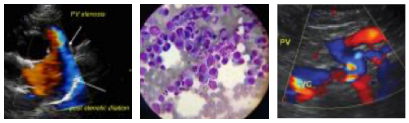
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
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DATE

7.10.2022

PATIENT

Dobby Inemer

SPECIES

Canine

BREED

Rat Terrier Mix

SEX

Neutered Male

AGE

26.3 lbs

WEIGHT

2008

INTERPRETED BY

Andrea Nicastro, DMV, Diplomate DACVIM (Small Animal Internal Medicine)

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Dr. Nacke-Horney

INVOICE

11213

PRESENTING CLINICAL SIGNS

Presenting Complaint: Appetite Decreased. Attack – Dog. Vomiting.
History: Date: 07-09-2022 Notes: Past 2-3 days started eating grass and had decrease appetite and drinking Had 2 episodes of vomiting today - did not eat anything and was lethargic Was on a walk tonight and a GSD off leash ran after patient to attack him - owner noted torn dew claw Owner noted that switched him to bravecto a few weeks ago that caused an upset stomach Known sensitive stomach - on GILF - recently been feeding chicken and rice Produce stool that was dark in color and formed Current meds: - Apoquel SID as needed

Assessment: Vomiting. Hyporexia. Diarrhea. Torn declaw.
Current Medications: buprenorphine, maropitant, protonix
Lab Results: Attached.
BUN 30. ALP 338. ALT 182. CBC Unremarkable.
Radiographs: decreased detail noted- thickened/inflamed intestines; still has bunched appearance in the cranial abdomen- not normal- but not 100% obstructive
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

Imaging Performed By: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** wall is 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 **prostate** is not definitively visualized due to its pelvic location.

The **left kidney** is normal size (5.24 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. Several, small cortical cysts are seen. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The **right kidney** is normal size (5.64 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. A few, small cortical cysts are seen. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The **left adrenal gland** is normal size (0.68 cm at cranial pole) (0.65 cm at caudal pole) (2.12 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 mildly enlarged (0.63 cm at cranial pole) (0.73 cm at caudal pole) (2.63 cm in length); with a normal shape and smooth peripheral contours. A 0.64 x 0.54 cm hypoechoic nodule is observed at the caudal pole. The remaining glandular echogenicity and detail are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen
The **spleen** is prominent in size (0.27 cm in width at the level of the hilus) with normal curvilinear peripheral contours. The parenchyma is subtly mottled in appearance. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver
The **liver** is subjectively prominent in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and heterogenous in appearance with several, ill-defined hypoechoic nodules, the largest measuring 1.28 cm in length. In addition, several, ill-defined hyperechoic nodules/areas are seen, the largest measuring 2.29 cm in length. Hepatic vasculature and intrahepatic 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 scant amount of echogenic debris is 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 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. There is no evidence of an obstructive pattern.

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 clinical signs is not identified in this study. Considerations include primary gastrointestinal disease (i.e., food allergy/intolerance, inflammatory bowel disease, infectious/parasitic disease, dietary indiscretion), mild pancreatitis, underlying metabolic issue, other.

Secondary Findings

- 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.

- Age-related pancreatic remodeling with suspected fibrosis. Concurrent chronic pancreatitis is also possible, particularly if the patient exhibits pain on cranial abdominal palpation.

- Bilateral, chronic renal changes with small cortical cysts

- The hypoechoic right adrenal nodule could be consistent with an emerging tumor. Alternatively, benign nodular hyperplasia may be present.

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

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

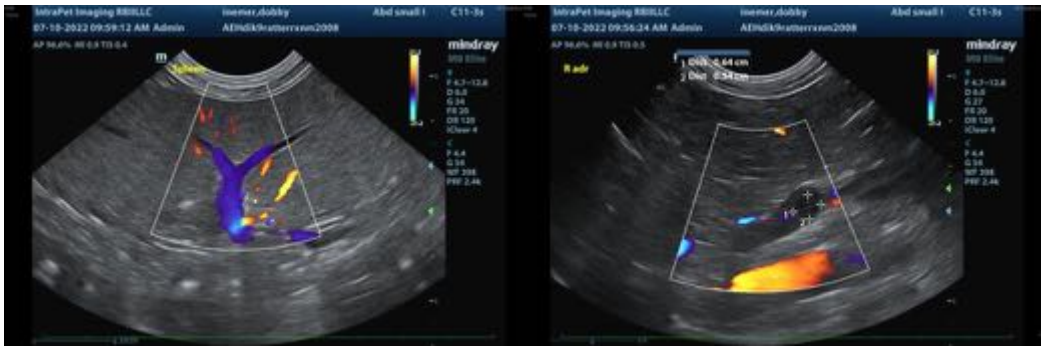
- Consider a malabsorption panel, including serum cobalamin and folate, TLI and PLI, as well as a fecal evaluation for ova and Giardia.

- Prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.

- When the patient's appetite improves, consider transitioning to a limited antigen diet.

- Consider a fine-needle aspirate of the spleen to help rule out lymphoma as a possible underlying cause for the patient's underlying signs.

- Ultimately, endoscopic or surgical GI biopsies may be necessary to get a definitive diagnosis. In the meantime, supportive care is recommended.



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.

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