



PATIENT

Jett Behan

SPECIES

Canine

BREED

Lab

SEX

Neutered Male

AGE

9 years, 11 mos

WEIGHT

35.9 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Brian Barnes

HOSPITAL NAME

Westview VH

REFERRING VET

Dr. Brian Barnes

INVOICE

10814

DATE

4/27/22

PRESENTING CLINICAL SIGNS

History: Geriatric slowing down mobility issues if over exercises. Occasional vomiting. Routine Echo and AUS

Abnormal PE/Chem/CBC/UA Results: Left sided gr 3/6 AV murmur PMI left hemithorax. lungs clae
CBC HCT 0.37 L/L (0.38 - 0.57) Acanthocytes - mild Microcytosis - present Chemistry SDMA 16 (0-14
ug/dL) Creatine Kinase 237 (10-200 IU/L) Cardiopet ProBNP 1602 (0-900 pmol/L) TT4 WNL UAFew
struvite , USG 1.054, Protein 1+

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 and the visualized portion of the proximal urethra are normal.

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

The left kidney presented normal size (6.72 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.

The right kidney presented normal size (6.99 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.

Adrenal Glands

The left adrenal gland is normal size (0.38 cm at cranial pole) (0.56 cm at caudal pole) (2.40 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 (1.11 cm at cranial pole) (0.62 cm at caudal pole) (3.50 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 (2.44 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 contours and structure. 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. Luminal contents are anechoic. The cystic and common bile ducts are normal.

Gastrointestinal

The gastric lumen is not distended. The gastric wall is 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 region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional 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

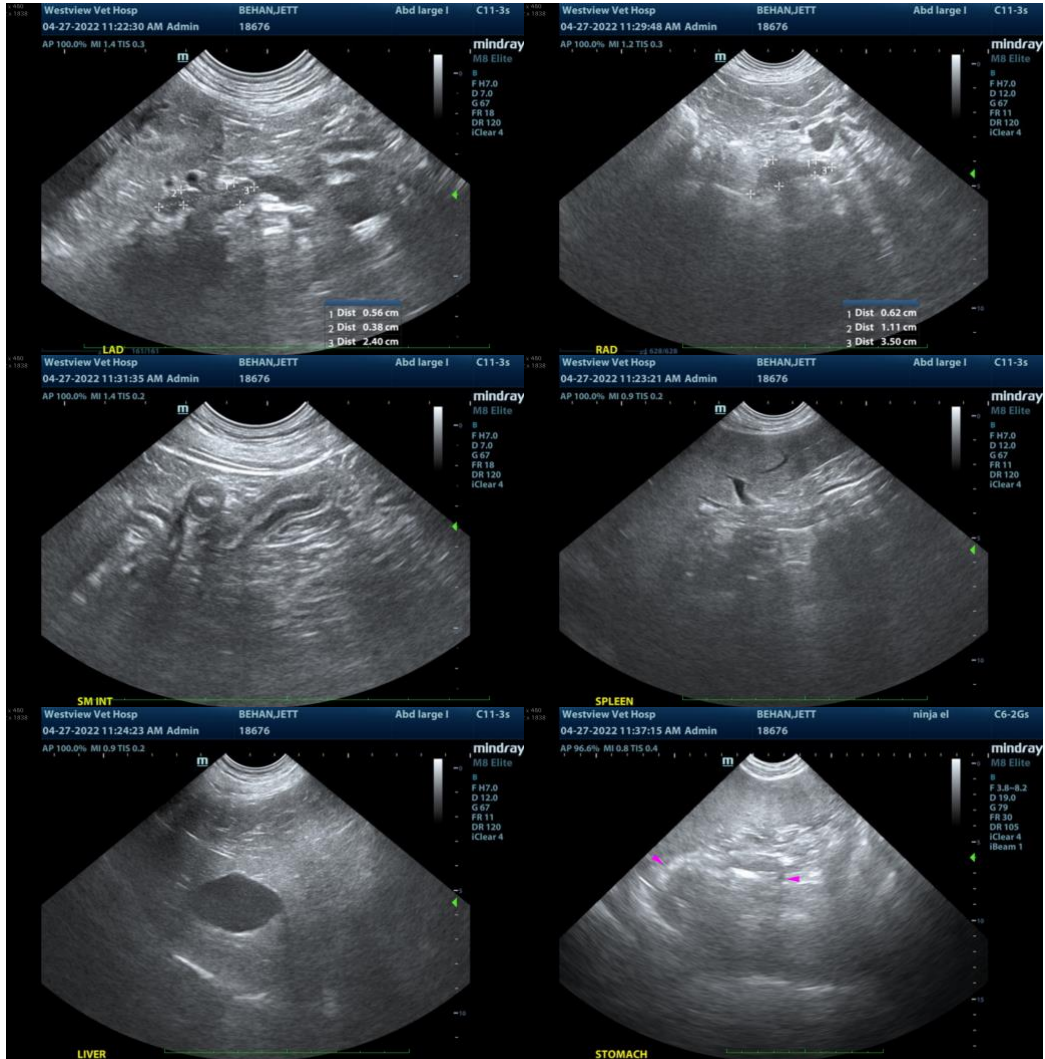
Primary Findings

- Minor, chronic age-related renal changes

*An obvious cause for the patient's vomiting is not identified in this study. Considerations include intermittent dietary indiscretion or other microscopic gastrointestinal disease, low-grade pancreatitis, underlying metabolic issue, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- If further work-up for the vomiting is desired, consider the following:
 1. Malabsorption panel, including serum cobalamin and folate, TLI and PLI.
 2. Fecal evaluation for ova and Giardia
 3. A 6-week limited antigen diet trial to assess for food allergies
 4. Given acanthocytosis and microcytosis, consider pre-and postprandial serum bile acids to assess for occult hepatic dysfunction.
 5. A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended.
 6. Depending on the results of the above diagnostics, endoscopic or surgical gastrointestinal biopsies may be necessary to get a definitive diagnosis. Three-view thoracic radiographs are recommended prior to anesthesia to assess cardiopulmonary status, if not already performed.
 - 7.
- Given the proteinuria, a UPC should be considered.



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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