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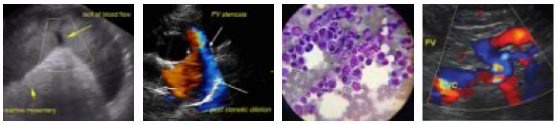


ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

PATIENT

Pippin Noll

SPECIES

Canine

BREED

Mini Schnauzer

SEX

Neutered Male

AGE

2 years

WEIGHT

17.4 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Jenna Walsh, CVT

HOSPITAL NAME

West Hills AH

REFERRING VET

Dr Remcho

INVOICE

12882

DATE

4.27.23

PRESENTING CLINICAL SIGNS

History: Recent hx of vomiting and diarrhea with some frank blood present. Hx as a pup of chronic diarrhea that responded to food trial and resolved long term. Current Medications Cerenia, metronidazole and gabapentin along with home cooked diet Radiographic Findings from 4/14/23 (checking for FB) Findings: Abdominal radiographs (3 projections; compared to a prior study dated April 12, 2022): – The liver and spleen are normal in size and margination. – The visualized portions of the kidneys and urinary bladder are normal. – The stomach and majority of the small intestine contain mild gas. The stomach is normal in size and normal in anatomic positioning.The small intestine is normal in size and uniform in distribution. The colon is normal in diameter and contains mild to moderate soft tissue opaque feces and a few linear mineral opaque foreign bodies, measuring up to 3 mm maximal length. – The peritoneal and retroperitoneal serosal detail is normal. – The extra-abdominal structures are normal. – The included portions of the pelvis and coxal joints are normal. Assessment: Smart multifocal mineral foreign bodies, likely secondary to a prior dietary indiscretion. Otherwise, radiographically normal abdomen with no evidence of gastric or small intestinal foreign material or gastrointestinal mechanical obstruction. Gastroenteritis is not excluded. The remainder of the intra-abdominal structures is radiographically unremarkable. Primary Question/Differential to Be Answered in This Exam focus on intermittent GI upset

Abnormal PE/Chem/CBC/UA Results: cPL "abnormal" and increased eosinophils. Fecal testing - negative

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended. The wall is normal in thickness with a smooth mucosal surface. At least two cystic calculi are observed (the largest measuring 0.30 cm in diameter). Luminal contents are otherwise anechoic. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

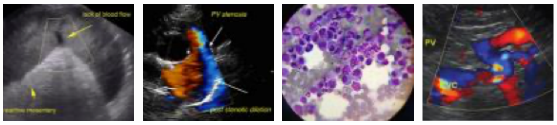
The prostate is normal in size (0.69 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal in size (4.28 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. An ill-defined hyperechoic medullary band is observed adjacent to th e corticomedullary junction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (4.60 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. An ill-defined hyperechoic medullary band is observed adjacent to th e corticomedullary junction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.33 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.



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The right adrenal gland is normal size (0.76 cm at cranial pole) (0.42 cm at caudal pole) (1.49 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 (1.26 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 is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No cholelithsare observed. The cystic and common bile ducts are normal/not seen.

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 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

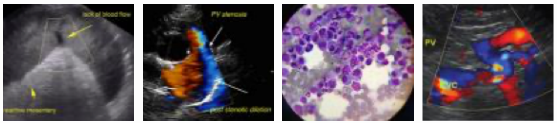
The peritoneal cavity is normal. There is no evidence of inflammation or effusion. A 1.11 cm medial iliac lymph node is visualized. A 1.00 cm gastric lymph node is also seen. A few prominent mesenteric lymph nodes are also seen (the largest measuring 1.45 cm in length).

ULTRASONOGRAPHIC FINDINGS

Findings

- Cystic calculi
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Bilateral chronic renal changes

*An obvious cause for the patient's GI signs is not definitively identified in this study. Considerations include primary gastrointestinal disease (i.e., inflammatory bowel disease, infectious/parasitic disease, food allergy/intolerance), underlying metabolic issue, other.



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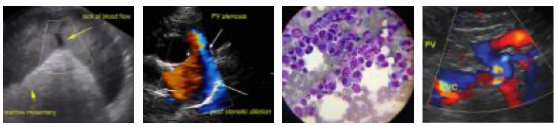
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Regarding the GI signs, consider the following:

- A fecal evaluation for ova and Giardia (if not already performed), as well as a fecal PCR infectious disease panel is recommended. Also consider prophylactic deworming with Fenbendazole.
- Given the eosinophilia and the patient's clinical history, a resting cortisol level is recommended to assess for atypical hypoadrenocorticism.
- Also consider a malabsorption panel, including serum cobalamin and folate, TLI and PLI.
- A new 2-4-week hydrolyzed protein or limited antigen diet trial is also recommended evaluate for food allergies.
- Consider initiation of a probiotic with a high colony count (i.e., Proviable Forte or Visbiome) +/- a fiber supplement (i.e., psyllium).
- Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical GI biopsies may be necessary to get a definitive diagnosis.

Regarding the cystic calculi, a cystotomy with stone removal, analysis and culture is recommended. Alternatively, medical dissolution of the stones can be considered with a prescription renal diet and broad-spectrum antibiotic therapy. If there is no improvement in stone size after 4 weeks of therapy, a cystotomy should be reconsidered. If the stone size is reduced, continue therapy until complete dissolution has been achieved.

Given the bilateral renal changes, consider periodic monitoring (i.e., every 3-6 months) of the patient's kidney values to assess for the development of azotemia. A urine specific gravity is also recommended to assess for isosthenuria.



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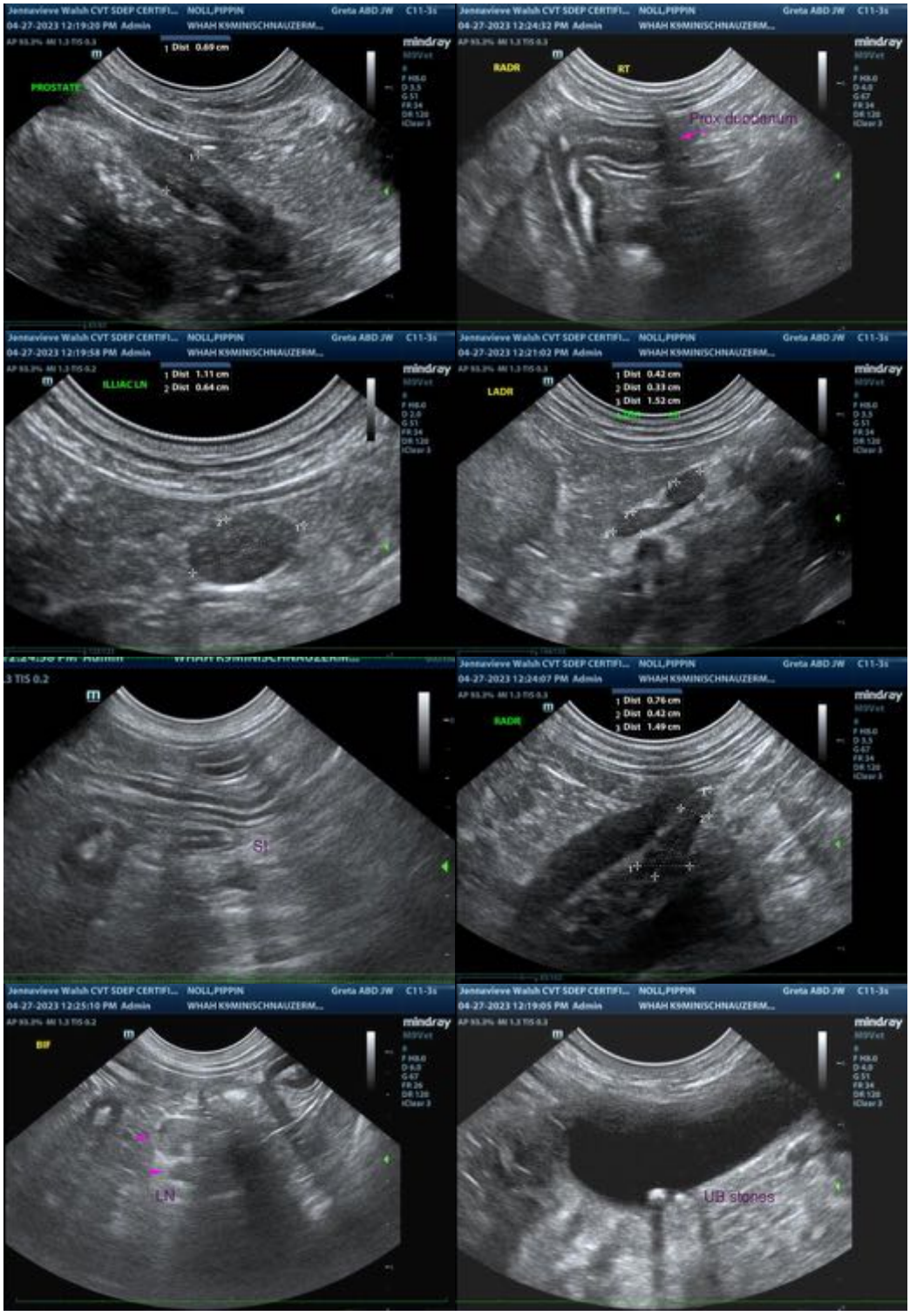

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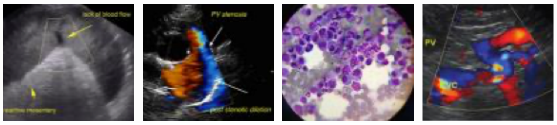

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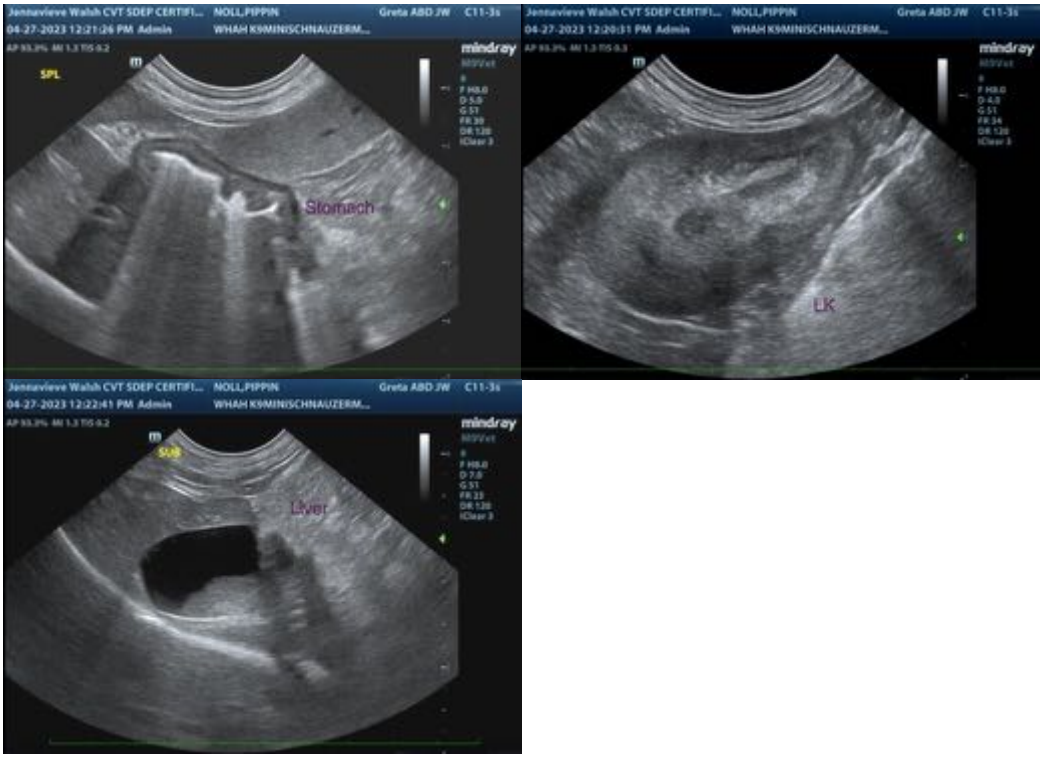

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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