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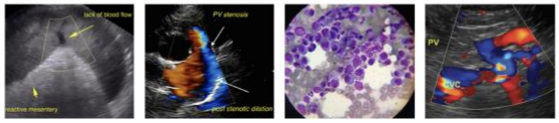


Charleston Mobile Veterinary Services
IMAGING PERFORMED BY
CharlestonMobile.Net 800.403.5408

PATIENT

Capers Farrell

SPECIES

Canine

BREED

Rhodesian Ridgeback

SEX

Spayed Female

AGE

4/1/2018

WEIGHT

81.6 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

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

HOSPITAL NAME

Park West Vet.

REFERRING VET

Dr. Anna Decker

INVOICE

11126

DATE

6/21/22

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Presenting today for sedated AUS with Dr. Nicastro for PLE work-up. P has had chronic diarrhea the past 2-3 weeks - not responsive to bland diet, Metro, Fortiflora, Endosorb or Pro-Pectalin. P was started on Fluoxetine 2 month ago - when diarrhea initially started, P's dose was dropped from 2mg/kg to 1mg/kg. No improvement to diarrhea. BAR on presentation. O believes she's lost weight as her appetite and energy have changed/decreased. P has lost 8# since starting Fluoxetine. Low TP/Globulin/Albumin - r/o PLE. Non-responsive Diarrhea - r/o PLE

Abnormal Lab-work Values: Total Protein 3.1. Albumin 1.8. Globulin 1.3
Current Medications: Fluoxetine 40mg SID, Apoquel 16mg (1.5T SID)
Panhypoproteinemia, 8-lb weight loss and chronic diarrhea

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 mildly 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 left kidney is normal size (7.08 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 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 right kidney is normal size (7.13 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

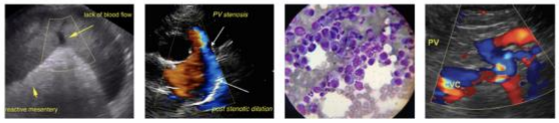
Adrenal Glands

The left adrenal gland is normal in length (0.34 cm at cranial pole) (0.39 cm at caudal pole) (2.28 cm in length); with a flattened contour. 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 small in size (1.03 cm at cranial pole) (0.38 cm at caudal pole) (1.91 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 normal in size (2.55 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.



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Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative, or regenerative pathology is evident. 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 thin and smooth. A scant amount of gravity dependent, echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is minimally fluid 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 segmentally fluid distended (mild). The small intestinal wall is diffusely thickened (up to 0.63 cm) with retention of the normal layering pattern There is evidence of mucosal fogging in several segments +/- occasional mucosal striations. Discreet masses are not identified. The colonic wall is normal. The lumen of the descending colon contains liquid-appearing fecal material. There is no evidence of an obstructive pattern.

Pancreas

The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

Free Abdomen

The mesentery in the midabdominal region is hyperechoic. Trace free fluid is observed. A few, prominent mesentery lymph nodes are visualized, the largest measuring 2.51 cm in length.

Other

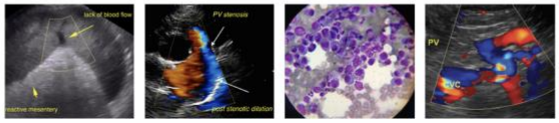
A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Based on the clinical history and sonographic changes, a protein-losing enteropathy is suspected. Top differentials include inflammatory bowel disease, lymphangiectasia, infectious/parasitic disease, emerging lymphoma, other.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The trace ascites and mild peritonitis are likely secondary to hypoalbuminemia and the bowel pathology.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS



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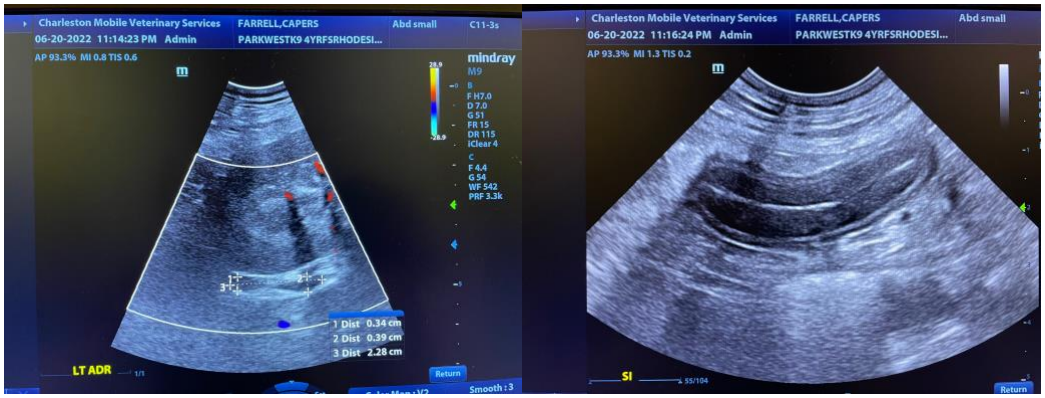
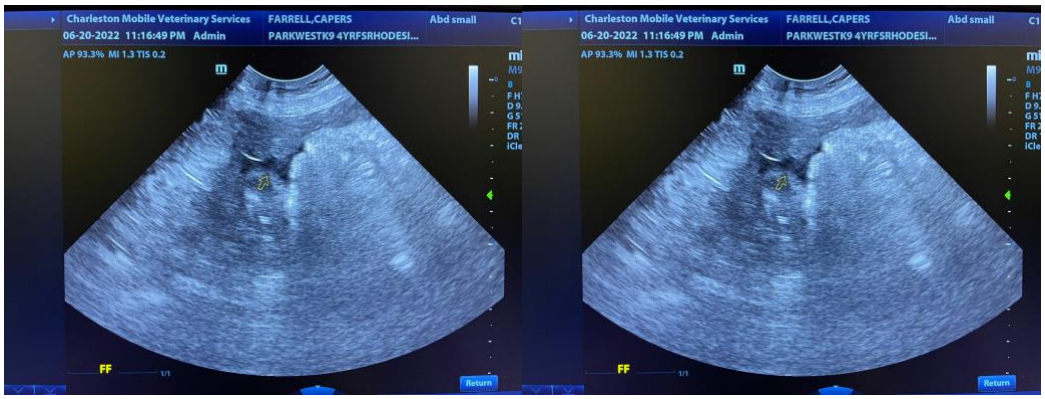
- Despite the negative fecal evaluation, prophylactic deworming with fenbendazole is recommended.
- Malabsorption panel including serum cobalamin, folate, PLI and TLI
- 6-week limited antigen diet trial to assess for food allergies
- Resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended.
- To evaluate for concurrent causes of hypoalbuminemia, consider a UPC (if proteinuria is present) as well as pre-and postprandial serum bile acids.
- While awaiting test results, consider empirical treatment for small intestinal bacterial overgrowth (i.e., a 4-week course of Tylosin), a probiotic with a high colony count (i.e., Proviable Forte or Visbiome), and initiation of a hypoallergenic diet.
- Ultimately, endoscopic, or surgical gastrointestinal biopsies may be necessary to get a definitive diagnosis. Surgical biopsies are preferred in that all areas of bowel can be accessed.





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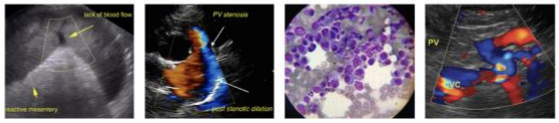

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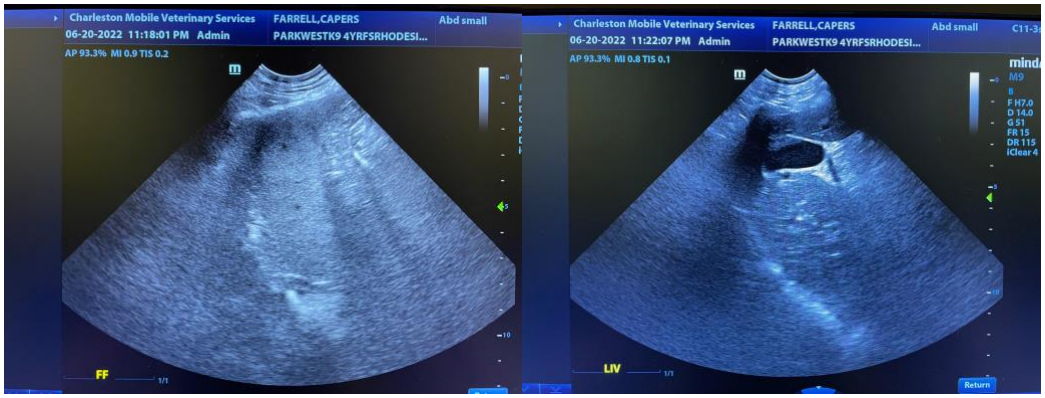

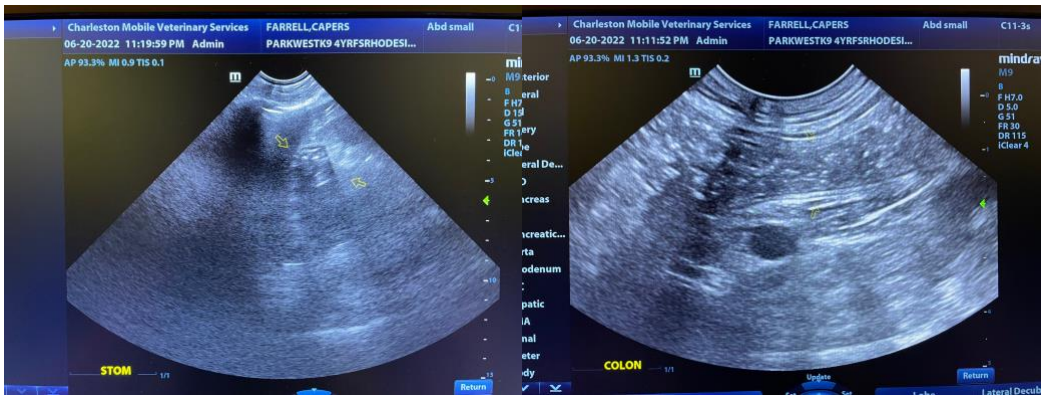

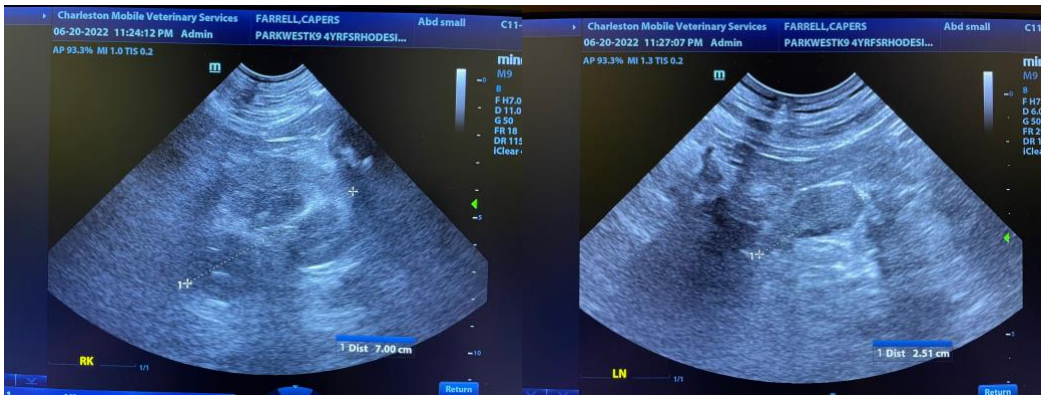

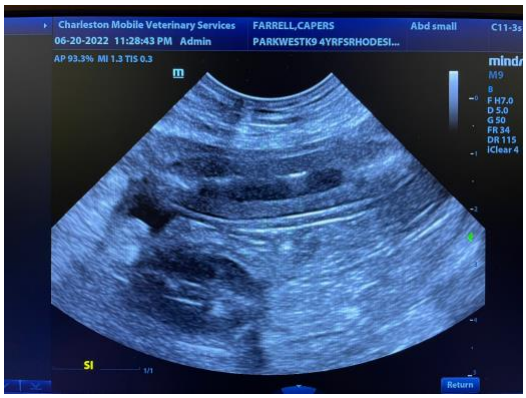

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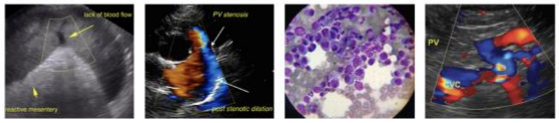

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com