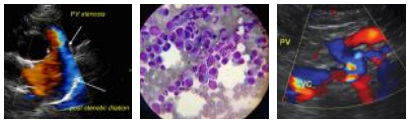
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
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DATE

4/5/2022

PATIENT

Anja Domack

SPECIES

Canine

BREED

Miniature Schnauzer

SEX

Spayed Female

AGE

6/25/2012

WEIGHT

18.7 lbs

INTERPRETED BY

Andrea Nicastro, DMV, Diplomate DACVIM (Small Animal Internal Medicine)

HOSPITAL NAME

Animal Medical Center of Bel Air

REFERRING VET

Dr. Chaudry

INVOICE

10666

PRESENTING CLINICAL SIGNS

Lethargic, eating less.

Current Medications: None listed.
Lab Results: See attached.
CBC unremarkable. Chemistry shows an ALP of 932.
Radiographs: See attached.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Requested by DVM.

Imaging Performed By: Stephanie Pearce RDCS, RVT

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 scant amount of echogenic debris is suspended within the lumen. No cystic calculi are observed. The region of the trigone is normal. The visualized portion of the urethra is diffusely thickened (up to 0.77 cm in diameter). The urethral wall is mildly heterogenous, with at least one small, hyperechoic-to-mineralized focus. The urethral lumen is not overtly dilated

The left kidney is normal size (4.43 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.

The right kidney is normal size (5.14 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 mildly enlarged (0.52 cm at cranial pole) (0.68 cm at caudal pole) (1.71 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 in size (0.67 cm at cranial pole) (0.53 cm at caudal pole) (2.30 cm in length); with a slightly irregular 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 (1.53 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 prominent in size, with normal curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular 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. A small amount of aggregated, echogenic, partially dependent debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

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.

Gastrointestinal
The gastric lumen is distended hard shadowing material. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract appears patent at the time of this scan. 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.

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 evidence of free fluid. Two to three prominent lymph nodes are observed at the aortic trifurcation, the largest measuring 0.93 cm in length.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The urethral changes could be consistent with infiltrative neoplasia (i.e., transitional cell carcinoma) or urethritis (i.e., secondary to chronic urinary tract infections, if applicable).
- The gastric luminal contents could be consistent with foreign material and/or ingesta. An outflow tract obstruction is not evident at the time of this study. However, an intermittent outflow tract obstruction cannot be completely excluded.

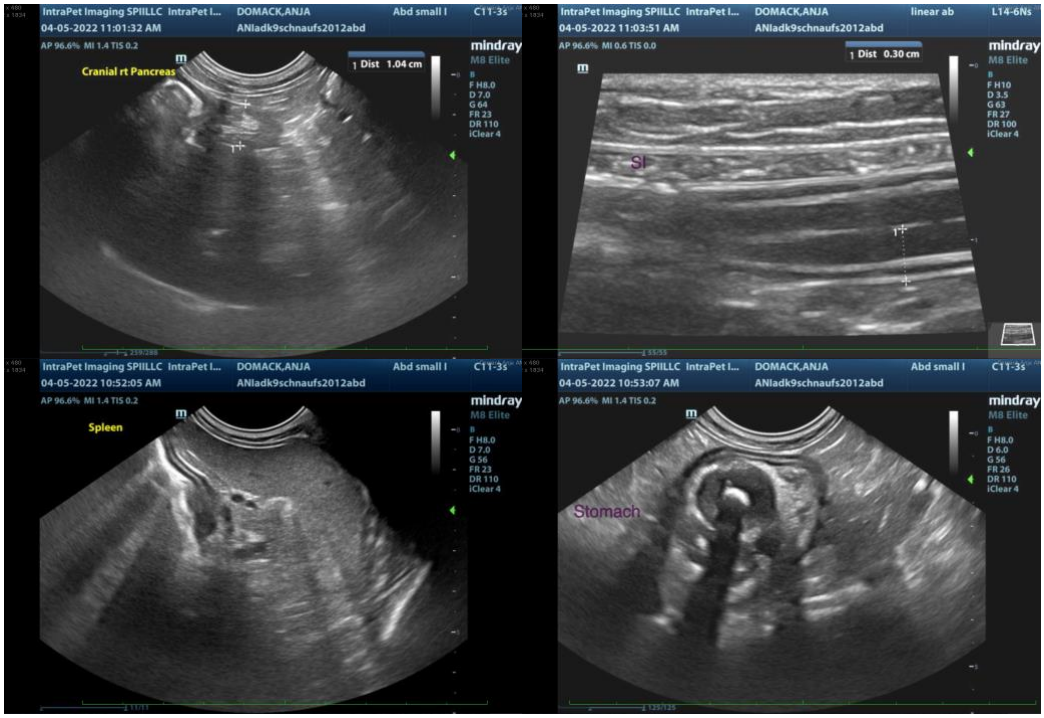
Secondary Findings

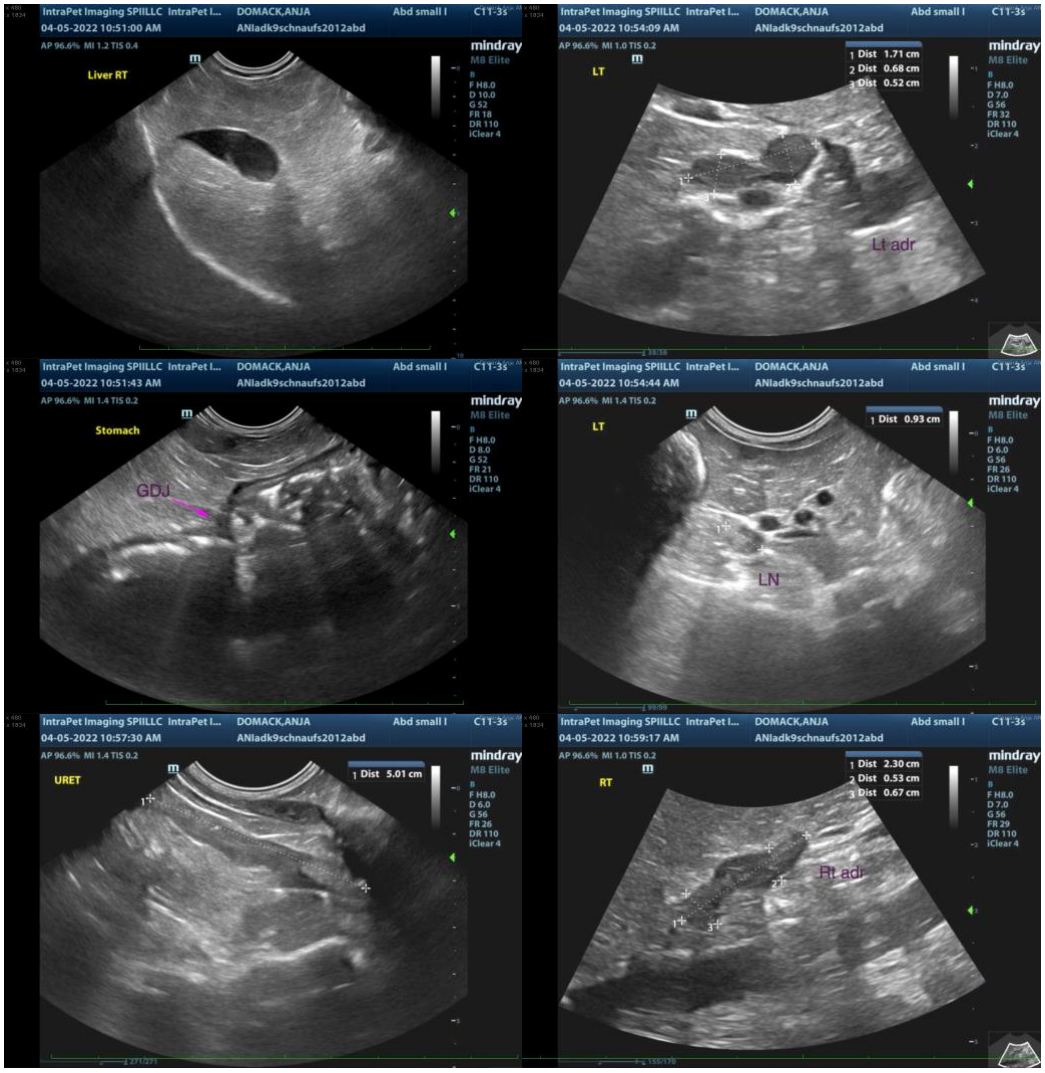
- Nonspecific benign hepatopathy. Top differentials include vacuolar hepatopathy and regenerative nodular hyperplasia.
- Mild left adrenomegaly, most consistent with hyperplastic change.
- Minor bilateral age-related renal changes
- Age-related pancreatic remodeling
- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.

**Is it unclear whether the patient's clinical signs are related to gastric foreign material, other underlying gastrointestinal disease, low-grade pancreatitis or a metabolic issue.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider a repeat abdominal ultrasound in 8-12 hours to assess for persistent gastric foreign material. If present, a gastrotomy along with gastrointestinal biopsies may be warranted. Also consider a malabsorption panel, including serum cobalamin and folate, TLI and PLI.
- Three-view thoracic radiographs should be considered to assess for occult neoplasia in the chest.
- Given the urethral changes, a urine culture and sensitivity as well as a urine BRAF test are recommended to further assess for infection and neoplasia, respectively.
- Consider testing for hyperadrenocorticism with a low-dose dexamethasone suppression test or ACTH stimulation test if clinical signs (i.e., PU/PD) develop in the future.





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)
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