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Clinical Sonography & Telecytology
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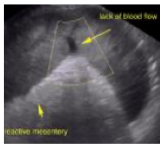
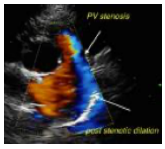
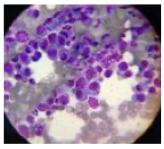
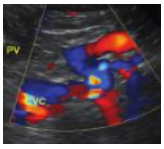

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Hudson Jacobson

SPECIES

Canine

BREED

Mixed Breed

SEX

Neutered Male

AGE

2 years

WEIGHT

8.2 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Frank Antonopoulos

HOSPITAL NAME

Vet Emerg Group Nanuet

REFERRING VET

Frank Antonopoulos

INVOICE

13757

DATE

7.20.23

PRESENTING CLINICAL SIGNS

History: Hudson presented today for vomiting and diarrhea. His radiographs and bloodwork were non-specific, but he has continued to vomit and regurgitate after administration of multiple gastroprotectants. He is to be hospitalized until clinical signs improve or an abdominal ultrasound can be performed. On physical exam, Hudson is QAR-H, with mm pink/moist and CRT <2s. Heart and lungs auscult WNL, with no murmurs/arrhythmias, no crackles/wheezes. Abdomen was soft, non-painful however Hudson was lick-licking and hard swallowing on palpation. Soft stool on rectal. Normal ambulation, with no M/S or Neuro deficits.

Abnormal PE/Chem/CBC/UA Results: CBC: HCT 57.3%, mild leukocytosis characterized by neutrophilia, thrombocytopenia (blood smear showed 5 PLT/HPF, considered adequate PLTs) -Chemistry: ALT mildly elevated (137) -PCV/TS 40%/7.4 -Lactate: 1.9

Radiologist Conclusions: Suspect enterocolitis. There are no signs of gastrointestinal mechanical obstruction or foreign body at the moment. Treatments LRS 60mL/hr Cerenia 1mg/kg IV q24h Ondansetron 0.5mg/kg IV q12h Pantoprazole 1mg/kg IV q24 Sucralfate 0.5G PO in slurry q8h

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (0.60 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal in size (4.01 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. The cortex is isoechoic relative to the spleen. There is minimal loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. Trace pyelectasia is present. Several mineralized foci are visualized. There is no evidence of infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal in size (4.58 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. The cortex is isoechoic relative to the spleen. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.44 cm at cranial pole) (0.43 cm at caudal pole) with a normal shape, smooth peripheral margins, and normal internal architecture. The cortex is isoechoic relative to the spleen. There is minimal loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

The right adrenal gland is in normal size (0.40 cm at cranial pole) (0.37 cm at caudal pole) with a normal shape and 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 (1.34 cm in width at the level of the hilus) with a normal capsular contour. The parenchyma is subtly mottled in appearance. No focal lesions are observed. Splenic vasculature is normal.

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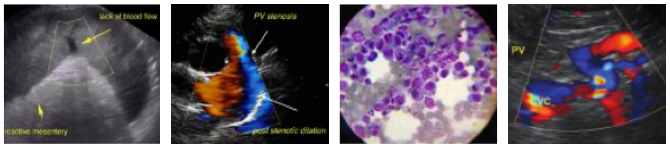

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Liver

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. Luminal contents are anechoic. 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 mildly 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 not dilated. The small intestinal wall is normal in thickness 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 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

There is no obvious evidence of free fluid. A few prominent mesenteric lymph nodes are visualized (the largest measuring 1.40 x 0.39 cm). The nodes are normal in shape and echogenicity.

ULTRASONOGRAPHIC FINDINGS

Findings

- The diffuse splenic changes are non-specific and could be consistent with lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.
- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.
- Bilateral mild nonobstructive nephrocalcinosis

*An obvious cause for the patient's clinical signs is not definitively identified in this study. Considerations include microscopic gastrointestinal disease (i.e., acute gastroenteritis/esophagitis, infectious/parasitic disease, food allergy/intolerance, dietary indiscretion, inflammatory bowel disease), underlying metabolic issue, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A fecal evaluation for internal parasites is recommended along with prophylactic deworming with Fenbendazole.
- Consider a Texas GI panel including serum cobalamin and folate, TLI, PLI and resting cortisol levels, particularly if the patient's clinical signs become chronic in nature.
- Given the regurgitation, three-view thoracic radiographs are recommended to assess for esophageal disease and aspiration pneumonia.

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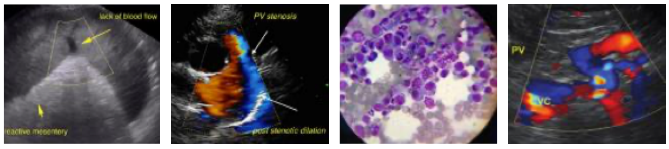

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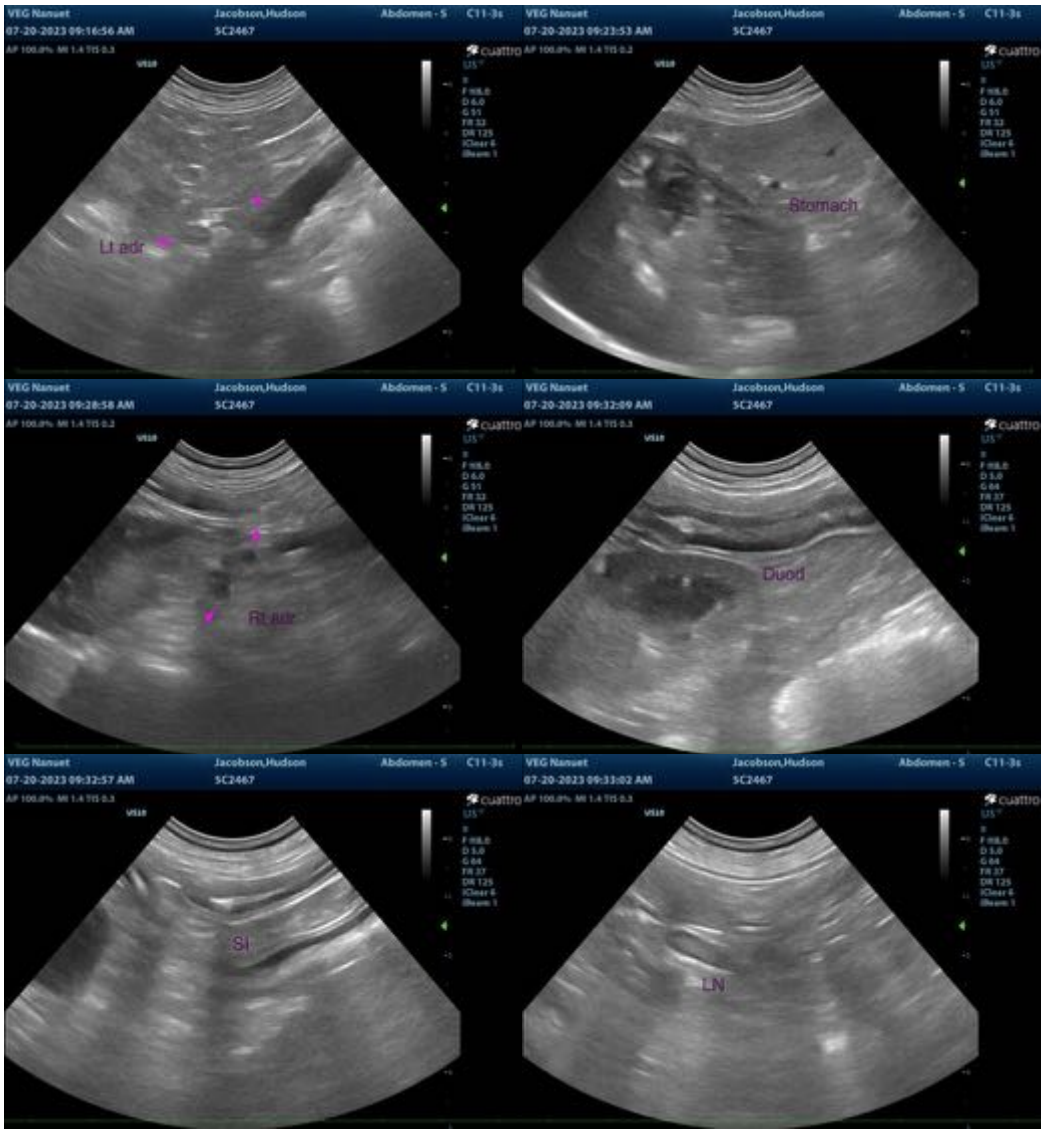
- While awaiting test results, continued symptomatic care for acute gastroenteritis is recommended.
- If the clinical signs do not improve with medical management, an upper GI endoscopy with biopsies may be necessary to get a definitive diagnosis.



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