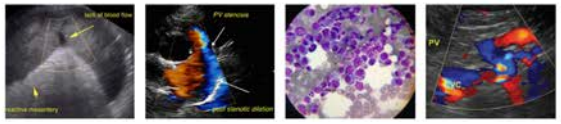


PATIENT

Farley Hoefel

SPECIES

Canine

BREED

Saint Bernard

SEX

Neutered Male

AGE

4/7/17

WEIGHT

147.6 Pounds

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 Veterinary Associates

REFERRING VET

Dr. Jen Brogie

INVOICE

38413

DATE

6/6/22

PRESENTING CLINICAL SIGNS

Chronic diarrhea - currently okay, about two soft cow patty bowel movements per day
Dull hair coat
Previously diagnosed IBD at rDVM (Massachusetts)
Was on prednisone, switched to budesonide
Had about 20lb weight loss when moved to Charleston (Feb 2022), but has since regained and weight is stable
Hx grade II/VI cardiac murmur (appreciated intermittently; echo diagnosed increased aortic outflow velocity and mild aortic stenosis)

April 2022
Lymphopenia (445)
Hypoalbuminemia (2.4) - improved from previous 1.7 (Feb 2022)
Hypocalcemia (8.0)
TT4 <0.5

Budesonide 5mg SID, Hills z/d, fortiflora SA, B12 injections

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 distended. A scant amount of suspended echogenic debris is observed within the lumen. 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 prostate is normal in size and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

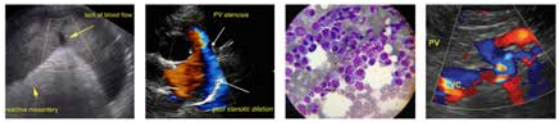
The left kidney presented normal size (8.85 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. Pyelectasia is present at 0.26 cm in the longitudinal plane. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney presented normal size (8.73 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.62 cm at cranial pole) (0.56 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 normal size (1.30 cm at cranial pole) (0.79 cm at caudal pole) (3.19 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.



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Spleen

The spleen is normal in size (3.1 cm) with a normal capsular contour. The parenchyma is subtly mottled in appearance. No focal lesions are observed. Splenic vasculature is normal.

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 is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No cholelithsare observed. The cystic and common bile ducts are normal.

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 small intestinal lumen is segmentally fluid distended (mild). 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 or overt infiltrative disease is noted.

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 peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

Other

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

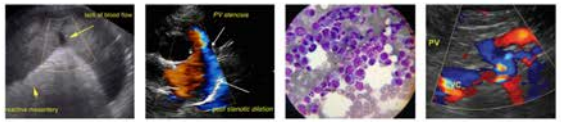
PRIMARY FINDINGS

- An obvious cause for the patient's clinical signs is not identified in this study. However, given the clinical history, a protein losing enteropathy (i.e., inflammatory bowel disease, lymphangiectasia, infectious/parasitic disease). An underlying metabolic issue (i.e., hypoadrenocorticism) also cannot be completely excluded.

SECONDARY FINDINGS

- The mild pyelectasia in the left kidney may be secondary to pyelonephritis, age related remodeling, PU/PD (if applicable), other.

- The splenic parenchyma changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, antigenic stimulation, or splenitis with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).



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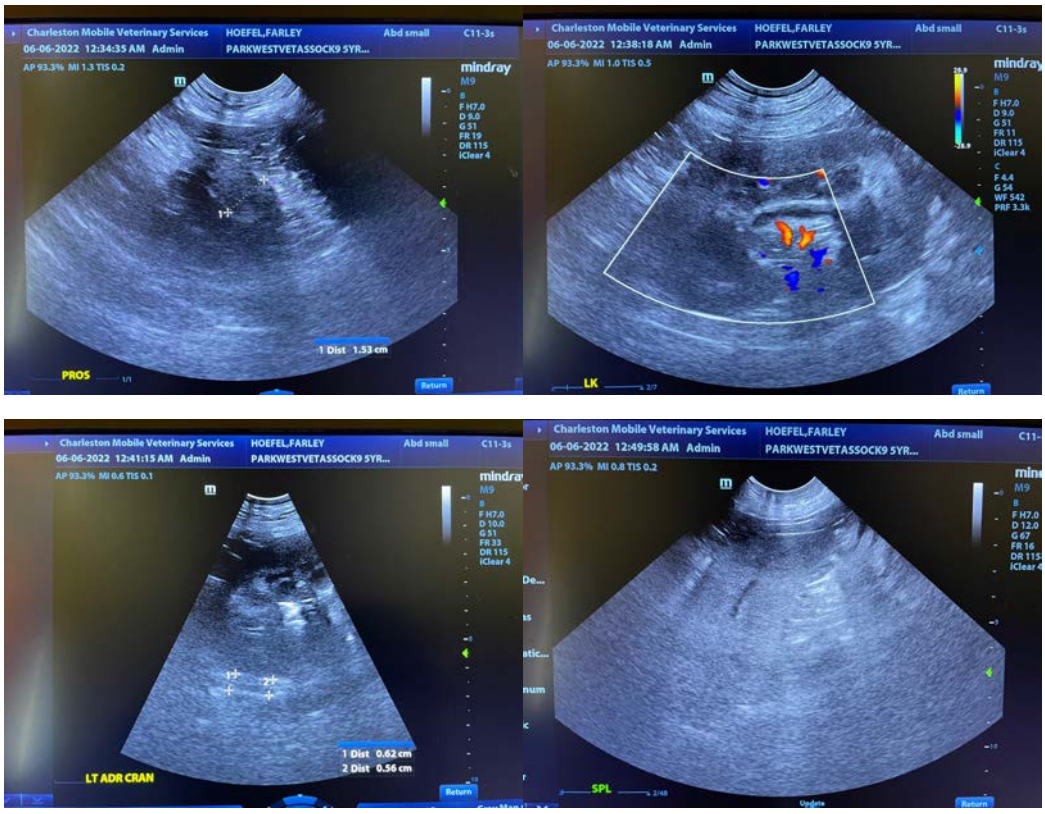
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended.
- Consider a recheck cobalamin level in 2-3 weeks to see if continued supplementation is warranted.
- Ultimately, GI biopsies (i.e., endoscopic or surgical may be necessary to get a definitive diagnosis. If biopsies are not pursued, consider switching from Budesonide to Prednisone to attempt better regulation of the GI signs.
- Regarding the pyelectasia, consider a urinalysis +/- culture and sensitivity to assess for occult infection.

To further evaluate for concurrent causes of hypoalbuminemia, consider the following:

1) Pre- and post-prandial serum bile acids
2) UPC (if proteinuria is present).



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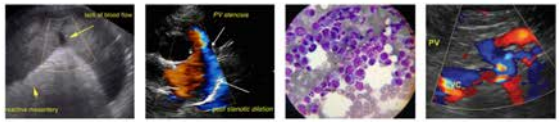

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IMAGING PERFORMED BY
CharlestonMobile.Net 800.403.5408

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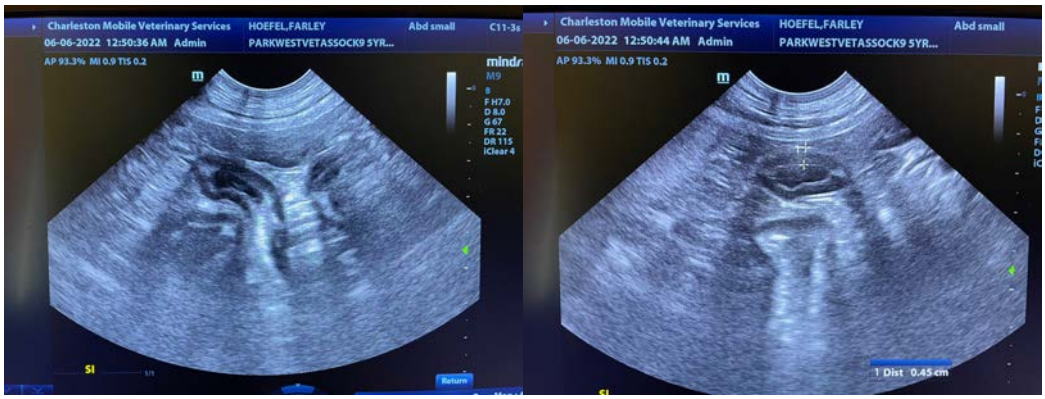

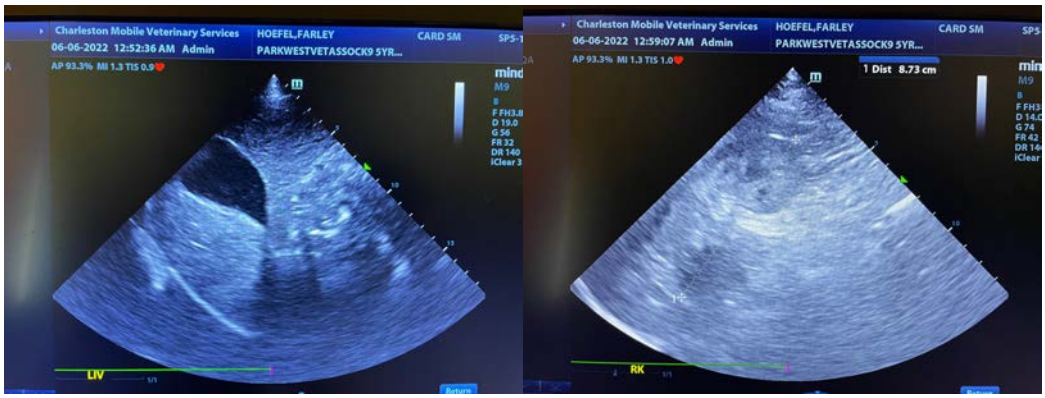

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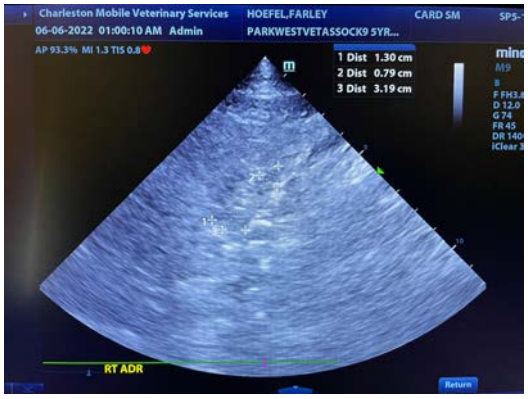

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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@CharlestonMobile.net