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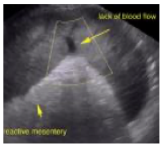
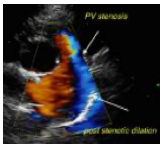
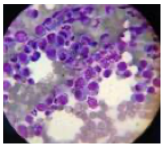
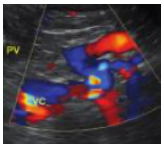
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT
Lady Soto Aviles

SPECIES
Canine

BREED
Chihuahua

SEX
Intact Female

AGE
10 years

WEIGHT
3.9 lbs

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

IMAGING PERFORMED BY
Dr. Ferrer DVM

HOSPITAL NAME
Paseos VC

REFERRING VET
Dra. Rodriguez

INVOICE
2669

DATE
4.5.23

PRESENTING CLINICAL SIGNS

History: Presented as a referral for an abdominal ultrasound to evaluate ascites. The patient presented to rDVM on 4/3/23 with digid and distended abdomen. Pt eats well. No Vomiting or diarrhea. She is a female intact and doesn't have a vaccine nor prevented it. On January 31st was taken to another vet because she wasn't eating, had diarrhea, and a distended abdomen. The other clinic recommended Xray but didn't have the facility. Treatment was PO Lixotinic, Panacur, Kaolin Pectin Famotidine, Mirtazapine, Spironolactone, sulfa, metro y Baytril inj. Diagnosis: Periodontitis, Heart murmur grade 3/6, Ascites

Abnormal PE/Chem/CBC/UA Results: PE: grade 3/6 systolic HM, distended abdomen. CBC: WBC: 25 RBC: 4 CHEM: ALB 10 Fecal: Positive

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The left kidney is normal size (2.84 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal size (3.29 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal in size (0.40 cm at cranial pole) (0.52 cm at caudal pole) (1.18 cm in length) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature appear normal.

The right adrenal gland is in normal size (0.49 cm at cranial pole) (0.40 cm at caudal pole) (0.97 cm in length) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature appear normal.

Spleen

The spleen is normal in size (1.15 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 appears normal.

Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and homogenous in appearance. No focal lesions are observed. One to two intrahepatic biliary stones are suspected. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

What is thought to be gall bladder is moderately distended. The wall is normal in thickness. The lumen is filled with hyperechoic-to-mineralized debris/sludge. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

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. There is evidence of mucosal speckling/fogging in some segments. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

The base and limbs of the pancreas are 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

A moderate-to-large amount of anechoic free fluid is present. A few prominent lymph nodes are observed at the aortic trifurcation (the largest measuring 0.59 cm in length). A 0.64 cm jejunum lymph node is also seen. All nodes are normal in shape and echogenicity.

Other

The uterine body is visible and is normal in size (0.37 cm in width). No obvious pathology is observed.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Bowel pattern suggestive of an inflammatory process and/or lymphangiectasia
- The ascites may be secondary to low oncotic pressure, increased hydrostatic pressure or increased vascular permeability.

Secondary Findings

- Bilateral chronic age-related renal changes
- Suspected intrahepatic biliary stones – incidental
- Mineralized gall bladder sludge
- Minor age-related pancreatic remodeling
- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Repeat baseline bloodwork is recommended, including CBC, chemistry panel, urinalysis and T4. If the patient is hypoalbuminemia, consider the following:

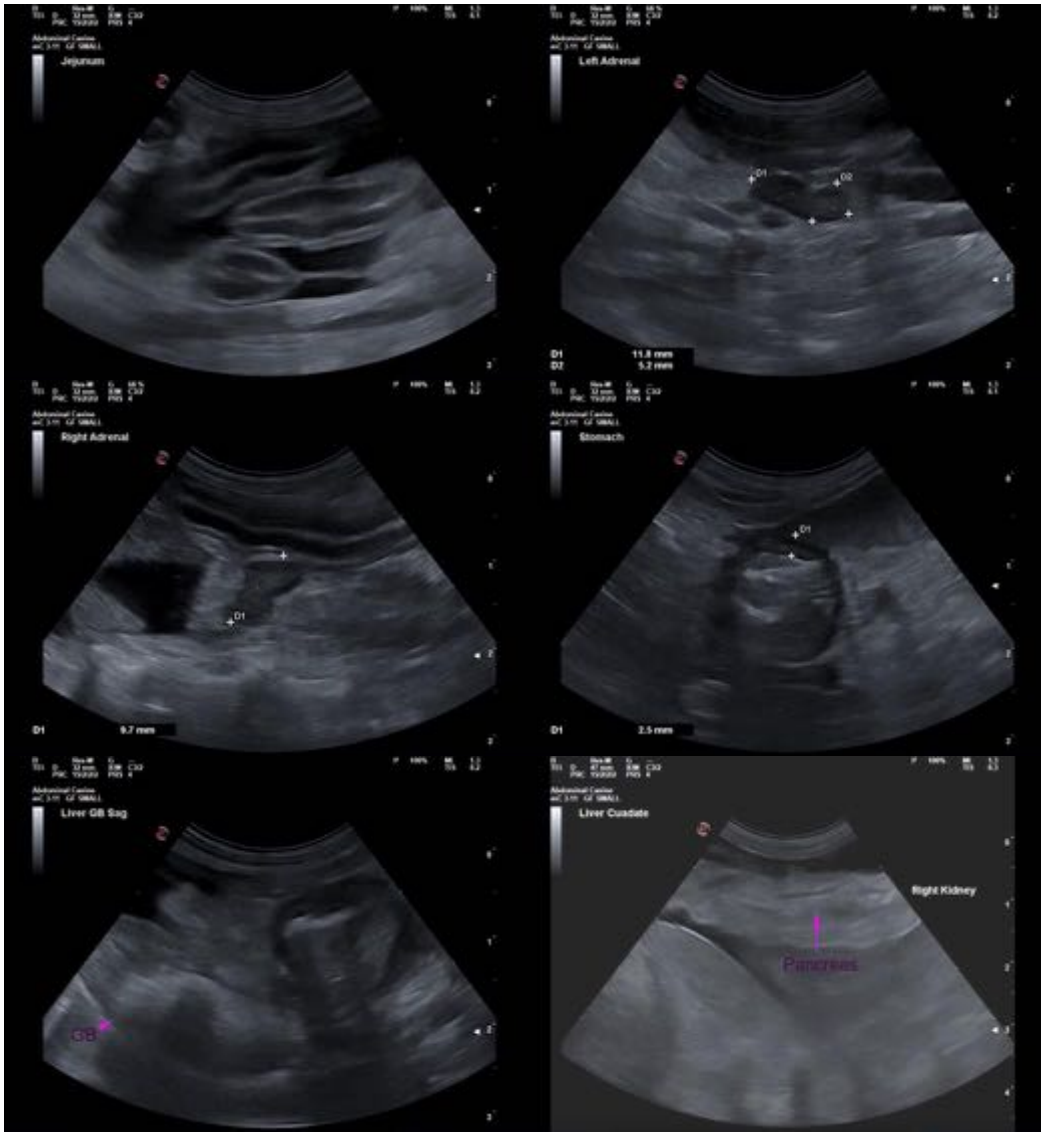
    1. UPC (if proteinuria is present in the absence of infection)
    2. Pre-and postprandial serum bile acids

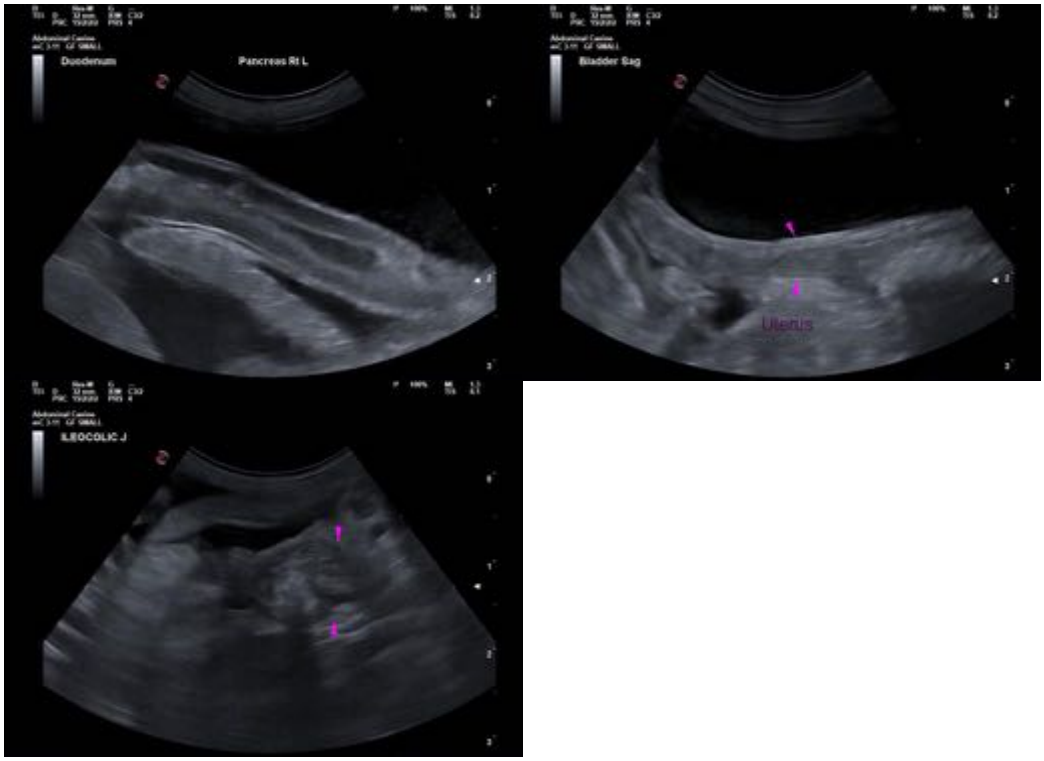
3. Resting cortisol level

- Other diagnostic considerations include the following:

1. Submission of the abdominal fluid for analysis and cytology evaluation
2. Malabsorption panel, including serum cobalamin and folate, TLI and PLI
3. Three-view thoracic radiographs to assess cardiopulmonary status.

- Based on the above test results, further work-up (i.e., GI biopsies) may be warranted.





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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