



PATIENT

Bailey Ruszkowski

SPECIES

Canine

BREED

Yorkie

SEX

Male, neutered

AGE

7.5 Yrs.

WEIGHT

10.9 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Adrienne Waffle

HOSPITAL NAME

Torch Lake VC

REFERRING VET

Dr. Lewis

INVOICE

14670

DATE

3/1/23

PRESENTING CLINICAL SIGNS

P presented with ascites. RDVM wanted to rule out hemoabdomen. Hematocrit 30%. Increased reticulocyte count. Leukocytosis with a neutrophilia, monocytosis, thrombocytosis, panhypoproteinemia, albumin 1.3.

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. The region of the trigone and the visible portion of the proximal urethra are normal.

The prostate is normal in size (0.89 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 (3.69 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 is normal size (3.75 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.

Adrenal Glands

The left adrenal gland is normal size (0.45 cm at cranial pole) (0.39 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.

The right adrenal gland is not definitively visualized in the available images.

Spleen

The spleen is normal in size (0.64 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 lumen is mildly to moderately distended. The wall is thickened (up to 0.30 cm), with a "double-walled" effect. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is mildly distended with ingesta and gas. The gastric wall is normal in thickness with a normal layering pattern. The small intestinal lumen is not dilated. The small intestinal wall is diffusely thickened (up to 0.51 cm) with retention of the normal layering pattern. There is evidence of mucosal



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striations and fogging in most segments. Discreet masses are not identified. The colonic wall is normal. No obvious obstructive disease is noted.

Pancreas

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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.

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Free Abdomen

The mesentery throughout the abdomen is hyperechoic. A moderate to large amount of echogenic free fluid is present. The abdominal lymph nodes are normal/not visible.

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ULTRASONOGRAPHIC FINDINGS

Primary Findings:

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- Based on the patient's breed, clinical history and sonographic changes, a protein losing enteropathy (i.e., lymphangiectasia, inflammatory bowel disease, infectious/parasitic disease, or emerging neoplasia (i.e., lymphoma)) is suspected.

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- The ascites is likely secondary to hypoalbuminemia. However, other causes cannot be completely excluded.

Secondary Findings:

- The "double-walled" gallbladder may be secondary to low oncotic pressure, cholecystitis, increased hydrostatic pressure, anaphylaxis, other. Low oncotic pressure is the suspected cause.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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- Cytologic evaluation of the abdominal fluid is recommended. If results are consistent with a transudate, hypoalbuminemia is the likely cause.
- To further evaluate for protein losing enteropathies, consider the following:
 - A fecal evaluation for ova/Giardia
 - GI panel including serum cobalamin, folate, TLI and PLI
 - Low fat, limited antigen diet trial
 - GI biopsies (i.e., endoscopic or surgical). Surgical biopsies are risky in patients with hypoalbuminemia due to the risk of dehiscence.
 - If the patient is to undergo anesthesia for any reason, thoracic radiographs should be performed to assess for the presence of pleural effusion, which can also occur with hypoalbuminemia.

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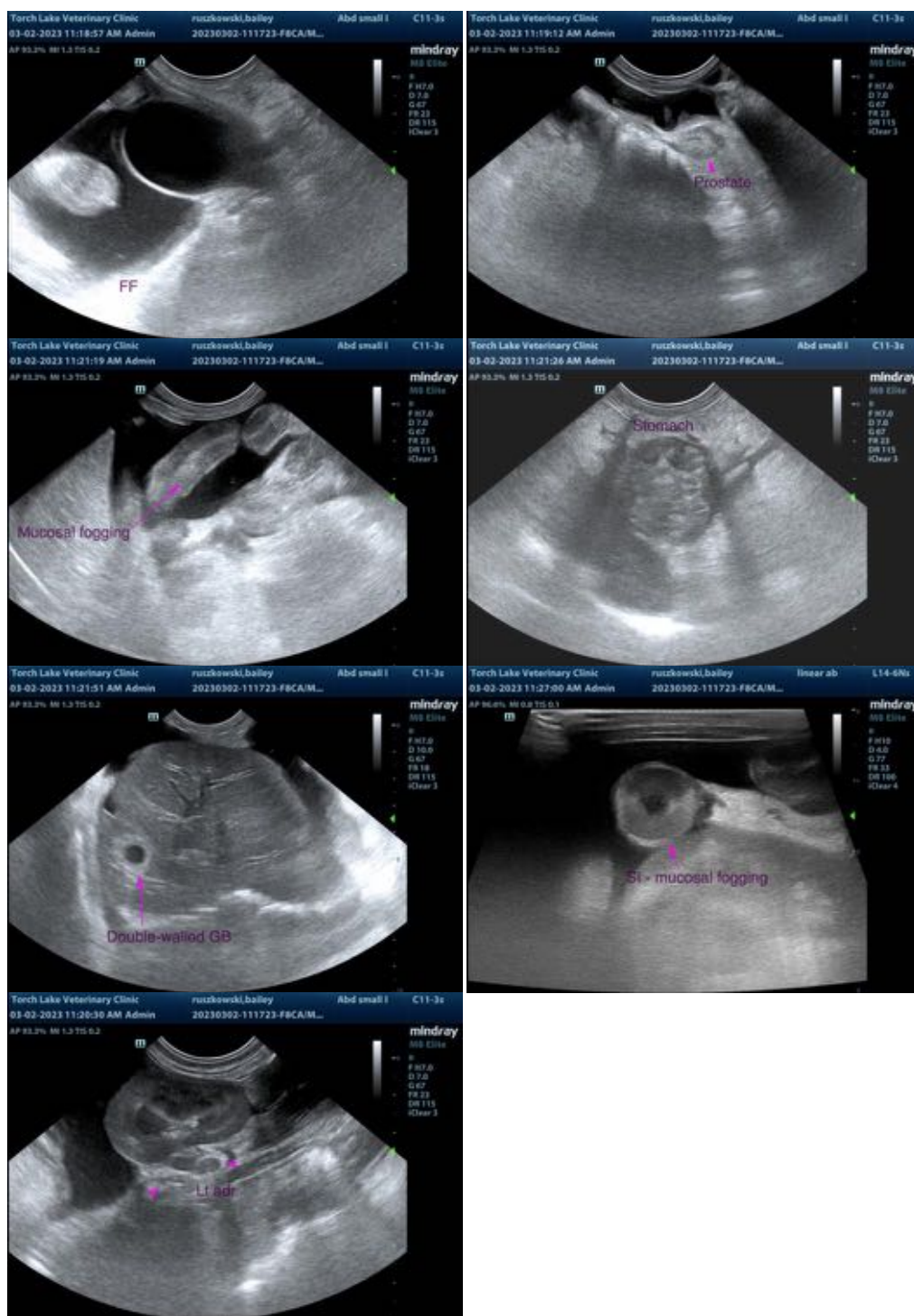
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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