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Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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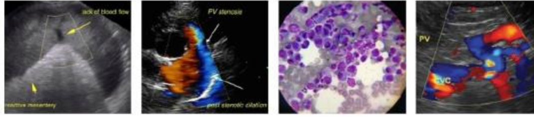


PAWS
Portable Animal Western Sonography, Inc.
IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT
Stella Davis

SPECIES
Canine

BREED
Lab Retr.Mix

SEX
Spayed Female

AGE
10 years

WEIGHT
36 lbs

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

IMAGING PERFORMED BY
Loetitia Saint-Jacques, RVT

HOSPITAL NAME
Donner Truckee VH

REFERRING VET
Dr India Vannini

INVOICE
10293

DATE
2/5/22

PRESENTING CLINICAL SIGNS

History: Presented for strong smelling, frequent urination, increased thirst and marked progressive muscle wasting/weight loss on 1/28/22. Has been hungry and eating more since November. Dewormed with panacur 10/2021 after first presentation for weight loss. Has started to urinate in the house occasionally. Vomited a lot one week ago and then started having the increased frequency of urination. No C/S/D.

Meds: Galliprant, Hx unexplained weight loss and generalized muscle atrophy. - urinary signs improved with short course of Amoxicillin since visit on 1/28. Rectal exam unremarkable. CBC: Hct 47%, Neut 7134, Lymph 574 (L), otherwise wnl Chem: TP 5.7, AST 90 (H), ALT 47, ALKP 220 (H), BUN 10, Creat 0.7, Glu 62 (L), Ca 9.2, Corrected Ca 10, K 5.8 (H), Na/K 26 (L), Cl 118, Chol 226, otherwise wnl T4: 0.9, fT4 27.5 UA: spg 1.025, pH 5.0 (L), Protein trace, fat droplets 21-50/hpf, WBC 0-1 Resting cortisol: 2 1) Severely muscle wasted. Weight loss over the past year despite good appetite r/o Addison's vs other metabolic vs neoplasia 2) Increased frequency and urgency of urination r/o DM r/o UTI r/o renal disease vs HAC vs other 3) PU/PD r/o Addison's vs HAC vs DM vs hyperthyroid (less likely) vs other metabolic vs UTI vs bladder neoplasia/urolithiasis

LIMITED ULTRASONOGRAPHIC EXAMINATION

Urinary System

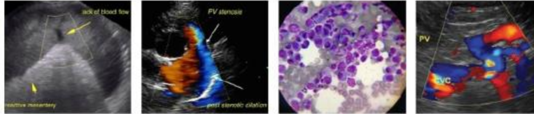
***Images from 2/5/2022*
The urinary bladder is moderately distended. The wall is normal in thickness, with a smooth mucosal surface. Luminal contents are anechoic. No cystic calculi are seen. The region of the trigone is normal.
***Additional urinary bladder images submitted on 2/6/2022*
The urinary 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 and the visible portion of the proximal urethra are normal

The left kidney presented normal size (6.75 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney presented normal size (6.64 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. One to two cortical infarcts are visualized. There is no evidence of pyelectasia nephroliths or hydroureter.

Adrenal Glands
The left adrenal gland is normal size (0.66 cm at cranial pole) (0.59 cm at caudal pole); (2.31 cm 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.

Adrenal Glands
The left adrenal gland is normal size (0.66 cm at cranial pole) (0.59 cm at caudal pole); 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.



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The right adrenal gland is normal size (0.74 cm at cranial pole) (0.55 cm at caudal pole) (2.82 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. 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 gall bladder is of normal contours and contains some dependent echogenic to mineralized debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal/not seen.

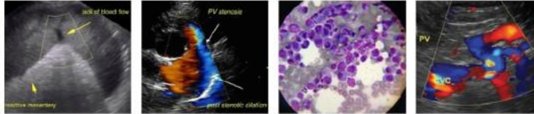
Gastrointestinal
The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The small intestinal lumen is segmentally dilated with chyme. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. The ileocecocolic junction is normal. A 0.95 x 0.59 cm hypoechoic nodule/lesion is observed in the colonic wall. The remaining colonic wall is normal in thickness with a normal layering pattern. There is no 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
Trace free fluid is observed. A few prominent caudal abdominal lymph nodes are visualized, the largest measuring 3.20 cm in length

Other:
A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.

Other (Cervical evaluation)
The left thyroid lobe measures 2.22 x 0.35 cm. A 0.35 x 0.13 cm parathyroid gland is observed at the caudal aspect in the sagittal view. No obvious pathology is observed. The right thyroid lobe measures 2.32 x 0.53 cm. A 0.76 x 0.56 cm slightly lobulated irregular hypoechoic to anechoic avascular nodule is observed at the cranial aspect. The nodule causes mild capsular expansion. The remaining thyroid parenchyma is subtly heterogenous. A few visible lymph nodes are also observed in the cervical area.



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ULTRASONOGRAPHIC FINDINGS

Abdominal Findings

- Right renal cortical infarcts.
- The mural nodule within the colonic wall could be consistent with a polyp, tumor, granuloma, other.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The trace ascites may be secondary to low oncotic pressure, increased hydrostatic pressure, or increased vascular permeability. Correlation with clinical findings is recommended.

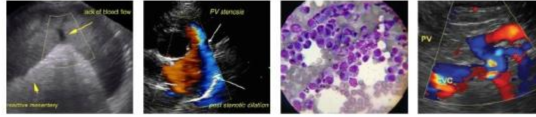
**An obvious cause for the patient's clinical signs is not identified in this study. Considerations include microscopic gastrointestinal disease, underlying metabolic issue, occult neoplasia, other.

Cervical Findings

- The right thyroid lesion could be consistent with a cyst, tumor (i.e., adenoma, adenoma carcinoma), granuloma, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the patient's weight loss, consider the following:
  1. Three-view thoracic radiographs to assess for occult neoplasia in the chest
  2. A malabsorption panel including serum cobalamin, folate, TLI and PLI
  3. Fecal evaluation for ova and Giardia
  4. A thorough neurologic exam is recommended, as weight loss can be the sole clinical sign with primary brain tumors.
- Depending on the results of the above diagnostics, endoscopic or surgical gastrointestinal biopsies may be warranted.
- Regarding the right thyroid nodule, serial sonographic monitoring is recommended to assess for progression.
- Regarding the colonic lesion, a repeat ultrasound is recommended in 3-4 weeks to assess for progression. Alternatively, a colonoscopy can be considered.



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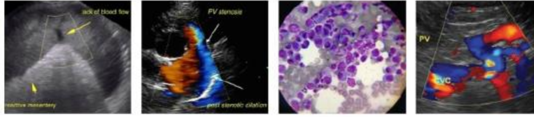

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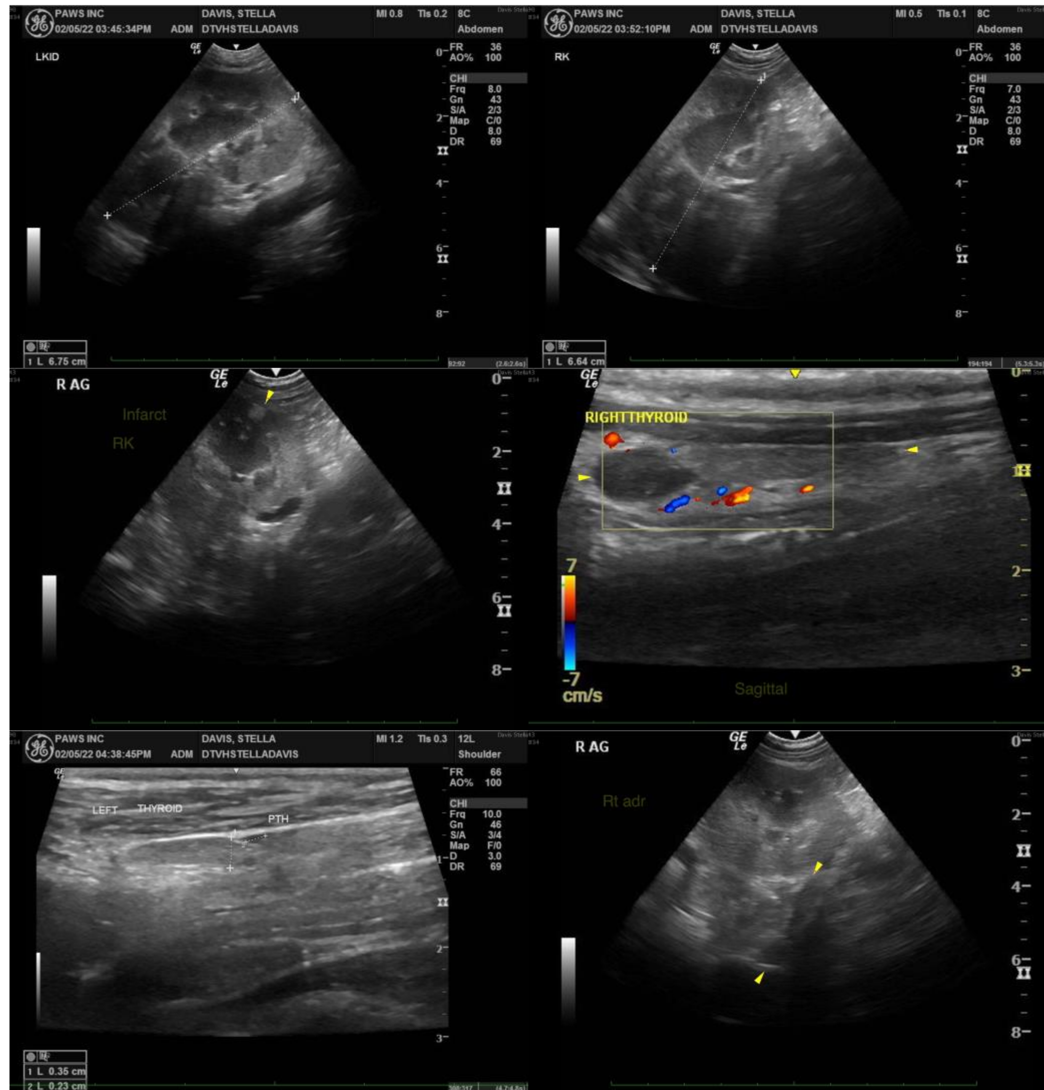

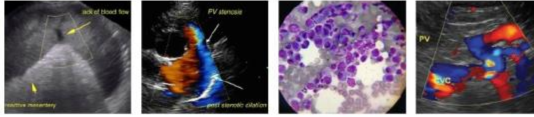

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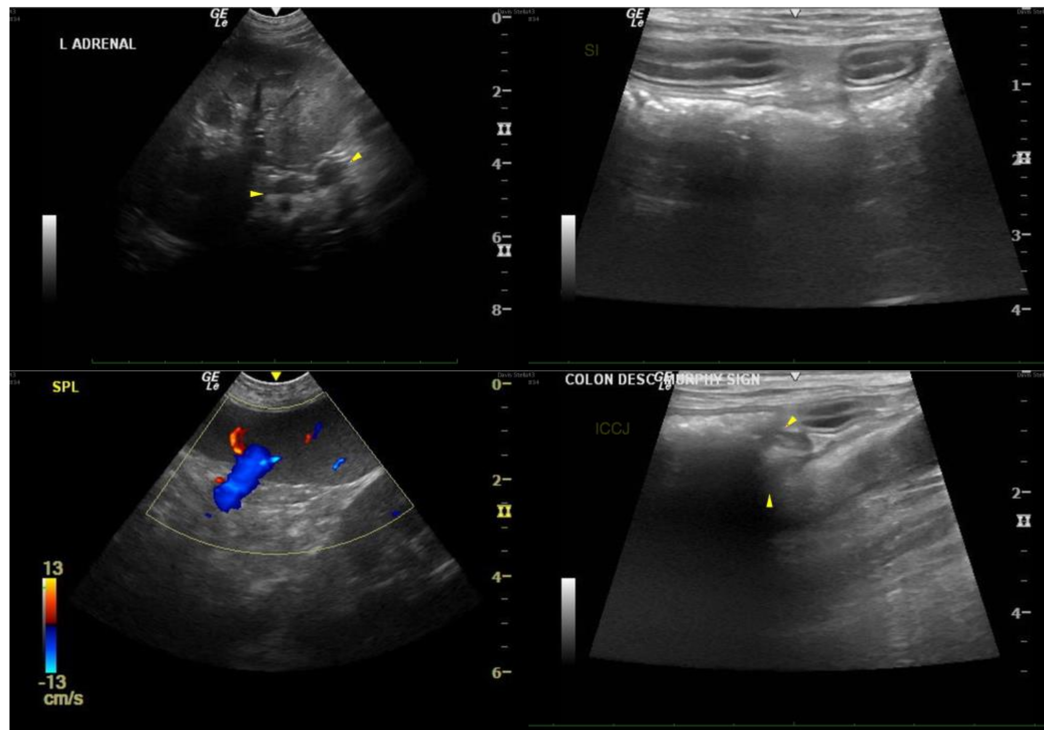

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com