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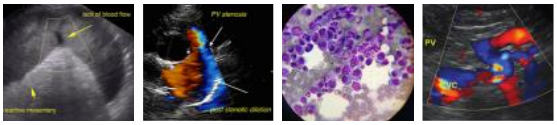


ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

PATIENT

Matcha LI

SPECIES

Canine

BREED

Pomeranian Mix

SEX

Spayed Female

AGE

10 years

WEIGHT

10.86 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Jenna Walsh, CVT

HOSPITAL NAME

West Hills AH

REFERRING VET

Dr. Cole

DATE

6/3/22

INVOICE

11024

PRESENTING CLINICAL SIGNS

History: 10-year-old FS Pomeranian with history of acute what o perceives as pain - pt does not want to move, will not go up or down stairs, does not want to eat. P presented in March for Weeklong history of inappetence, vomiting. Round, firm abdomen on PE, increased respiratory effort. Lethargic at home per owner. Previously diagnosed collapsing trachea and 3/6 heart murmur Current Medications Cerenia, Gabapentin Radiographic Findings Obesity, hepatomegaly Primary Question/Differential to Be Answered in This Exam Cause of hepatomegaly? Cardiac changes? Wondering if lethargy may be cardic in nature

Abnormal PE/Chem/CBC/UA Results: Na:K Ratio 26 (28-37), nRBC 6 (0-2), all other lab work WNL

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. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal in size (3.58 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. Pinpoint hyperechoic foci are observed within the cortex. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal size (3.82 cm in length); with a normal shape, smooth peripheral margins, and normal internal architecture. There is moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. Pinpoint hyperechoic foci are observed within the cortex. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

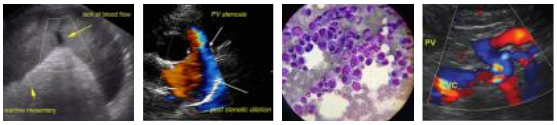
Adrenal Glands

The left adrenal gland is normal size (0.37 cm at cranial pole) (0.38 cm at caudal pole) (1.57 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 (0.52 cm at cranial pole) (0.44 cm at caudal pole) (1.09 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 (0.89 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



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vasculature is normal.

Liver

The liver is subjectively enlarged with slightly swollen peripheral contours. The parenchyma is hypoechoic 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.

The gall bladder lumen is distended. The wall is normal in thickness. A moderate to large amount of aggregated, echogenic, suspended sludge, in a partially stellate pattern is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. 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 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 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.

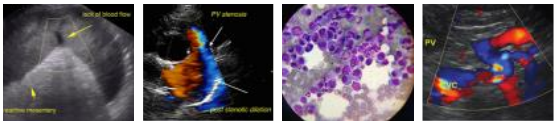
Free Abdomen

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 gall bladder changes are consistent with a developing mucocele.
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory and infiltrative disease are considered less likely.



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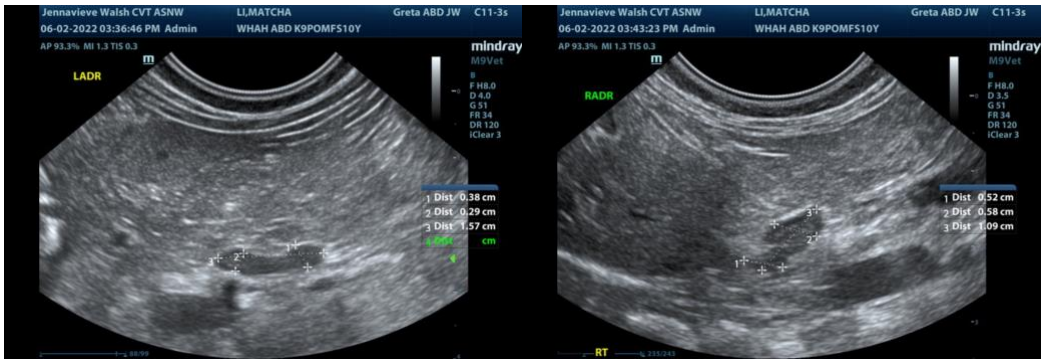
*An obvious cause for the patient's clinical signs is unclear. However, occasionally gall bladder disease can cause intermittent gastrointestinal signs, such as vomiting and inappetence, particularly if infection occurs.

Secondary Findings

- Bilateral, chronic, age-related renal changes with dystrophic mineralization
- Age-related pancreatic remodeling +/- fibrosis. Mild, chronic pancreatitis is possible, particularly if the patient exhibits pain on cranial abdominal palpation.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Initiation of ursodiol therapy is recommended with serial sonographic monitoring (i.e., every 4-6 weeks) of the gall bladder, to assess for progression to a fully formed mucocele. Also consider empirical treatment for cholecystitis (i.e., amoxicillin and clavulanic acid) given the gall bladder changes.
- Three-view thoracic radiographs are also recommended to assess for occult disease in the chest, as well as bony abnormalities that may be causing pain.
- A urine culture and sensitivity can also be considered, as occult pyelonephritis can be a source of abdominal pain.
- Orthopedic and neurologic examination should also be considered to assess for non-metabolic causes of pain.



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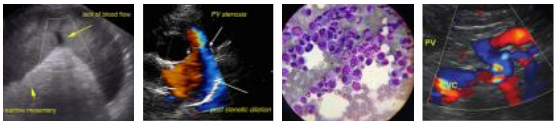

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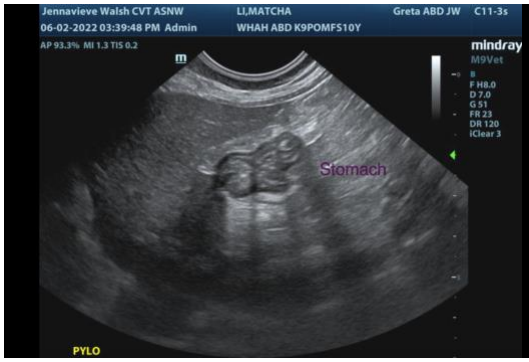

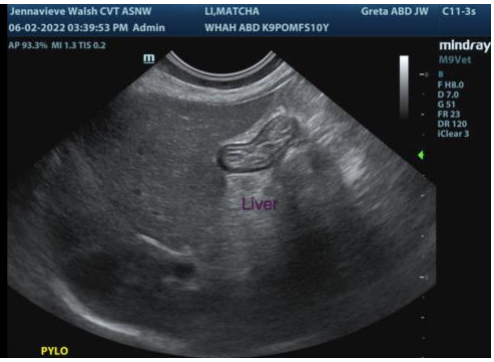

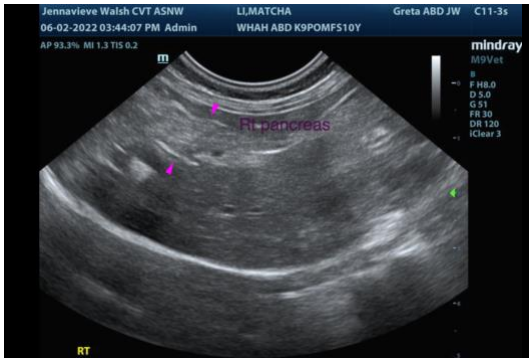

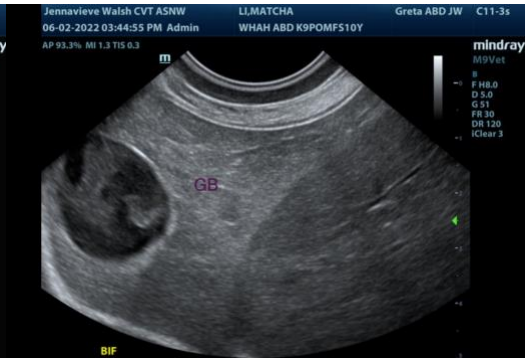

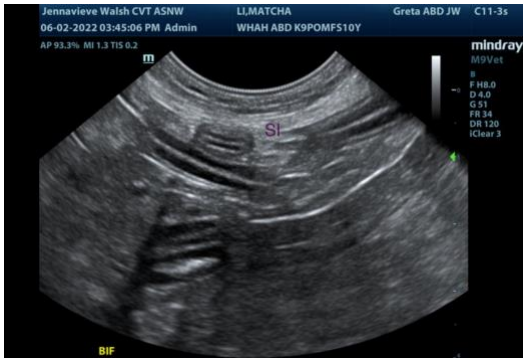

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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