


PATIENT

Amber Walo

PRESENTING CLINICAL SIGNS

History: Amber presents into the ER today for vomiting, inappetence, and not defecating. Patient has been vomiting off and on for about a month. P has lost 1lb from what she normally weighs (O notes P normally weighs 9lbs 2oz). Over the past 3 days, P has worsened. P has been lethargic and not eating over the past 3 days and will strain to defecate but not produce a bowel movement at all. She is vomiting more frequently. She has been crying over the past 2 days. No change in diet Eating and drinking very little RADIOGRAPHS OFFICIAL REPORT ASSESSMENT No gastrointestinal foreign body or signs of mechanical obstruction are seen. Gastroenteritis the consideration; differentials include dietary indiscretion, dietary sensitivity, viral, parasitic, or bacterial etiologies, toxin, other diffuse enteropathy, or infiltrative disease (inflammatory or neoplastic). Pancreatitis is not excluded on the study. Correlation with clinical and laboratory findings is recommended. Medical management of clinical signs is recommended as indicated (i.e. fasting/NPO, gastroprotectants, IV fluids, supportive care) with recheck three-view abdominal radiographs after an 8-12 hour fast for evaluation of gastrointestinal emptying. If clinically indicated, ultrasound could be considered to better evaluate the abdomen.

SPECIES

Canine

BREED

Terrier

SEX

Spayed Female

Abnormal PE/Chem/CBC/UA Results: DIAGNOSTICS CBC NEU 23.62 (H) otherwise nsf CHEM ALB 1.9 (L) ALP 448 (H) TBIL 0.6 (H) BUN 6 (L) CRE 0.2 (L) GLU 123 (H) K+ 3.5 (L) GLOB 5.2 (H)

AGE

8 years

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.

WEIGHT

8.19 lbs

INTERPRETED BY

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

The left kidney presented 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 minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

IMAGING PERFORMED BY

Jenna Walsh, CVT

The right kidney presented normal size (3.91 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

HOSPITAL NAME

VCA Salem AH

Adrenal Glands

The left adrenal gland is normal size (0.25 cm at cranial pole) (0.40 cm at caudal pole) (0.69 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.

REFERRING VET

Dr. Wermuth

The right adrenal gland is normal size (1.18 cm at cranial pole) (0.42 cm at caudal pole) (1.53 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.

INVOICE

10755

Spleen

The spleen is normal in size (0.86 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.

DATE

4/14/22

Liver

The liver is subjectively small in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and homogenous in appearance. No distinct focal lesions are observed. There is an increase in portal markings. Hepatic vasculature is of normal volume with no evidence of congestion.

The gall bladder is moderately distended. The wall is slightly thickened (up to 0.19 cm), irregular and hypoechoic. A small to moderate amount of gravity dependent, echogenic 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 mildly distended with ingesta and a 0.42 cm hyperechoic shadowing structure. 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. Discreet masses are not identified. The colonic wall is normal. No obstructive or overt infiltrative disease is noted.

Pancreas

The pancreas is diffusely visible with minimal deviation from the normal peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated. The mesentery effacing the serosal surface is slightly hyperechoic.

Free Abdomen

Trace free fluid is observed. The abdominal lymph nodes are normal/not visible.

Other

A uterine stump is visible (0.41 cm in width). No obvious pathology is observed.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- An obvious cause for the patient's clinical signs is not identified in this study. Given the clinical history, a primary gastrointestinal issue (inflammatory bowel disease, infectious/parasitic disease, lymphangiectasia), hepatopathy, underlying metabolic issue (i.e., hypoadrenocorticism), and low-grade pancreatitis are possibilities.

Secondary Findings

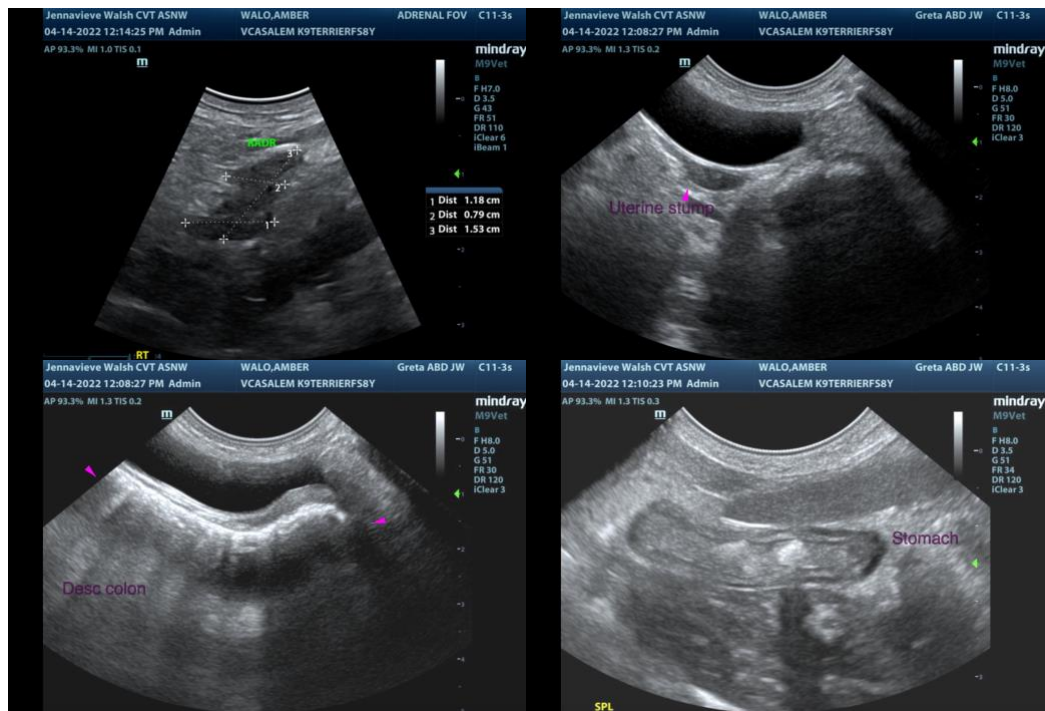
- The microhepatica may be a normal variant for this patient or may be secondary to a chronic hepatopathy (i.e., inflammatory, fibrosis).
- The gall bladder wall changes could be consistent with benign hyperplasia and/or cholecystitis. Correlation with clinical findings is recommended.
- The pancreatic changes may be a normal variant for this patient or could be consistent with mild, chronic pancreatitis.
- Trace ascites, likely secondary to low oncotic pressure

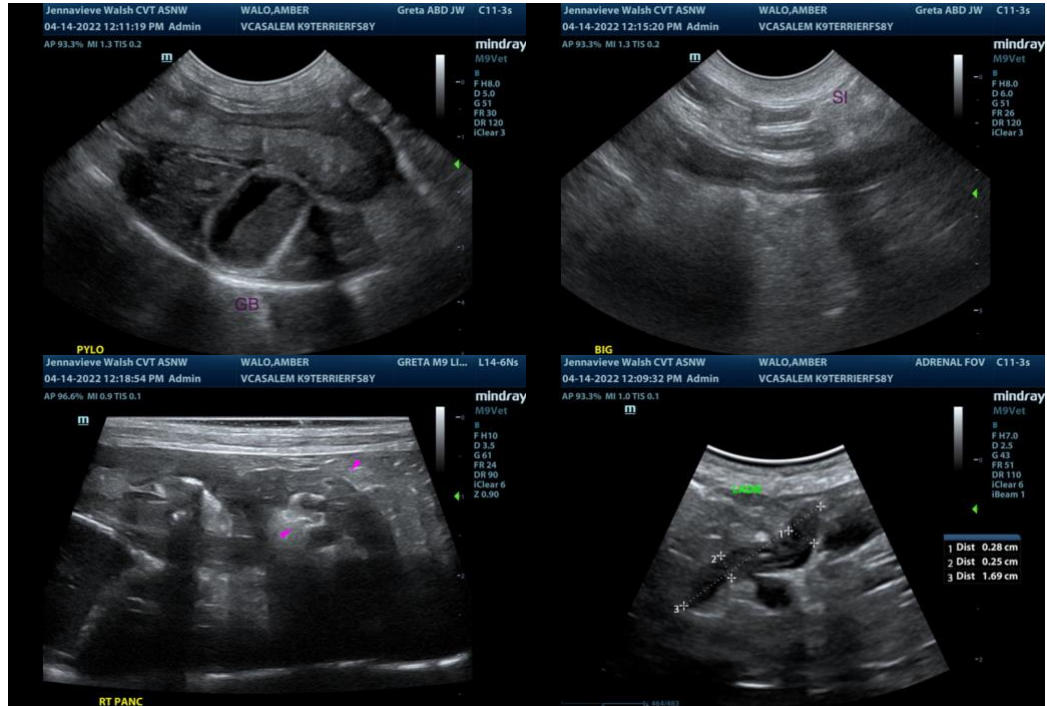
- Uterine stump – incidental
- The hyperechoic shadowing structure within the gastric lumen may represent medication (if applicable) or nonobstructive foreign material.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the hypoalbuminemia, consider the following diagnostics:

1. Pre-and postprandial serum bile acids to assess hepatic function
2. A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended.
3. UPC (if proteinuria is present)
4. Fecal evaluation for ova and Giardia
5. Prophylactic deworming with Fenbendazole
6. Malabsorption panel, including serum cobalamin and folate, TLI and PLI
7. +/- gastrointestinal biopsies (i.e., endoscopic or surgical) if clinical signs persist
8. Thoracic radiographs (three-view) should be performed prior to any anesthetic event to assess cardiopulmonary status.





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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