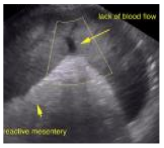
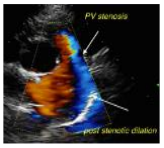
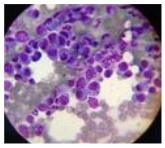
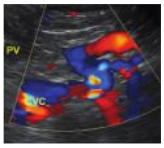
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™





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

PATIENT

Max Grove

SPECIES

Canine

BREED

Golden Retriever

SEX

Neutered Male

AGE

9 years

WEIGHT

40 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Erin Wicks

HOSPITAL NAME

Shores Vet Emerg Ctr

REFERRING VET

Dr. Moser

INVOICE

10752

DATE

4/15/22

PRESENTING CLINICAL SIGNS

History: Presented at our hospital for AUS. Started 2 yr ago with severe dh, tx for pancreatitis, has been better but stools remained soft. About 1 week ago he started with off and on vomiting; two days ago stopped eating and drinking. Took to rdvm, took rads, shows mass like effect. Owner rescued 5 years ago, had internal mass removed and was benign per owner. Owner says pet doesn't seem to bark normal now either, sounds hoarse. Previous Health Concerns: no Current Medications: apoquel, cosequin Abnormal PE/Chem/CBC/UA Results: bloodwork 4/4/22 wnl preanesthetic bloodwork 4/14/22 CBC/CHEM wnl Lipase 2,187; T4 0.9

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. The region of the trigone is normal.

The prostate is not definitively visualized due to its pelvic location.

The left kidney presented normal size (7.92 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 hydroureter. Renal vasculature is normal.

The right kidney presented normal size (8.02 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 hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.67 cm at cranial pole) (0.88 cm at caudal pole) (3.67 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 caudal pole of the right adrenal gland is visualized and is normal size (0.69 cm in width), with a normal shape, glandular echogenicity and detail. Surrounding vasculature appears normal.

Spleen

The spleen is normal in size (2.29 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 curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen with minor changes consistent with age-related remodeling. No 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 aggregated, echogenic, mostly gravity dependent debris is observed within the lumen. The cystic and common bile ducts are normal.

Gastrointestinal

The gastric lumen is minimally fluid-distended. 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 gas. The small intestinal wall thickness is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. The colonic lumen contains shadowing fecal material. There is no evidence of an obstructive pattern.

Pancreas

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely hyperechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The hepatic changes are consistent with age-related parenchymal remodeling and are not considered clinically significant at this time.
- Age-related pancreatic remodeling/fibrosis. Mild chronic pancreatitis is also a possibility, particularly if the patient exhibits a pain on cranial abdominal palpation.
- An obvious cause for the patient's chronic GI signs is not identified in this study. Considerations include microscopic gastrointestinal disease (i.e., inflammatory bowel disease, food allergy/intolerance, intestinal dysbiosis, gastroenteritis), low-grade pancreatitis, underlying metabolic issue, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- The following diagnostics/treatment recommendations can be considered:

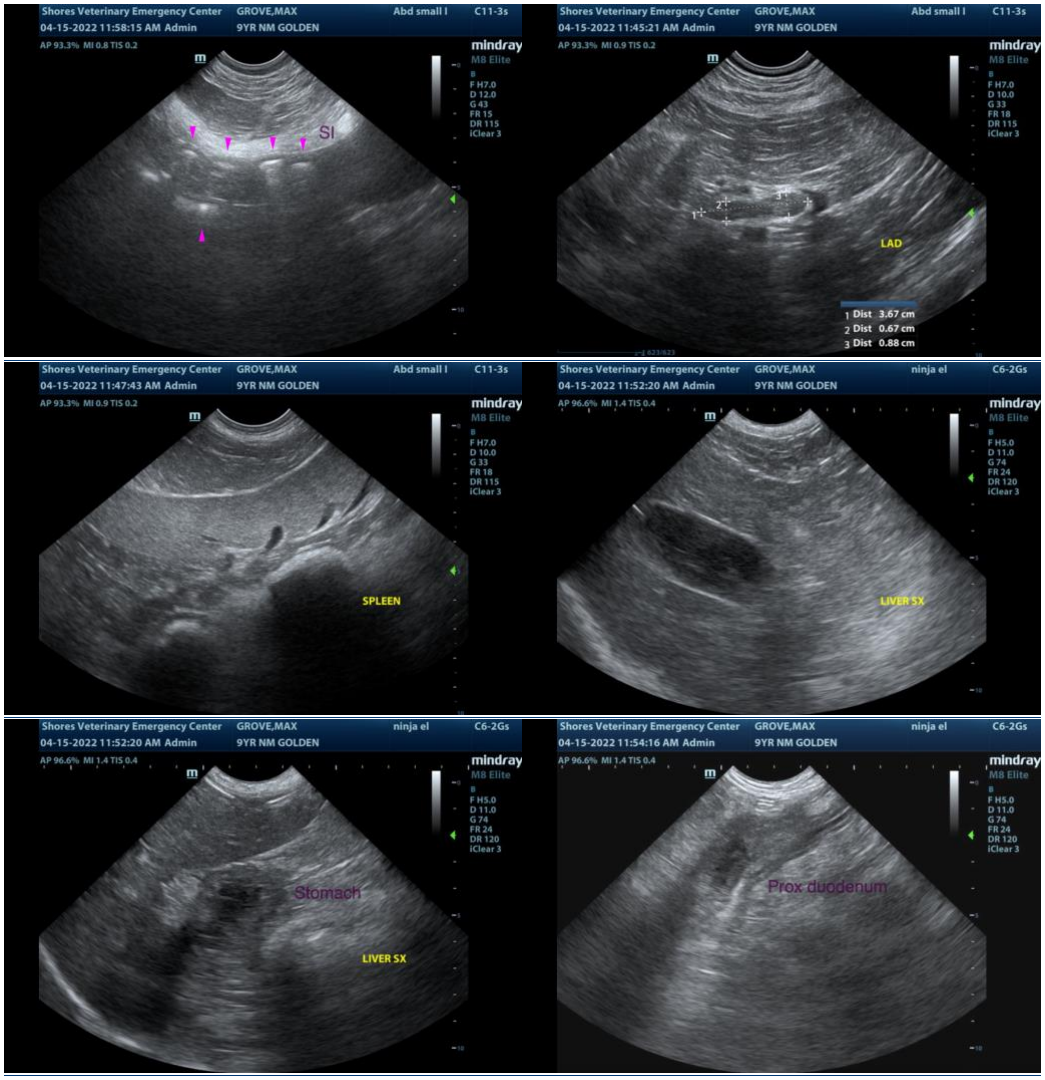
    1. Serum cobalamin, folate, PLI and TLI
    2. A fecal evaluation for ova/Giardia
    3. Prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.
    4. A 6-week limited antigen diet trial to assess for food allergies.
    5. Consider a 4-week course of Tylosin at 15-20 mg/kg by mouth every 12 hours as empirical treatment for small intestinal bacterial overgrowth.

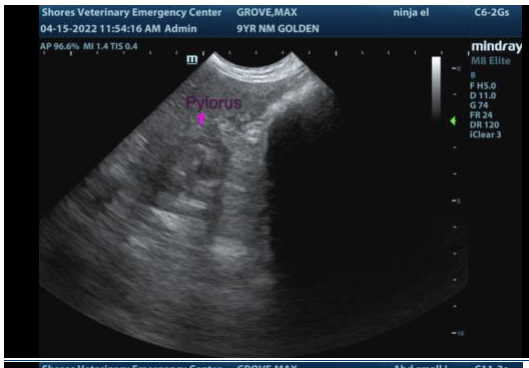
6. A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended.

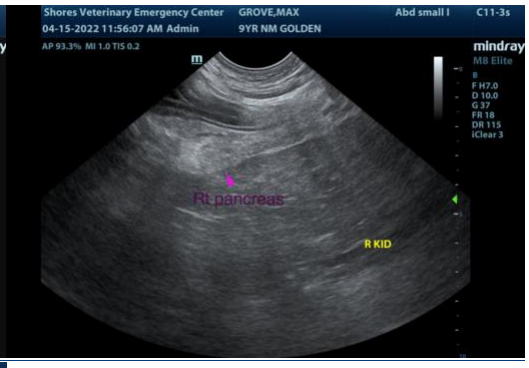
7. Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be warranted.

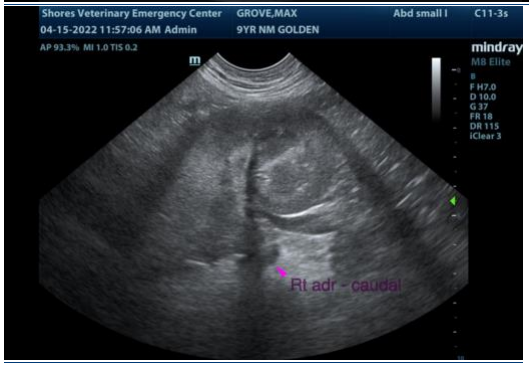
8. Three-view thoracic radiographs should be performed prior to any anesthetic event.

- Regarding the lack of bark, laryngeal paralysis may be present. Consider a sedated upper-airway evaluation to further assess for laryngeal paralysis.









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