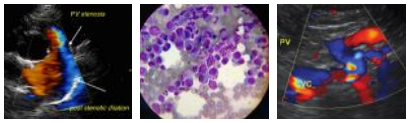
IMAGING PERFORMED BY

IntraPet.com



SonoPath
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DATE

3/17/2022

PATIENT

Tucker Egan

SPECIES

Canine

BREED

Shih Tzu

SEX

Neutered Male

AGE

10/2/2011

WEIGHT

20 lbs

INTERPRETED BY

Andrea Nicastro, DMV, Diplomate DACVIM (Small Animal Internal Medicine)

HOSPITAL NAME

Fullerton Animal Hospital

REFERRING VET

Dr. Stock

INVOICE

10573

PRESENTING CLINICAL SIGNS

P typically eats Purina Sensitive Stomach; however, once has bouts of GI issues – o changes the diet to ground beef and rice. Had been diagnosed more appropriate diets per history has had suspected IBD for years. P has been seen at Pet ER 2/17/22 for vomiting and bloody diarrhea. Problems wax/wane with Pepcid, Metronidazole, Cerenia and Proviable.

Current Medications: Cerenia 16mg SID/PRN.
Lab Results: Per ER- Phos 1.8 (2.5-6.8).
Radiographs: Per ER- NSF.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

Imaging Performed By: Andi Parkinson, RDMS.

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 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 (0.66 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 (4.02 cm in length); with a normal shape and smooth peripheral contours. The cortex is mildly thickened. There is poor corticomedullary distinction. Hyperechoic shadowing diverticular foci are visualized. There is no evidence of pyelectasia, infarcts or hydroureter.

The right kidney is normal in size (4.40 cm in length); with a normal shape and smooth peripheral contours. The cortex is mildly thickened. There is poor corticomedullary distinction. Hyperechoic shadowing diverticular foci are visualized. There is no evidence of pyelectasia, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is upper limits of normal size (0.56 cm at cranial pole) (0.59 cm at caudal pole) (1.73 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 (0.56 cm at cranial pole) (0.51 cm at caudal pole) (1.79 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 (1.04 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A few small irregular hyperechoic are visualized, mainly along the medial aspect. 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. No distinct focal lesions are observed. Hepatic vasculature 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 echogenic debris is observed within the lumen. The cystic and common bile ducts are normal.

Gastrointestinal
The gastric lumen is not distended. The gastric wall is normal in thickness with a normal layering pattern. 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 or overt infiltrative disease is noted.

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
The peritoneal cavity is normal. There is no evidence of inflammation or effusion. A 1.78 cm jejunal lymph node is visualized. The node is normal in shape and echogenicity.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Bilateral chronic nonspecific nephropathy.

Secondary 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.
- Splenic myelolipomas
- The prominent jejunal lymph node is likely reactive.

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

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The following diagnostics/treatment recommendations can be considered:

1. Serum cobalamin, folate, PLI and TLI
2. A fecal evaluation for ova/Giardia, if not already performed

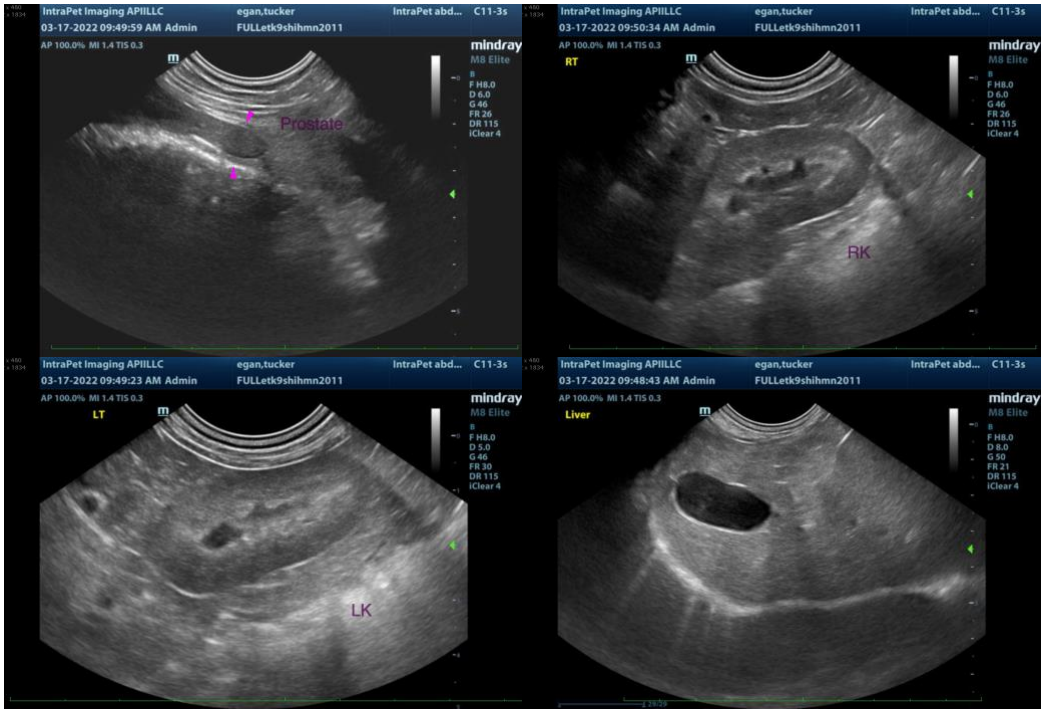
3. Prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.

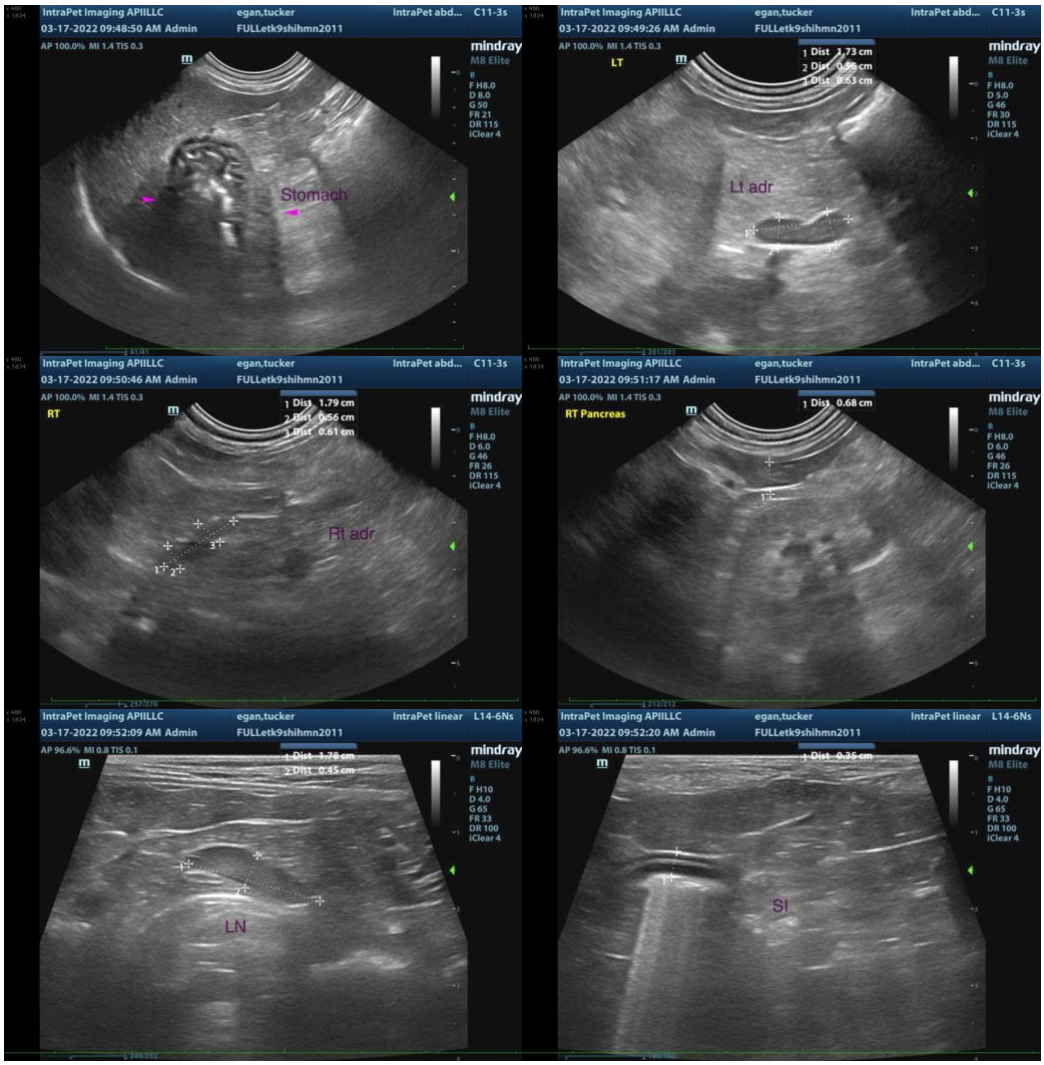
4. A 6-week limited antigen diet trial to assess for food allergies.

5. Consider empirical treatment for small intestinal overgrowth with a 4-week course of Tylosin (in lieu of Metranidazole).

6. A resting cortisol level to screen for hypoadrenocorticism.

7. Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be warranted. Three-view thoracic radiographs should be performed prior to any anesthetic event.





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)
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