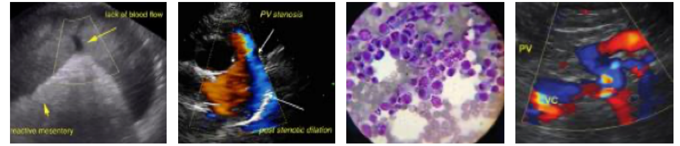

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1-800-838-4268 info@sonopath.com

PATIENT
Yosi Wu

SPECIES
Canine

BREED
Pomeranian

SEX
Male, neutered

AGE
15 Yrs.

WEIGHT
11.4 lbs.

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

IMAGING PERFORMED BY
Dr. Lynette Reyes

HOSPITAL NAME
Mobile Vet Ultrasound

REFERRING VET
Dr. D'Ambrose

INVOICE
13310

DATE
5/3/22

PRESENTING CLINICAL SIGNS

History: Chronic vomiting and diarrhea. Had done multiple test and all normal. History of grade 3/6 murmur. Currently on metronidazole, cerenida and Metoclopramide daily. Pet doesn't do well if meds are stopped.
Abnormal PE/Chem/CBC/UA Results: SDMA: 27 Amylase: 2,423 Lipase: > 1,800 Cardio pet: 7,887 Urine SG: 1.019 Protein: 1+

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 with anechoic urine. No masses, inflammatory changes or calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The prostate is normal in size (1.08 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal size (4.37 cm in length); 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. Trace pyelectasia is present (0.16 cm in the longitudinal plane). There is no evidence of nephroliths or hydroureter. Numerous small cortical cysts are observed.

The right kidney is normal size (4.37 cm in length); 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. Trace pyelectasia is present (0.20 cm in the transverse plane). There is no evidence of nephroliths or hydroureter. Numerous small cortical cysts are observed.

Adrenal Glands

The left adrenal gland is normal size (0.31 cm at cranial pole) (0.44 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.

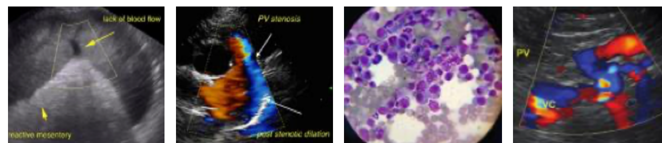
The region of the right adrenal gland is evaluated. No obvious pathology is observed.

Spleen

The spleen is normal in size (0.81 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 slight rounding of the peripheral contours. The parenchyma is hypoechoic relative to the spleen and mottled in appearance. No distinct focal lesions are observed. There is evidence of intrahepatic biliary stones. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. The gall bladder lumen is moderately distended. The wall is mildly thickened (up to 0.25 cm), hyperechoic and irregular. A small



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to moderate amount of echogenic to mineralized debris along with a few small choleliths are observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is not distended. The gastric wall is normal in thickness with a normal layering pattern. 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. Several cm of the descending colonic wall are thickened (up to 0.50 cm) with retention of the normal layering pattern. The colonic lumen is empty. No obstructive disease is noted.

Pancreas

The left limb of the pancreas is prominent in size with minimal deviation from the normal peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and mottled in appearance. No distinct focal lesions are observed. The pancreatic duct is visible but not overtly dilated (0.18 cm in diameter).

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:

- The descending colonic wall changes are most consistent with an inflammatory process with a lower possibility of 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.
- Suspected benign diffuse hepatopathy (i.e., age-related remodeling, regenerative nodular hyperplasia) with intrahepatic biliary stones, which are an incidental finding.

Secondary Findings:

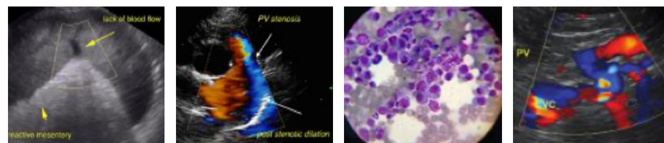
- The gallbladder wall changes could be consistent with cholecystitis and/or benign age-related hyperplasia. Non-obstructive choleliths were present.
- Bilateral chronic age-related renal changes with cortical cysts.

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

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The following diagnostics/treatment recommendations can be considered:

1. Serum cobalamin, folate, PLI and TLI



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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.

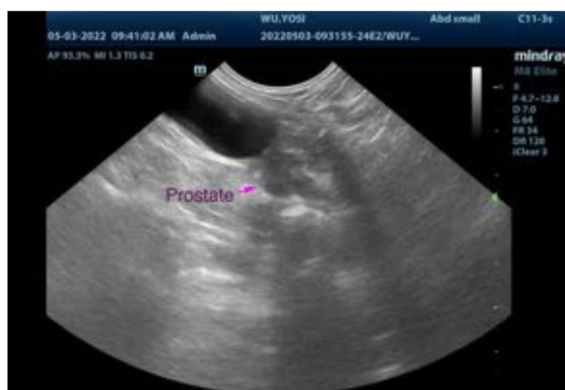
5. Consider a 4-week course of Tylosin at 15-20 mg/kg by mouth every 12 hours as empirical treatment for small intestinal bacterial overgrowth.

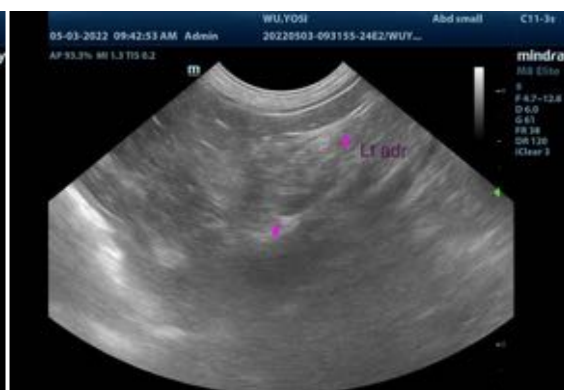
6. A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended.

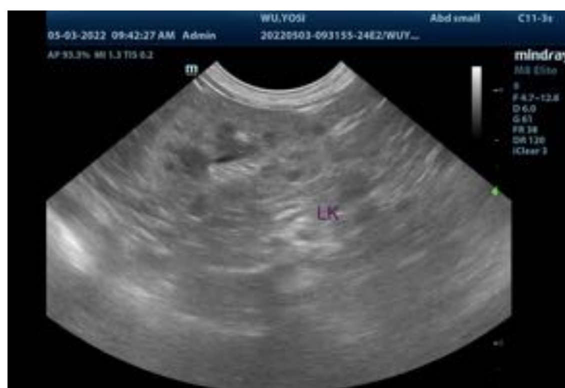
7. Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be warranted.

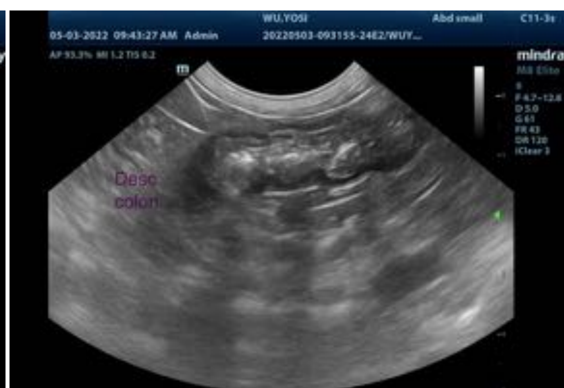
8. Three-view thoracic radiographs should be performed prior to any anesthetic event.

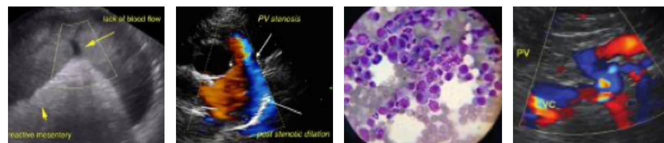
9. Given the proteinuria, a UPC is recommended.











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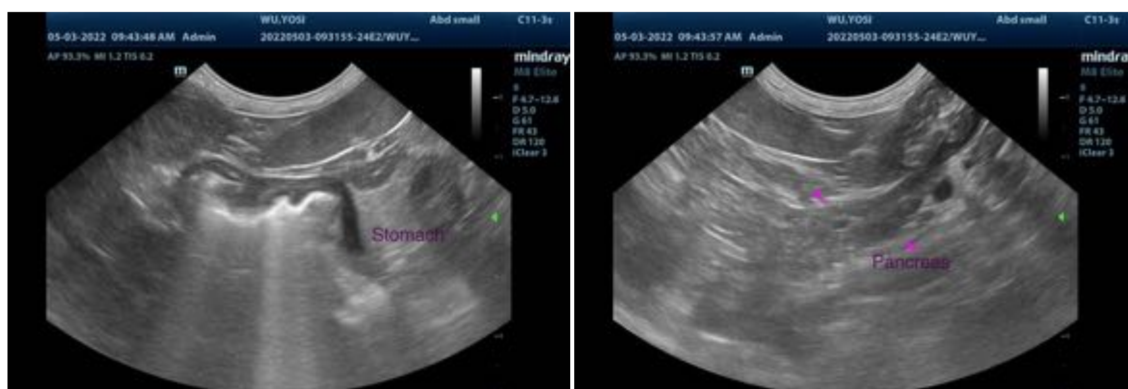

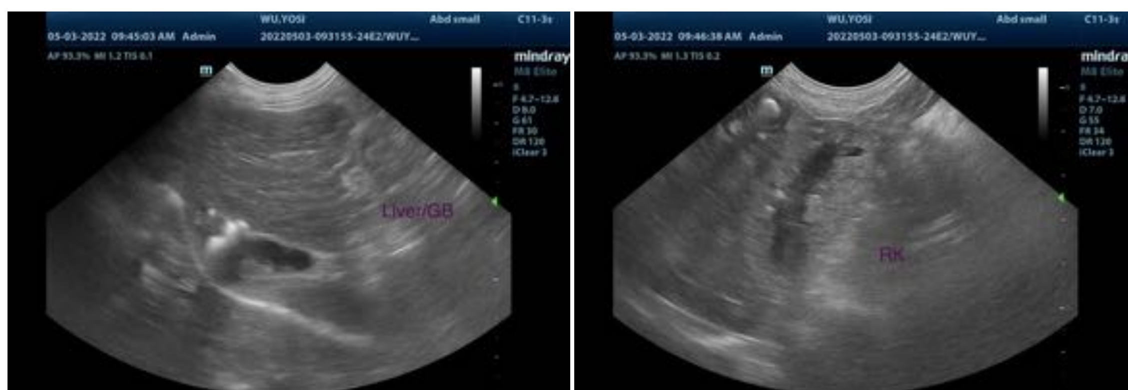

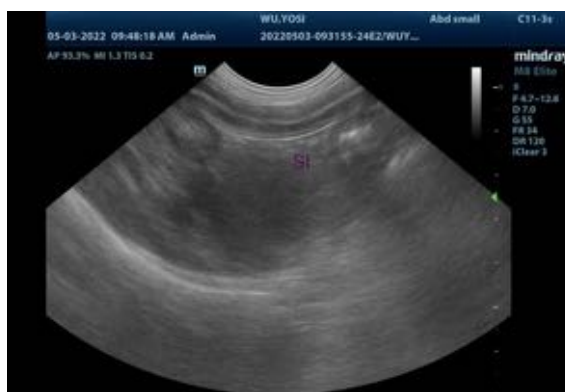

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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*)

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