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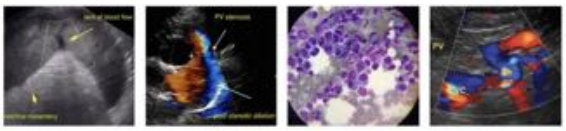

Charleston Mobile Veterinary Services
IMAGING PERFORMED BY
CharlestonMobile.Net 800.403.5408

PATIENT

Henri Corona

SPECIES

Canine

BREED

Toy Fox Terrier

SEX

Neutered Male

AGE

08-23-2008

WEIGHT

8.4 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

Park West VA

REFERRING VET

Elise Mauer

INVOICE

12842

DATE

4.24.23

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: QAR, MM pink, moist, CRT<2sec. HR 200 bpm, RR 40 bpm, T 101.3 F, BCS 5/9; FAS 1, Pain Score 0

EENT: mature cataract OD, OS wnl. AU wnl
ORAL: healthy teeth and gums, missing multiple teeth, only 104/204/304/208 and a few premolars left
INTEG: ~1-2 mm pink hairless firm dermal nodule on left ventral neck, otherwise WNL, flat sq growth on left dorsal thorax, 17 mm sq round mobile mass on right lateral thigh
CV: Grade IV/VI murmur, no arrhythmias noted,
RESP: Normal bronchovesicular sounds in all fields, no crackles/wheezes noted, increased abdominal effort on expiration, cough elicited when p picked up under chest
GI: Abdomen distended and slightly tense on palpation, fluid wave, no masses/organomegaly noted
MS: Ambulatory x4, stiff in hips and mild muscle atrophy over lateral thighs
NEURO: normal CPs x 4, amb x 4, intermittent weakness in hind end when turning but no listing or ataxia seen, normal mentation, normal menace OU, randomly kicks out back left leg
PLN: Peripheral nodes are small/soft/symmetrical

Abnormal lab-work values: CBC - leukocytosis and neutrophilia
Chem - panhypoproteinemia, hypocalcemia
GLU 149 mg/dL
BUN 29 mg/dL
CA 6.6 mg/dL
TP 3.3 g/dL
ALB 1.3 g/dL
GLOB 2.0 g/dL
ALB/GLOB 0.7
CHOL 106 mg/dL
Cl 108 mmol/L
WBC 18.46 K/µL
NEU 14.75 K/µL

Current Medications: prednisone, keppra, vetmedin

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. Luminal contents are mostly anechoic. No cystic calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The prostate is normal in size (0.86 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 (3.30 cm in length) with a normal shape, architecture and 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 is normal in size (3.25 cm in length) with a normal shape, architecture and 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.

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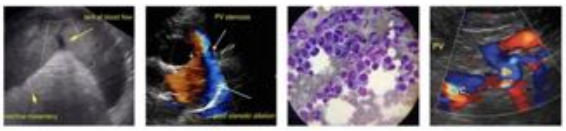

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Adrenal Glands

The left adrenal gland is normal size (0.51 cm at cranial pole) (0.47 cm at caudal pole) with a 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 (0.59 cm at cranial pole) (0.46 cm at caudal pole) with a 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 contracted (0.56 cm in width at the level of the hilus) with normal curvilinear peripheral contours. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively prominent in size with normal curvilinear peripheral contours. 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 moderately distended. The wall is thin and smooth. A scant amount of echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is mildly to moderately distended with ingesta. 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 diffusely thickened (duodenum: up to 0.58 cm / jejunum up to 0.48 cm) with retention of the normal layering pattern. The mucosa is mildly hyperechoic with speckling in several segments. Discreet masses are not identified. The wall of the descending colon is moderately thickened (up to 0.48 cm) with retention of the normal layering pattern. The colonic lumen is empty. There is no obvious evidence of an obstructive pattern.

Pancreas

The base and right limb are prominent in size with slightly irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and subtly mottled in appearance. No focal lesions are observed. The pancreatic duct is not overtly dilated.

Free Abdomen

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

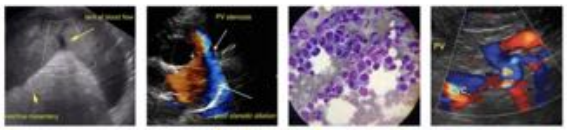
Other

A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass. A small to moderate amount of pleural effusion is visualized.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The patient's clinical history, in conjunction with the sonographic bowel changes are most concerning for a protein-losing enteropathy. Top differentials include inflammatory bowel disease, infectious/parasitic disease, lymphangiectasia, emerging lymphoma, other.



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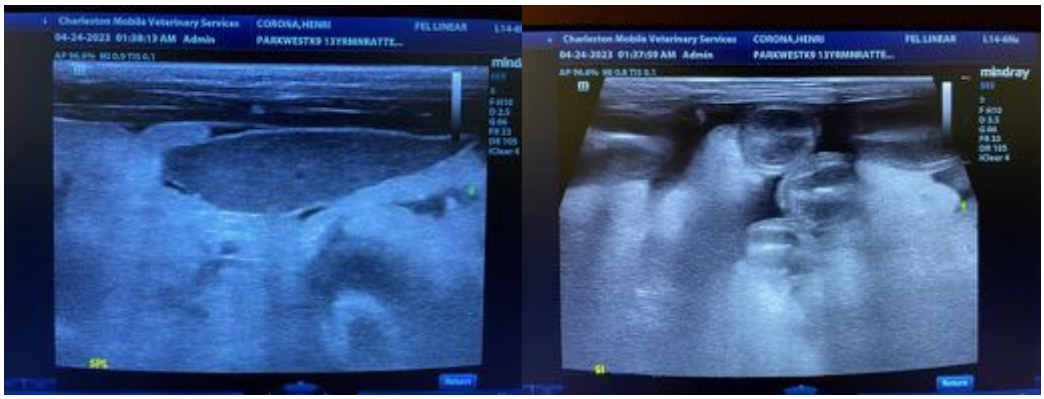
- Ascites and pleural effusion (likely secondary to low oncotic pressure)
- The pancreatic changes could be consistent with edema (secondary to hypoalbuminemia) and/or mild pancreatitis.

Secondary Findings

- The hepatic parenchymal changes are most consistent with age-related remodeling and/or mild regenerative nodular hyperplasia, with a lower possibility of more insidious hepatic pathology.
- The splenic contraction is likely secondary to dehydration.
- If the patient was fasted for this study, the presence of ingesta within the gastric lumen could suggest delayed gastric emptying.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Fecal evaluation for ova and Giardia (if not already performed)
- Consider prophylactic deworming with Fenbendazole.
- Consider transitioning to a low-fat, hypoallergenic or hydrolyzed protein.
- Continuation of B12 supplementation is also recommended.
- Also consider initiation of a probiotic with a high colony count (i.e., Proviable Forte or Visbiome).
- Ultimately, GI biopsies may be necessary to get a definitive diagnosis. If pursued, corticosteroids should be weaned prior to tissue sampling. If biopsies are not pursued, continuation of corticosteroids can be considered as empirical treatment for inflammatory bowel disease (as long as the client understands the risks of treatment without a definitive diagnosis).
- Given the patient's breathing pattern, therapeutic thoracocentesis +/- abdominocentesis may be warranted.



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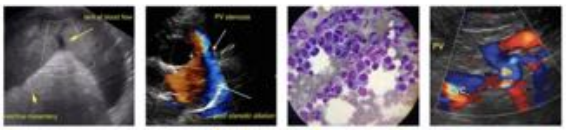

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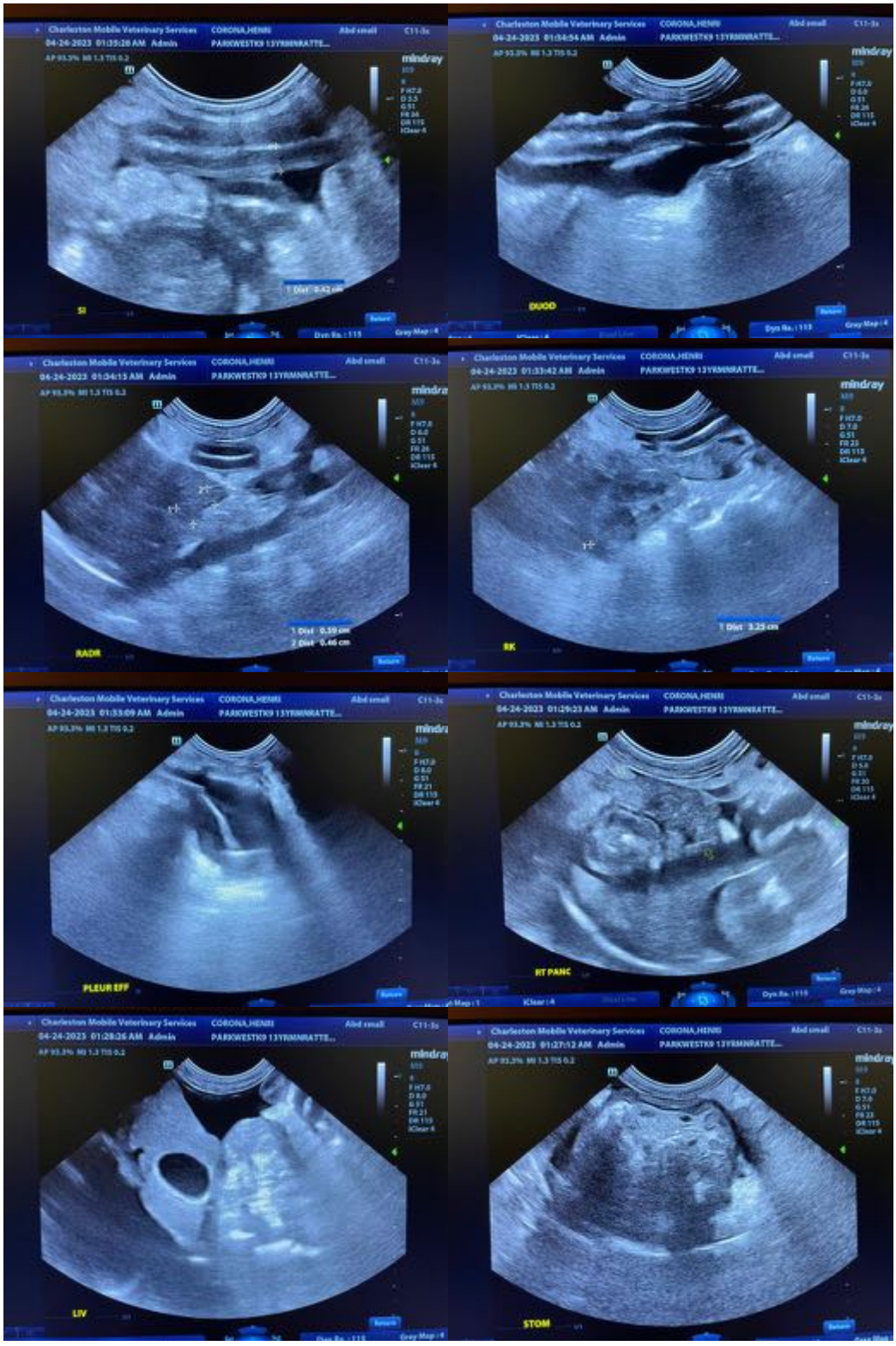

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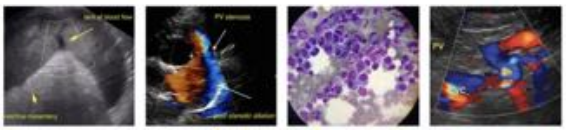

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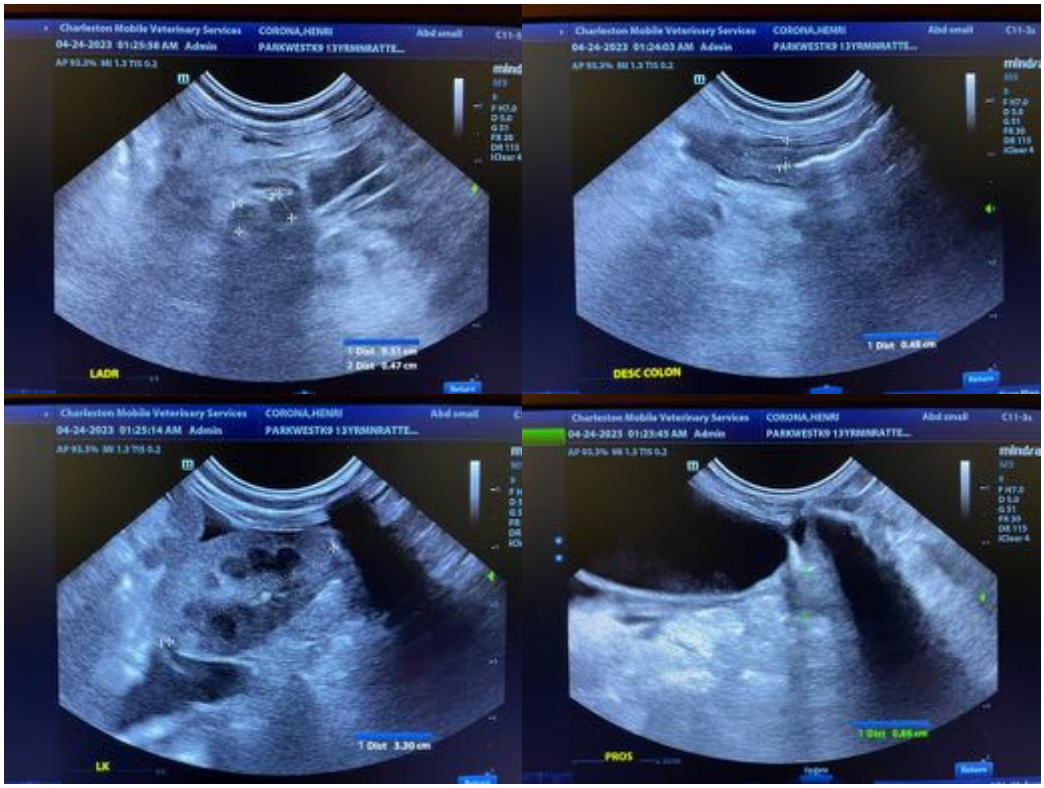

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com