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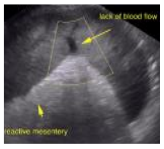
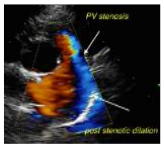
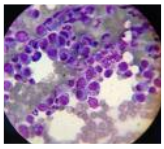
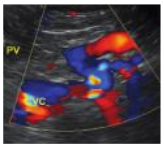





SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Jasper McClanahan

SPECIES

Canine

BREED

Yorkshire Terrier

SEX

Neutered Male

AGE

13 years

WEIGHT

2.9 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Woodside

HOSPITAL NAME

Sherwood Family Pet Clinic

REFERRING VET

Dr. Woodside

INVOICE

10419

DATE

2/18/22

PRESENTING CLINICAL SIGNS

History: Jasper has had mild, short acting (15sec) seizures once every 2-3 months for several years. Feb 17th morning he had a long seizure and extended postictal phase with circling. Anorexia and diarrhea were noted at home. Onset may have been prior to seizure. At the exam on 2/17, presenting complaint seizure, stomach was greatly distended with material suggestive of ingesta/food. This didn't fit with the history of weight loss and anorexia, so it raised concern for pyloric/gastric pathology. Ultrasound scheduled for 2/18. On exam 2/18, circling had resolved. Stomach was no longer distended. Owner did not notice any vomiting overnight, but diarrhea seemed worse. Significant gas present in small intestines at time of ultrasound but resolved later in the afternoon based on serial radiographs. Proceeded with ultrasound although immediate concern for pyloric/gastic pathology seems less urgent. Most recent labwork: 12/21; SDMA 23; remainder normal (including Cr/BUN)

Abnormal PE/Chem/CBC/UA Results: BCS 4/9; weight loss of 0.9# since May 2021. Moderate to heavy calculus, marked overbite (brachygnathism), base narrow, 404 impact on hard palate. 2/17: Head tilt to right and circling to left, generalized ataxia; 2/18: very mild head tilt to right; resolution of circling and ataxia. 2/17: Abdominal Palpation: pain, tense. mass effect in cranial left abdomen 2/18: normal abdominal palpation

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended. The wall is normal in thickness with a smooth mucosal surface. One to a few cystic calculi are observed within the lumen. Luminal contents are otherwise anechoic. The region of the and the visible portion of the proximal urethra are normal.

The prostate is normal in size (0.68 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

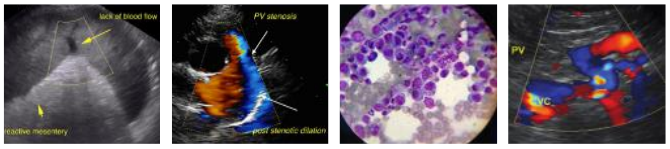
The left kidney is normal size (2.93 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. Several nonobstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. A few small cortical cysts are seen.

The right kidney is normal in size (3.26 cm in length) with a slightly irregular shape, smooth peripheral margins, and normal internal architecture. There is moderate loss of corticomedullary distinction. One small cortical cyst is observed at at the lateral aspect. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis.

Adrenal Glands

The left adrenal gland is normal size (0.40 cm at cranial pole) (0.46 cm at caudal pole) (1.60 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 (1.25 cm at cranial pole) (0.44 cm at caudal pole) (1.51 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are



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unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.80 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 prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits mild heterogeneity. A 1.26 cm irregular hyperechoic nodule is observed deep on the right side, near the diaphragm. Hepatic vasculature and biliary tracts are of normal volume with no evidence of congestion.

The gall bladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No cholelithsare observed. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is mildly to moderately distended with ingesta. 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 or overt infiltrative disease is noted.

Pancreas

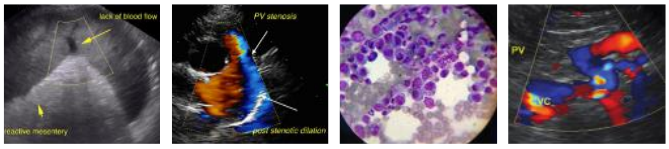
The right limb is prominent in size with irregular peripheral contours. The parenchyma is hyperechoic relative to surrounding omental fat and slightly mottled in appearance. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated.

Free Abdomen

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

ULTRASONOGRAPHIC FINDINGS

- Cystic calculus/calculi
- Bilateral degenerative renal changes with dystrophic mineralization and right nonobstructive nephrolithiasis
- 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.
- The hyperechoic hepatic nodule likely represents a benign process (i.e., regenerative nodule), with a lower possibility of emerging neoplasia.
- Age-relate related pancreatic remodeling/fibrosis. Concurrent pancreatitis is also possible, particularly if the patient exhibits cranial abdominal pain on palpation.



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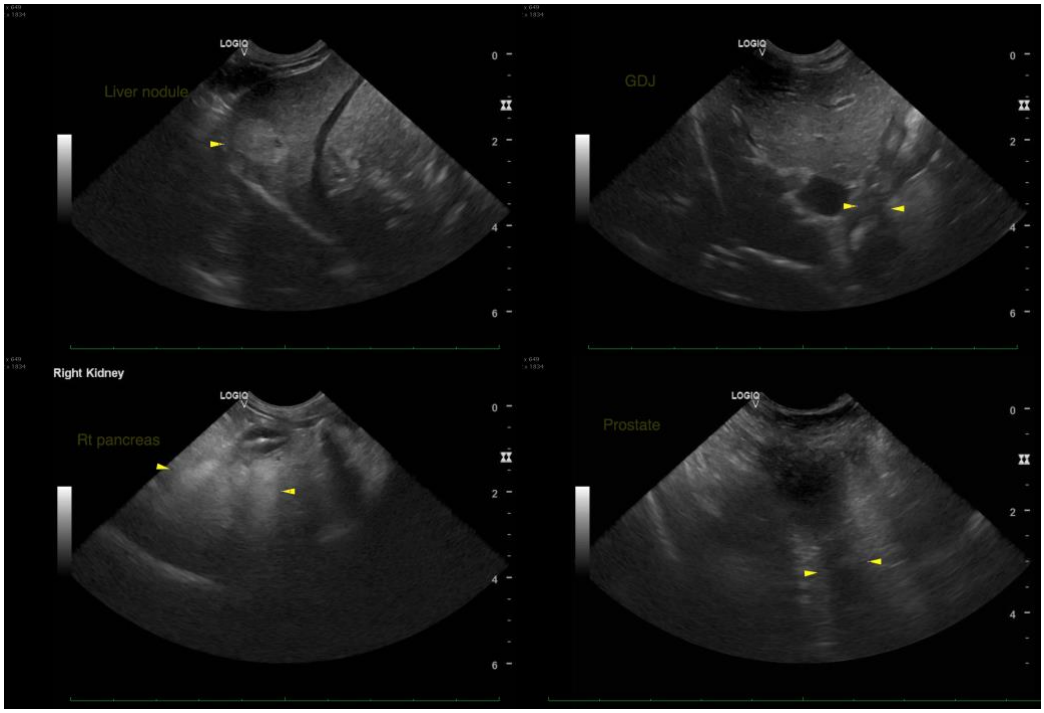
**An obvious cause for the patient's diarrhea is not identified in this study. Considerations include microscopic gastrointestinal disease, low-grade pancreatitis, underlying metabolic issue, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Fecal evaluation for ova and Giardia
- Consider prophylactic deworming with Fenbendazole as well as supplementation with a probiotic (i.e., Visbiome or Proviable Forte).
- Consider empirical treatment for small intestinal bacterial overgrowth with a 4-week course of Tylosin.
- If the above diagnostics are inconclusive and the diarrhea persists, further GI workup may be warranted.
- Regarding the cystic calculi, consider a cystotomy with stone removal, analysis and culture. Alternatively, medical dissolution of the stones can be considered with a prescription renal diet and broad-spectrum antibiotic therapy. If there is no improvement in stone size after 4 weeks of therapy, a cystotomy should be reconsidered. If the stone size is reduced, continue therapy until complete dissolution has been achieved.



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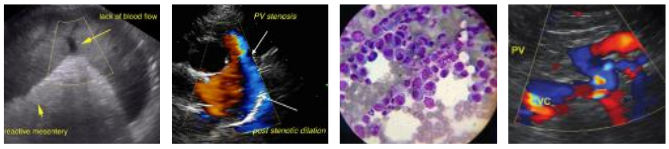

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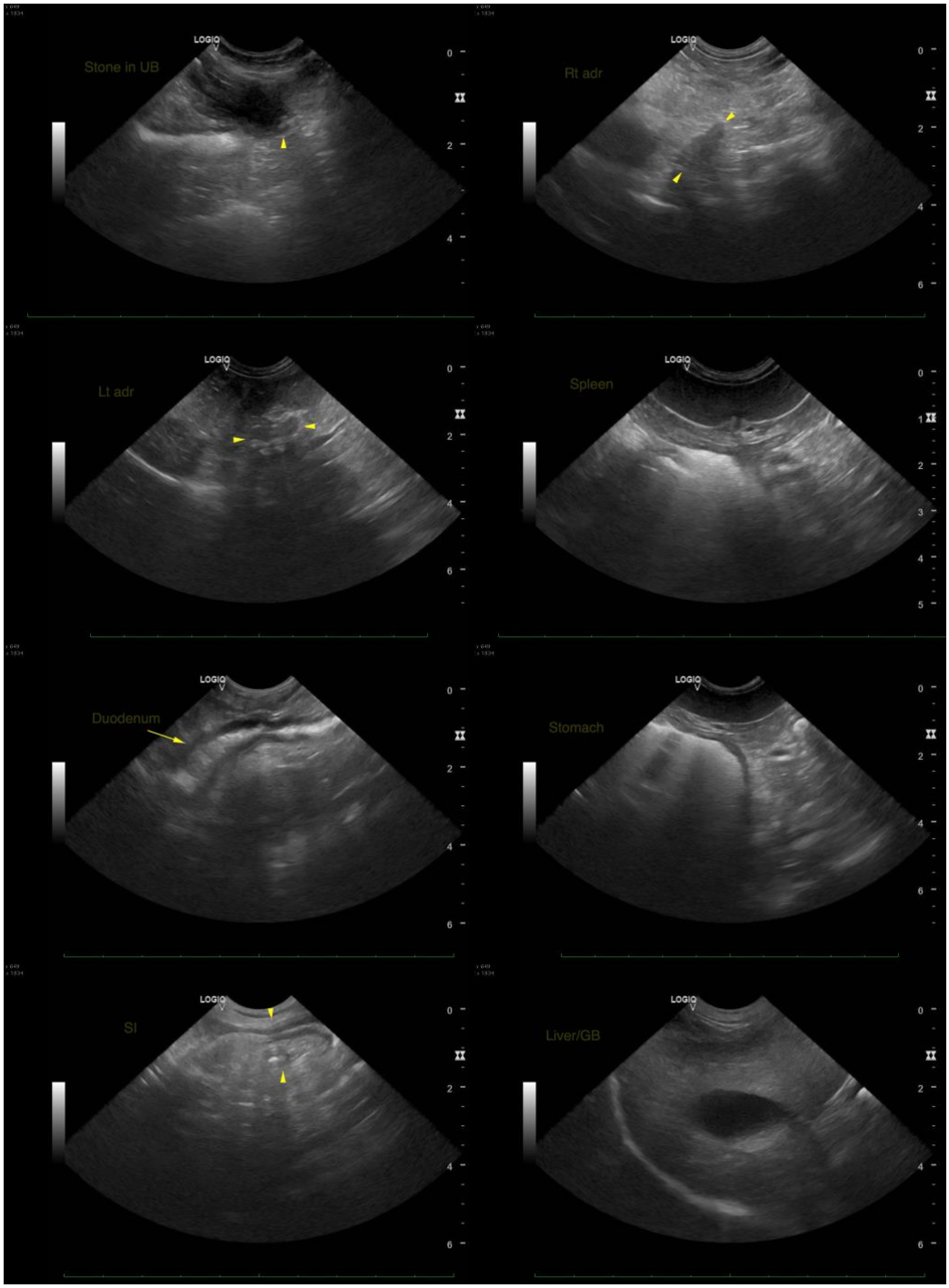

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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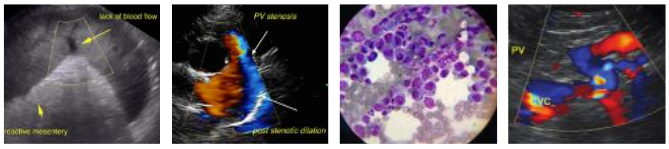

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