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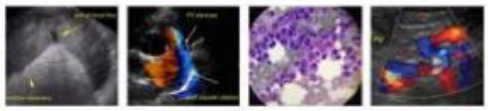


SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
1-800-838-4268 info@sonopath.com SonoPath.com

PATIENT

Molly Bodin

SPECIES

Canine

BREED

Silky

SEX

Spayed Female

AGE

15 years

WEIGHT

11.26 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Pamela Harrigan, RDCS

HOSPITAL NAME

Norfolk CO VS

REFERRING VET

Christina Poor, BVetMed

INVOICE

13775

DATE

7.20.23

PRESENTING CLINICAL SIGNS

History: Weight loss, pacing at night, v/d, DJD, controlled hypothyroid. On 1) Thyroxine 0.1g BID, 2) Amantadine 100 mg 1/4 SID 3) Galliprant 10 mg SID. *Sedated with Torb/Alfaxalone.

Abnormal PE/Chem/CBC/UA Results: AST 1.4, BUN 59, Phos 6.1, PSL 345.

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 mostly anechoic. No cystic calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The left kidney is normal in size (4.09 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 to moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. A few, small cortical cysts are seen. Trace pyelectasia is present (0.13 cm in the transverse plane). There is no evidence of infarcts or hydroureter.

The right kidney is normal in size (3.82 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 to moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. A few, small cortical cysts are seen. Mild pyelectasia is present (0.23 cm in the transverse plane). There is no evidence of infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal in size (0.44 cm at cranial pole) (0.49 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.

The right adrenal gland is in normal size (0.68 cm at cranial pole) (0.44 cm at caudal pole) with a normal shape and smooth peripheral contours. A 0.62 x 0.55 hypoechoic nodule is observed at the cranial aspect. Glandular echogenicity and detail at the caudal aspect are normal. The phrenicoabdominal vein and surrounding vasculature appear normal.

Spleen

The spleen is normal in size (1.31 cm in width at the level of the hilus) with a normal capsular contour. The parenchyma is mottled in appearance. A 1.09 cm hypoechoic-to-heterogenous nodule is observed at the medial aspect near the hilus. Splenic vasculature is normal.

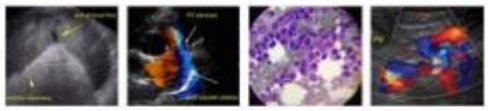
Liver

The liver is subjectively prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits mild heterogeneity. No distinct focal lesions are observed. Hepatic vasculature 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 moderate amount of gravity-dependent, echogenic-to-mineralized debris 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 mildly distended with ingesta. 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



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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 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 pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The splenic nodule could be consistent with an emerging tumor or a benign focus (i.e., lymphoid hyperplasia, inflammation, extramedullary hematopoiesis, other). The diffuse splenic parenchymal changes are nonspecific and may be secondary to lymphoid hyperplasia, extramedullary hematopoiesis, splenitis, antigenic stimulation, emerging neoplasia (i.e., lymphoma).

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.
- Mineralized gall bladder debris – incidental
- The right adrenal nodule could be consistent with a tumor (i.e., adenoma, adenocarcinoma, pheochromocytoma), inflammatory focus, granuloma, other.
- Bilateral chronic age-related renal changes with dystrophic mineralization, cortical cysts and pyelectasia.

*An obvious cause for the patient's vomiting, diarrhea and weight loss is not identified in this study. Considerations include microscopic gastrointestinal disease (i.e., food allergy/intolerance, infectious/parasitic disease, inflammatory bowel disease), underlying metabolic issue, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the splenic changes, consider fine-needle aspiration (if clotting status is appropriate). Twenty-five gauge-needles should be used. Particular attention should be paid to the nodule at the medial aspect.
- Regarding the gastrointestinal signs, consider the following:

1. Fecal evaluation for internal parasites
2. Prophylactic deworming with Fenbendazole

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3. Texas GI panel including serum cobalamin and folate, TLI, PLI and resting cortisol level.
4. Limited antigen or hydrolyzed protein diet trial
5. Consider initiation of a probiotic with a high colony count, as well as a fiber supplement (i.e., psyllium).
6. Ultimately, endoscopic or surgical GI biopsies may be necessary to get a definitive diagnosis.

- Regarding the weight loss, consider three-view thoracic radiographs to assess for occult disease in the chest.

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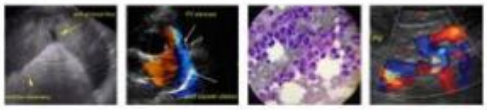

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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