



PATIENT

Mulan Cuebas

SPECIES

Canine

BREED

Dachshund LH

SEX

Spayed Female

AGE

11 years

WEIGHT

104 lbs

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Dr. G. Ferrer, DVM

HOSPITAL NAME

Paseos VC

REFERRING VET

Dr. Jenniffer Walker
Diaz

INVOICE

10681

DATE

4/5/22

PRESENTING CLINICAL SIGNS

History: Presented today for an abdominal ultrasound to evaluate history of vomiting and diarrhea. The patient vomiting intermittently with diarrhea for about a month, signs improved with medication. Patient had been under control with GI diet but 2 days ago vomited again because of the vomit owners added chicken to the diet yesterday No decrease in appetite and continue to be active Last bloodwork done March 2, 2022 unremarkable, fecal none seen this time no diarrhea at the moment owners think everything started when gabapentin and welactin were introduce to tx by Dr. Mongil due to hx of back sx No medications given at the moment only diet gastro and oral supplement Dasuquin, cbc: RBC: 9.4H, MCH: 20.9L, RDW: 21.8 H, LYM: 0.86L, BASO: 0.11H chem high Glob radiograph feces at rectum more solid than expected, no displacement or dilation GI track R/O IBD vs pancreatitis vs gastroenteritis recommended abdominal Ultrasound

Abnormal PE/Chem/CBC/UA Results: cbc: RBC: 9.4H, MCH: 20.9L, RDW: 21.8 H, LYM: 0.86L, BASO: 0.11H chem high Glob radiograph feces at rectum more solid than expected, no displacement or dilation GI track

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. A small to moderate amount of suspended echogenic debris is observed within the lumen. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal size (3.94 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 hydronephrosis.

The right kidney is normal size (4.20 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 hydronephrosis.

Adrenal Glands

The left adrenal gland is upper limits of normal size (0.45 cm at cranial pole) (0.55 cm at caudal pole) (0.65 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 (0.51 cm at cranial pole) (0.82 cm at caudal pole) (1.80 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 subjectively normal in size (1.07 cm in width at the level of the hilus) with normal curvilinear peripheral contours. The parenchyma is slightly mottled in appearance, with at least one small (0.40 cm) ill-defined, hypoechoic nodule observed. Splenic vasculature appears normal with no evidence of thrombosis.



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Liver

The liver is subjectively normal 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.

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Gastrointestinal

The gastric lumen is minimally fluid-distended. The gastric wall is normal to borderline thickened (up to 0.52 cm) with retention of the normal layering pattern. The pylorus is normal in thickness. The pyloric outflow tract appears 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 ileocecolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely mildly hyperechoic 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. A 0.67 cm sublumbar lymph node is visualized. The node is normal in shape and echogenicity. A 0.78 cm mesenteric lymph node is also seen.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The mild gastric wall thickening is most consistent with an inflammatory process, with a lower possibility of hypertrophy or emerging neoplasia.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

**An obvious cause for the patient's clinical signs is not identified in this study. Differentials include microscopic gastrointestinal disease (i.e., inflammatory bowel disease, intestinal dysbiosis, food allergies/intolerance), mild pancreatitis, underlying metabolic issue, other.

Secondary Findings

- The splenic parenchyma changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis or splenitis with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).



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- Suspected benign hepatopathy. Top differentials include vacuolar hepatopathy and regenerative nodular hyperplasia.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The following diagnostics/treatment recommendations can be considered:

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1. Serum cobalamin, folate, PLI and TLI
2. Despite the negative fecal, consider prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.
3. A 6-week limited antigen diet trial to assess for food allergies.
4. 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.
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/therapeutics, endoscopic or surgical gastrointestinal biopsies may be warranted.
7. Three-view thoracic radiographs should be performed prior to any anesthetic event.

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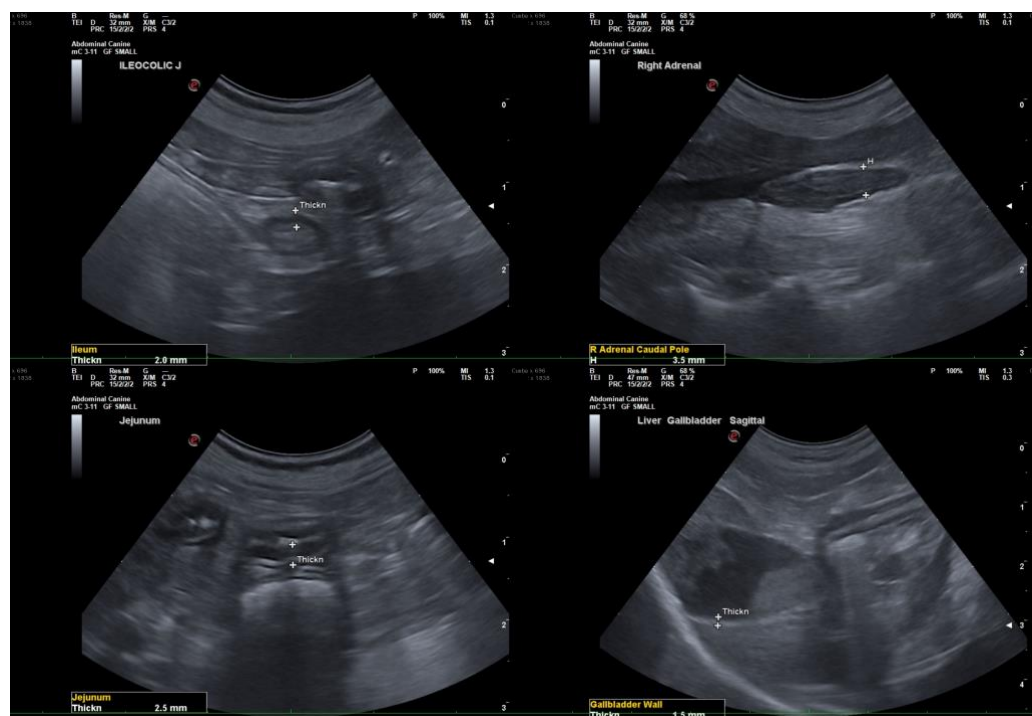
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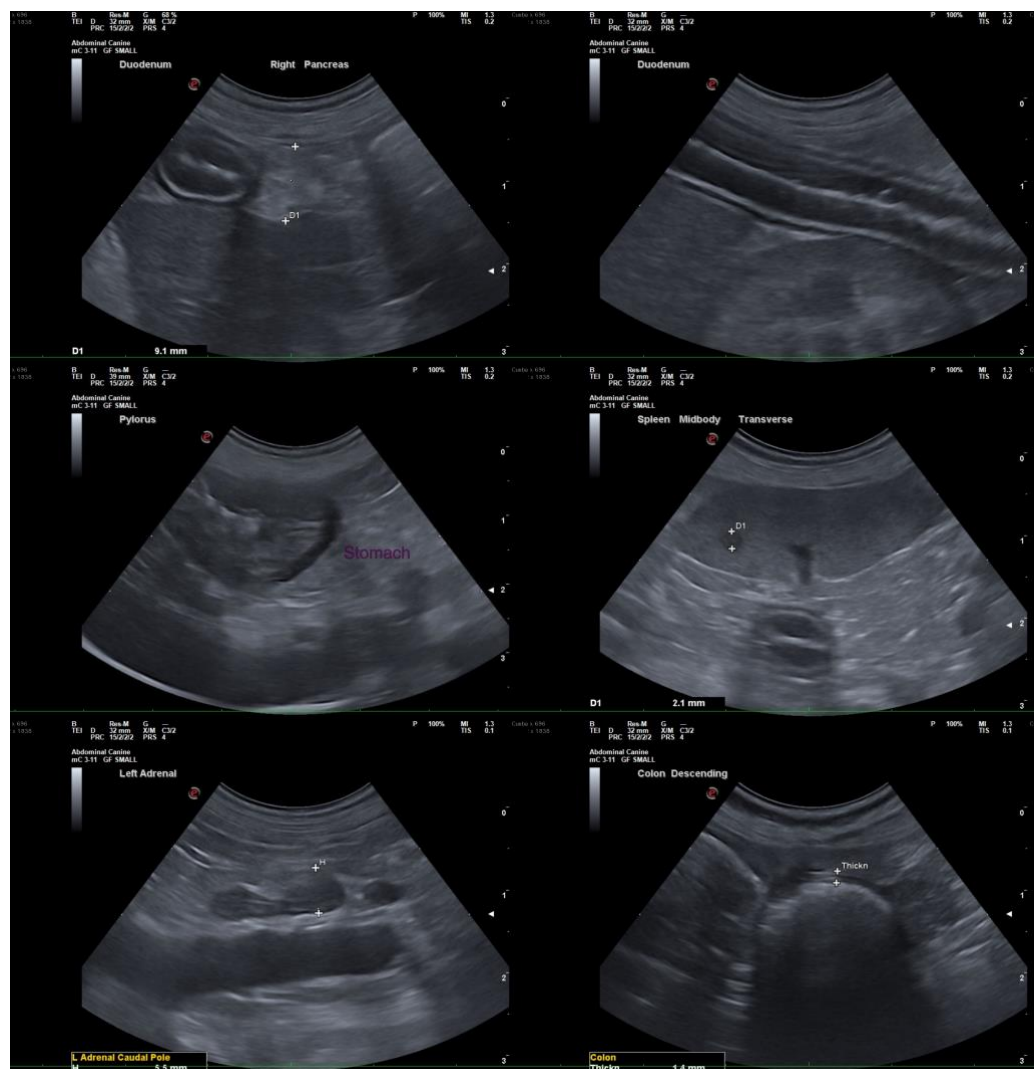
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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