a probiotic
    4. Ultimately, GI biopsies (i.e., endoscopic, or surgical) may be necessary to get a definitive diagnosis.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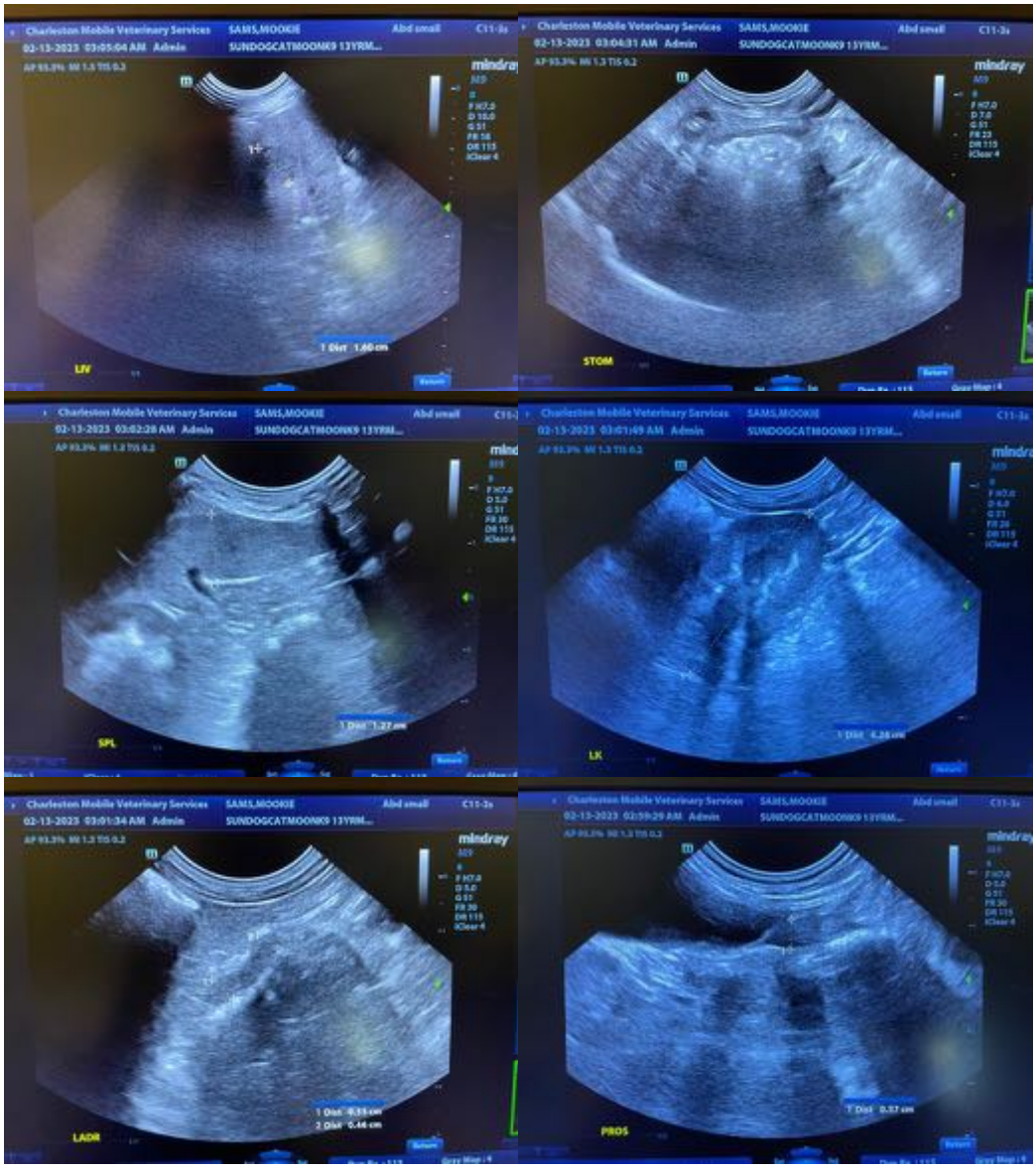

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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