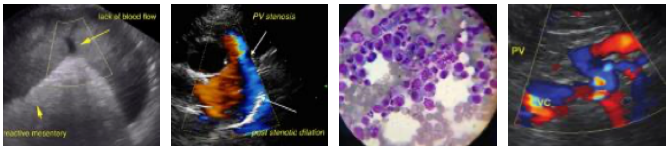
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



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

PATIENT
Cooper Wu

SPECIES
Canine

BREED
Yorkshire Terrier

SEX
Male

AGE
12 Yrs.

WEIGHT
5.0 lbs.

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

IMAGING PERFORMED BY
Dr. Reyes

HOSPITAL NAME
Mobile Vet Ultrasound

REFERRING VET
Dr. D'Ambrose

INVOICE
13312

DATE
5/3/22

PRESENTING CLINICAL SIGNS

History: Pet presented for a chronic hx of diarrhea and inappetence since April 28. Pet had a PU surgery and has had chronic UTI since then. Unsure about reason for PU surgery
Abnormal PE/Chem/CBC/UA Results: 04/30/22 RBC: 4.97 HCT: 39.3 MCV: 79 MCH: 28.4 Gluc: 62 SDMA: 33 Creat: 1.7 BUN: 52 NA:K ratio: 27 TP: 5.4 Alb: 2.5 Lipase: 267 UA: SG: 1.015 pH: 5.5 WBC: 10-15 RBC: 10-15 Bacteria: marked rods > 40/hpf UPC: 1.5 T4: 0.9

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 small to moderate amount of suspended echogenic debris along with a small amount of gravity-dependent mineralized sand is observed within the lumen. The region of the trigone is obscured by the sand.

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

The left kidney is subjectively normal size with a normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. The cortex is heterogeneous with numerous cortical cysts. There is no evidence of pyelectasia, nephroliths or hydroureter.

The right kidney is subjectively normal size with a normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. The cortex is heterogeneous with numerous cortical cysts. Trace pyelectasia is present. There is no evidence of nephroliths or hydroureter.

Adrenal Glands

The left adrenal gland is normal size (0.36 cm at cranial pole) (0.43 cm at caudal pole); 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.

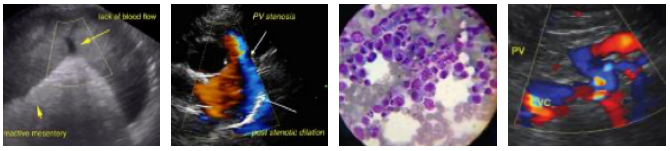
The right adrenal gland is enlarged (1.22 cm at cranial pole) (0.59 cm at caudal pole) (1.91 cm in length) with a slightly irregular shape. The parenchyma was subtly heterogeneous in appearance with some loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.86 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 enlarged with slightly swollen 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 distended. The wall is thin and smooth. A large amount of aggregated echogenic sludge is observed within the lumen, most of which is gravity-dependent and some of which is suspended. The cystic and common bile ducts are normal/not seen.



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Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is mildly distended with ingesta. 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 segmentally dilated with chyme. 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 disease is noted.

Pancreas

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely 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

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:

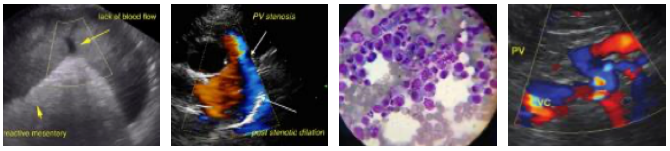
- An obvious cause for the patient's diarrhea and inappetence is not identified in this study. Differentials include microscopic gastrointestinal disease (i.e., inflammatory bowel disease, food allergy, intolerance, intestinal dysbiosis), underlying metabolic issue, low-grade pancreatitis, other.

Secondary Findings:

- Bilateral, age-related renal changes with cortical cysts.
- Urinary bladder debris/sand.
- Mild right adrenomegaly could be consistent with hyperplastic change or less likely, an emerging tumor.
- The gallbladder sludge may be secondary to fasting, cholestasis or an emerging mucocele (less likely).
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Suspected benign diffuse hepatopathy. Top differentials include vacuolar hepatopathy, regenerative nodular hyperplasia and/or age-related remodeling.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

With regard to the patient's clinical signs, consider the following:



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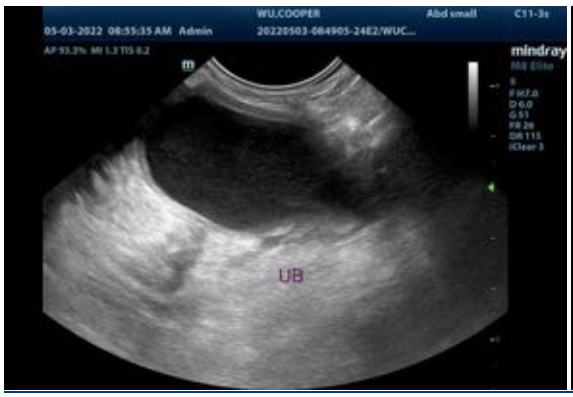
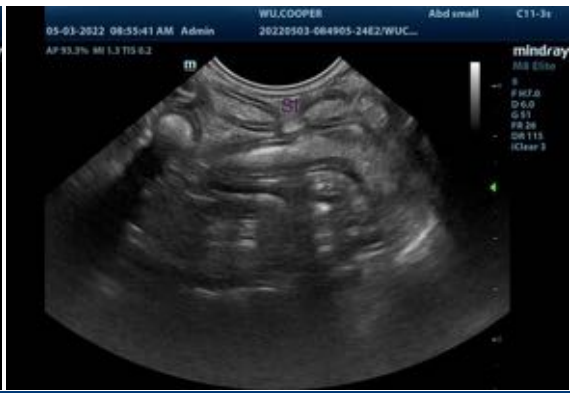
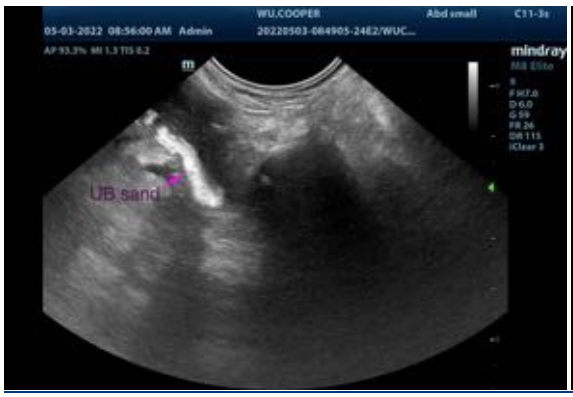
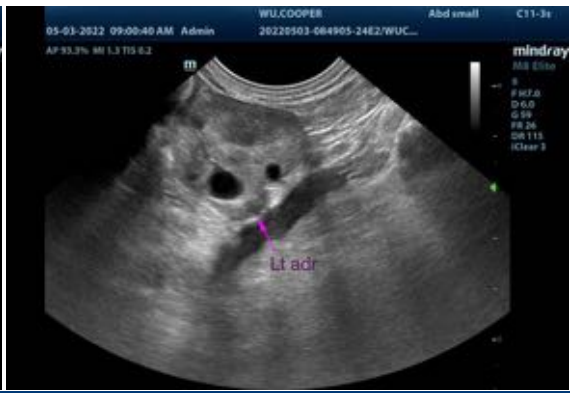
1. Serum cobalamin, folate, PLI and TLI
2. A fecal evaluation for ova/Giardia
3. Prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.
4. A 6-week limited antigen diet trial to assess for food allergies.
5. Consider a 4-week course of Tylosin at 15-20 mg/kg by mouth every 12 hours as empirical treatment for small intestinal bacterial overgrowth.
6. A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended.
7. Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be warranted.
8. Three-view thoracic radiographs should be performed prior to any anesthetic event.

Regarding the hypoglycemia, a recheck blood glucose on a glucometer is recommended. If hyperglycemia is persistent, further workup (i.e., insulin: glucose ratio, pre and post prandial serum bile acids) may be warranted.









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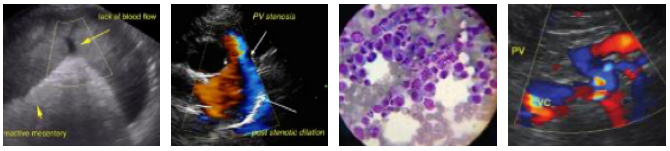

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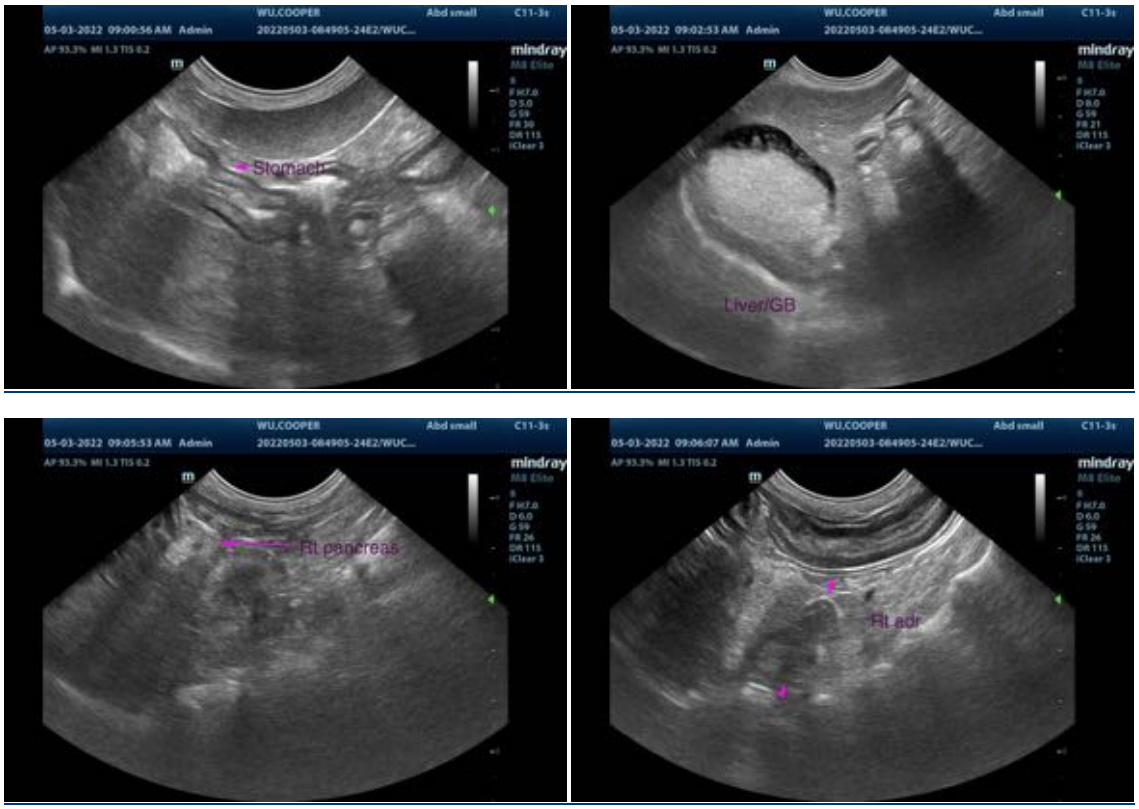

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

Andrea.nicastro@sonopath.com