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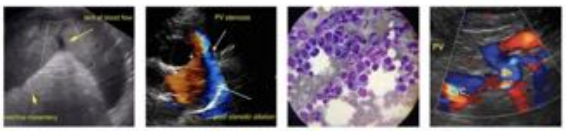

Charleston Mobile Veterinary Services
IMAGING PERFORMED BY
CharlestonMobile.Net 800.403.5408

PATIENT

Bailey Karen

SPECIES

Canine

BREED

Mixed

SEX

Neutered Male

AGE

3/3/2012

WEIGHT

49 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

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

HOSPITAL NAME

Salt Marsh AH

REFERRING VET

Samantha Thompson

INVOICE

12797

DATE

4.20.23

PRESENTING CLINICAL SIGNS

Abnormal lab-work values: Sending via email. GI panel and resting cortisol level are pending.

Current Medications Metronidazole 250mg: 1 BID - Started 4/17, Proviable Forte: Paste and Daily Capsules - Started 4/17

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended. The wall is normal in thickness with a smooth mucosal surface. a 1.30 cm cystic calculus is observed within the lumen. In addition, a 0.45 cm cystic calculus is observed in the cystourethral junction. A scant amount of echogenic debris is suspended within the lumen. The region of the trigone and the proximal urethra are normal.

The prostate is normal in size (0.97 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 (5.08 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. Several nonobstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (5.38 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. Several nonobstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.73 cm at cranial pole) (0.75 cm at caudal pole) with a normal shape and 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 in normal size (1.06 cm at cranial pole) (0.66 cm at caudal pole) with a normal shape and 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 (1.86 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.

Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and slightly mottled in appearance. No distinct focal lesions are observed. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1: 1.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A small to moderate amount of gravity-dependent, echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

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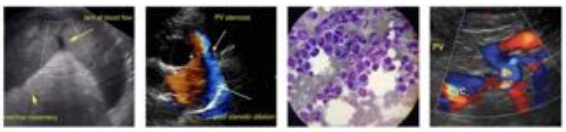

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Gastrointestinal

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 pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. 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 isoechoic 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

There is no obvious evidence of free fluid. Two periportal lymph node are visualized (the larger measuring 1.87 cm in length / the smaller measuring 0.26 cm in its longest dimension). The smaller node contains a few cystic areas. The larger node is homogenous in appearance.

Other

In the midabdominal region, a 3.59 cm hyperechoic to attenuating avascular mass effect is observed. The structure is of fat opacity.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

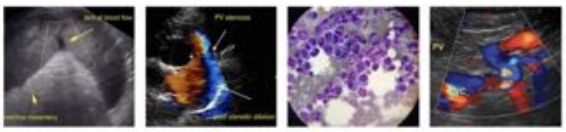
- An obvious cause for the patient's clinical signs is not definitively identified in this study. Considerations include a microscopic enteropathy (i.e., food allergy, inflammatory bowel disease, infectious/parasitic disease), underlying metabolic issue (i.e., atypical hypoadrenocorticism), other.
- Cystic calculi
- The hyperechoic mass in the midabdominal region is most consistent with a fatty tumor (i.e., lipoma, liposarcoma).

Secondary Findings

- The diffuse hepatic parenchymal changes are most consistent with a benign hepatopathy (i.e., age-related remodeling and/or regenerative nodular hyperplasia) with a lower possibility of a more insidious hepatic pathology.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Bilateral chronic age-related renal changes with nonobstructive nephrolithiasis
- The prominent periportal lymph node are likely reactive with a lower possibility of emerging neoplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Despite the negative fecal evaluation, consider prophylactic deworming with Fenbendazole.



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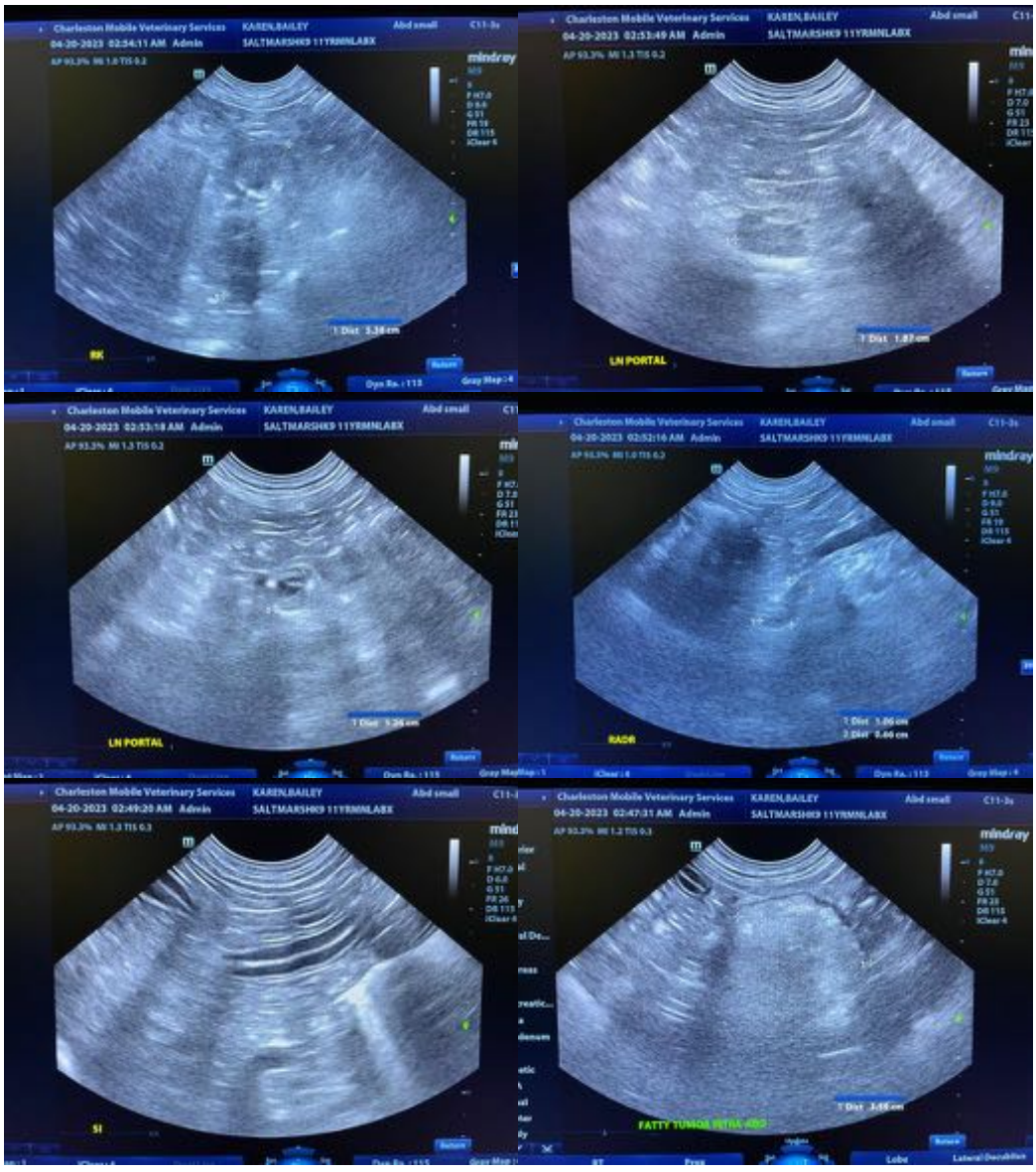
- Also consider re-initiation of a probiotic (i.e., Proviable or Visbiome)
- A fiber supplement may also prove beneficial.
- If the patient has not been on a strict limited antigen or hydrolyzed protein diet, consider initiating one to help rule out food allergies. Ultimately, endoscopic or surgical GI biopsies may be necessary to get a definitive diagnosis. In this patient, surgical biopsies may be preferable in that the cystic calculi can be removed and submitted for analysis and culture, and the fatty tumor can also be removed and submitted for histopathology. Three-view thoracic radiographs should be performed prior to any anesthetic event.



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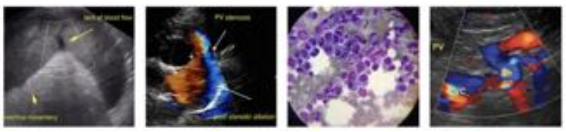

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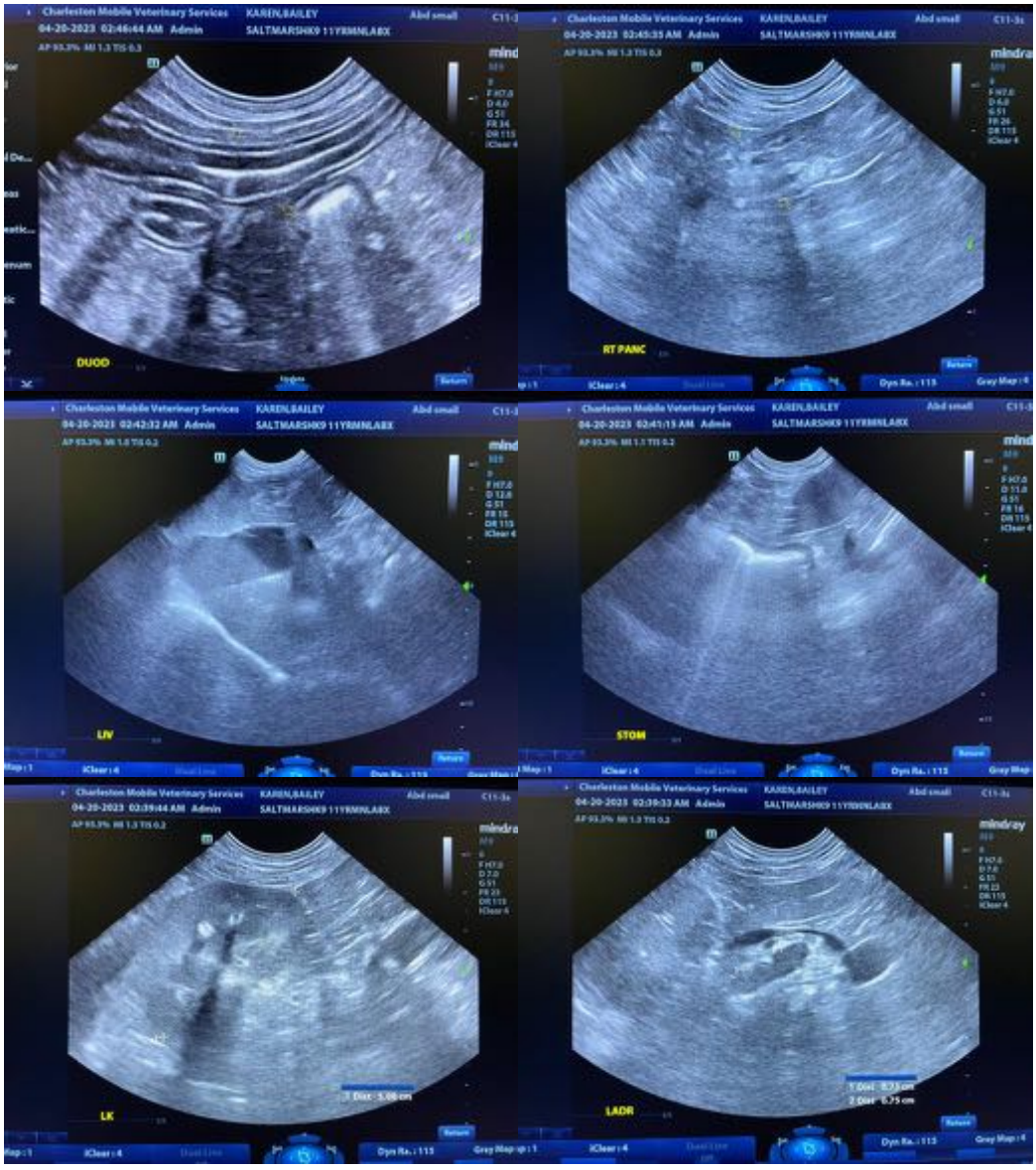

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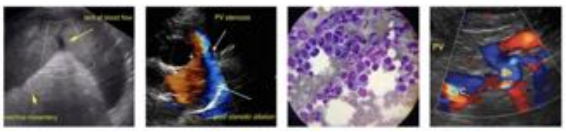

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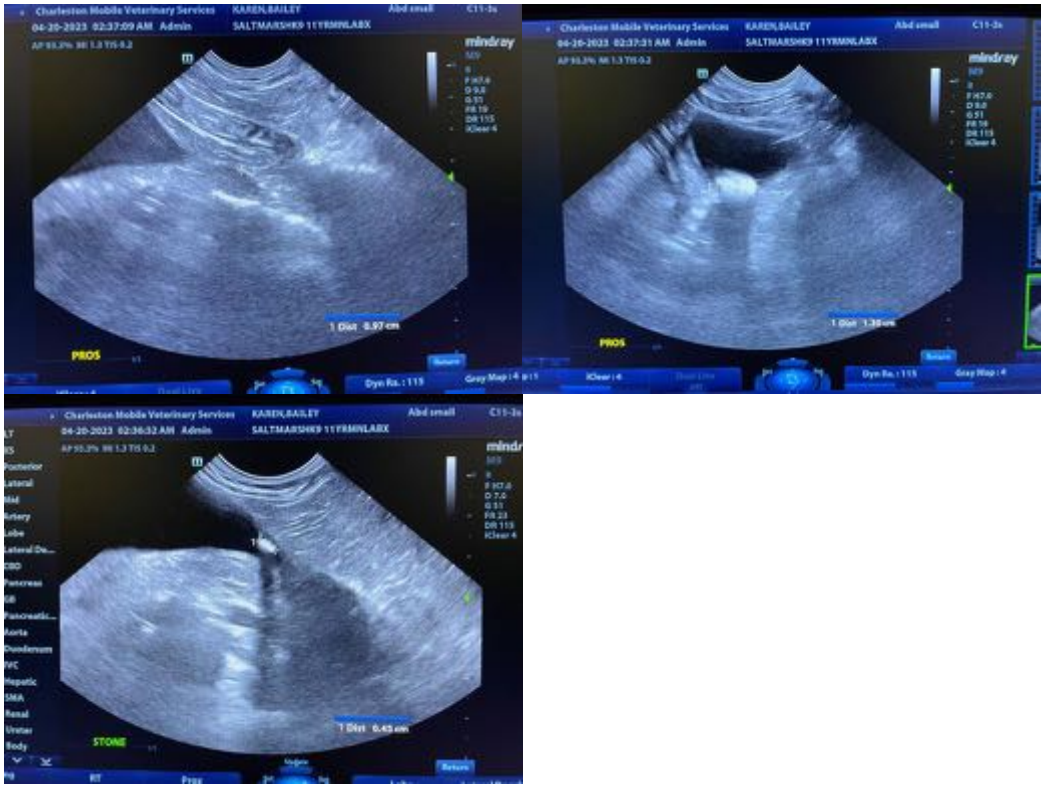

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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