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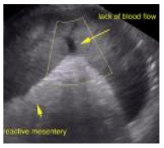
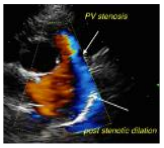
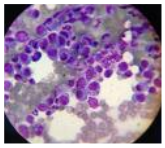
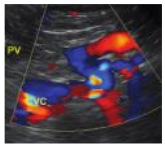
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT

Flint Prakash

SPECIES

Canine

BREED

Havanese

SEX

Neutered Male

AGE

11 years

WEIGHT

9.8 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Vazquez

HOSPITAL NAME

Animal General on Hudson

REFERRING VET

Dr. Vivian Ng

INVOICE

10817

DATE

4/27/22

PRESENTING CLINICAL SIGNS

History: Intermittent diarrhea, lethargy, responsive to bland diet and meds. Owner reports weight loss. No current meds. Blood work NSF.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly distended with anechoic urine. The wall in the region of the apex is thickened (up to 0.66 cm) with an irregular mucosal surface, and irregular. The wall tapers to a normal thickness as it extends toward the urinary bladder neck. No cystic calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The prostate is normal in size (0.80 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney presented normal size (4.39 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney presented normal size (4.11 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 hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.39 cm at cranial pole) (0.42 cm at caudal pole) (1.32 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 (0.83 cm at cranial pole) (0.42 cm at caudal pole) (1.52 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 (0.93cm 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. Luminal contents are anechoic. The cystic and common bile ducts are normal.

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 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 left limb is visible/prominent with minimal deviation from the normal peripheral contours. A 1.08 x 0.76 cm hypoechoic to anechoic lesion is observed within the parenchyma. In addition, a few smaller cystic areas are seen. The pancreatic duct is not overtly dilated. There is no evidence of peripancreatic 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

- An obvious cause for the patient's clinical signs is not identified in this study. Considerations include underlying gastrointestinal disease (i.e., inflammatory bowel disease, infectious/parasitic disease, intestinal dysbiosis, food allergy/intolerance), underlying metabolic issue (i.e., hypoadrenocorticism), low-grade pancreatitis, other.

Secondary Findings

- Bilateral age-related, chronic renal changes
- The hepatic changes are consistent with age-related parenchymal remodeling and are not considered clinically significant at this time.
- The urinary bladder wall changes are most consistent with cystitis. However, emerging neoplasia (i.e., transitional cell carcinoma) cannot be completely excluded.
- Suspected pancreatic cysts in the left limb.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The following diagnostics/treatment recommendations can be considered:

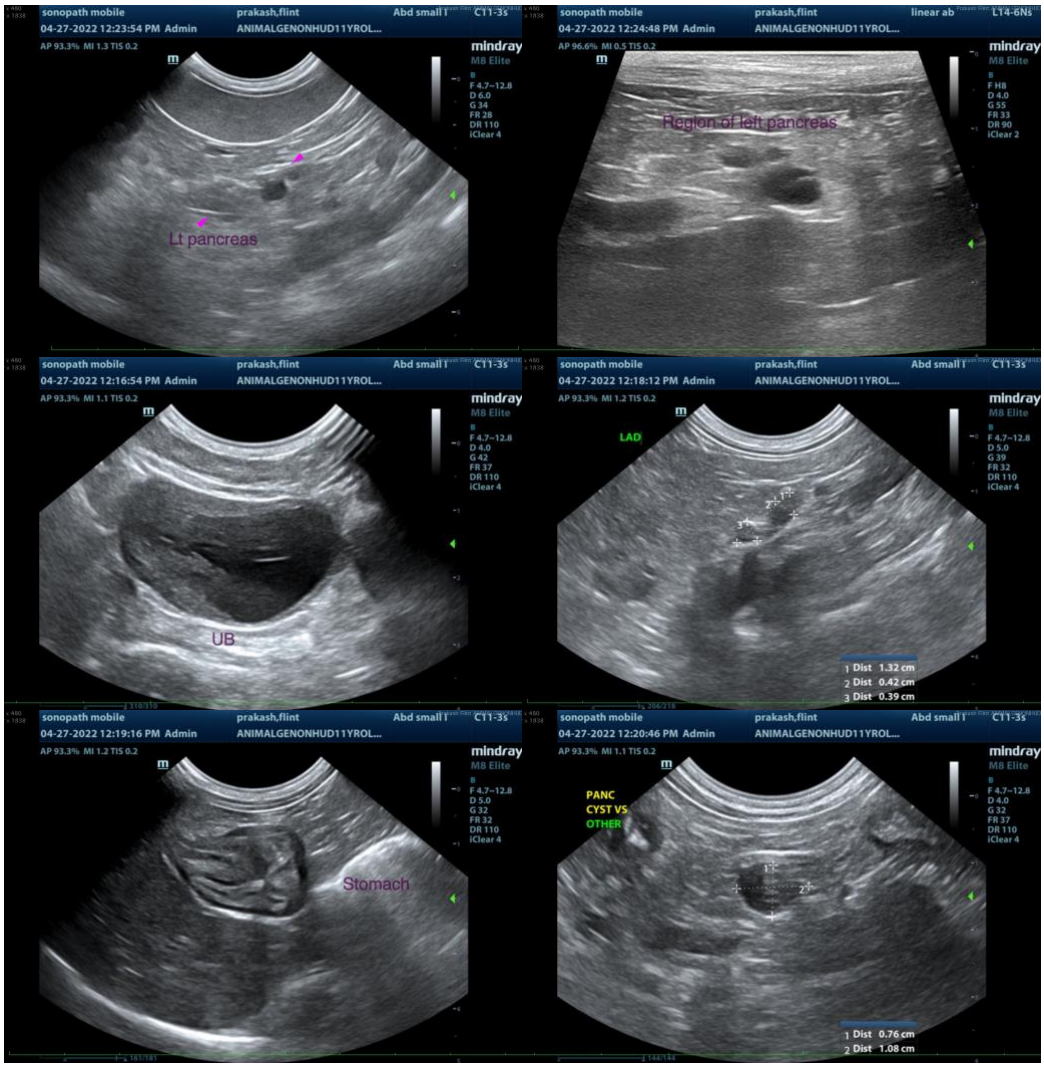
1. Serum cobalamin, folate, PLI and TLI
2. A fecal evaluation for ova/Giardia
3. Prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.
4. A 6-week limited antigen diet trial to assess for food allergies.

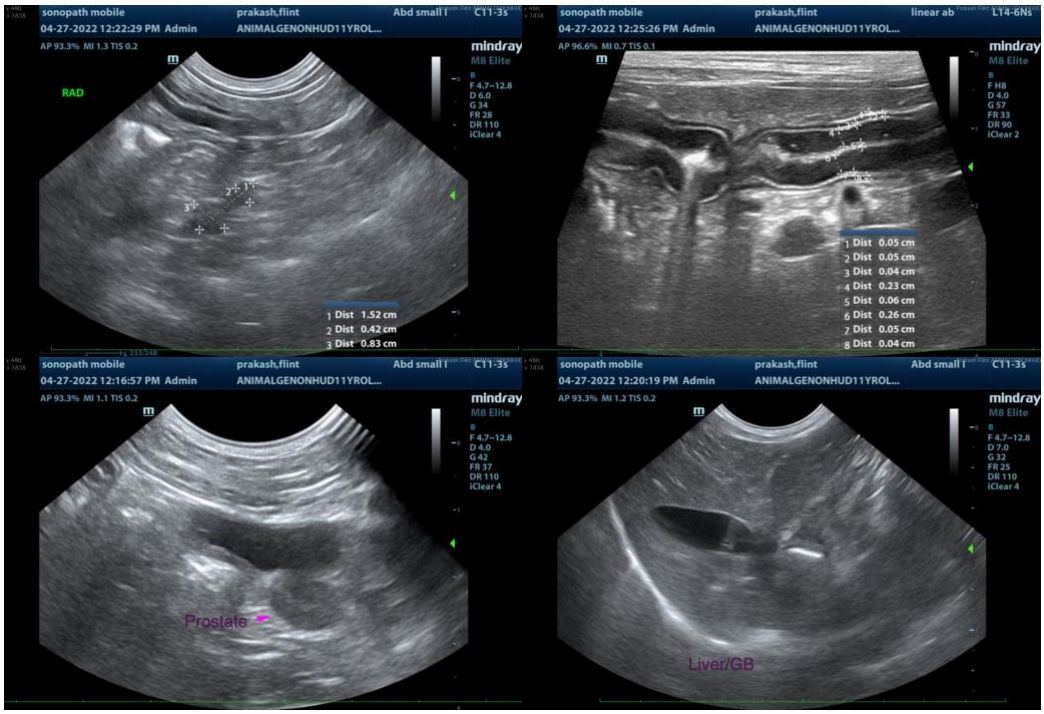
5. Consider a 4-week course of Tylosin at 15-20 mg/kg by mouth every 12 hours as empirical treatment for small intestinal bacterial overgrowth.

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.





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