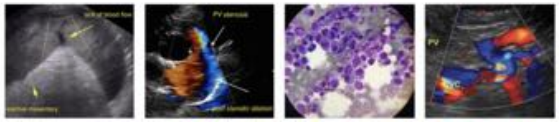


PATIENT

Hefner Bakst

SPECIES

Canine

BREED

Yorkshire Terrier

SEX

Neutered Male

AGE

2/6/07

WEIGHT

4 kg

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

Blue Pearl Mt Pleasant

REFERRING VET

Graham

INVOICE

11240

DATE

7.21.22

PRESENTING CLINICAL SIGNS

Clinical Exam Findings
Problem List: Vomiting r/o primary GI, secondary GI, open

Previous problems:
1. Anorexia, Dry heaving, Borborygmus
2. Ingested meloxicam 3.5 mg 3-4 doses over the past 2-3 days (last dose 7/16 PM or 7/17 AM)
3. Historical Hypothyroidism
4. Historical Cushing's
5. Historical proteinuria
6. Historical chronic ear infections
7. Historical increased BUN, isosthenuria

Abnormal lab-work values
Diagnostics: PCV/TS: 43/6.2 (improved from PCV 7/18 was 36/6). BUN: 31 (H, better than this morning at 32). Creat 0.7 (WNL). Snap cPL: abnormal

Current Medications: cerenia, omeprazole, sucralfate
Radiographic Findings Assessment:
The thorax appears within normal limits.
There is a redundant dorsal trachea membrane in the cervical region that can be incidental or associated with dynamic airway disease.
The hepatomegaly may be associated with the implied hyperadrenocorticism.
The gastrointestinal appearance is consistent with gastroenteritis but not for an underlying cause. Considerations include dietary indiscretion, dietary sensitivity, bacterial or parasitic enteritis, inflammatory bowel disease, systemic disease, and infiltrative intestinal disease. Ultrasound or endoscopy could be considered for further assessment as needed.
Multilevel intervertebral disc disease is present. Shoulder, elbow, and femoropatellar degenerative changes are noted.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

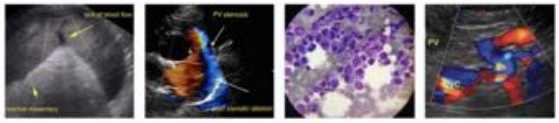
The **urinary bladder** and visible portion of the pelvic urethra are normal for the degree of luminal distension. The urine is anechoic with no evidence of debris. The cystourethral junction is normal.

The **prostate** is normal in size (0.92 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The **left kidney** is normal size (3.91 cm in length); with a slightly irregular shape. The cortex is diffusely thickened. There is moderate loss of corticomedullary distinction. Moderate pyelectasia is present (0.35 cm in the transverse plane). There is no evidence of nephroliths or hydroureter. Renal vasculature is normal.

The **right kidney** is normal size (4.20 cm in length); with a slightly irregular shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. A few, small cortical cysts are seen. Trace pyelectasia is present. There is no evidence of nephroliths or hydroureter. Renal vasculature is normal.

Adrenal Glands



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The **left adrenal gland** is enlarged (0.50 cm at cranial pole) (0.74 cm at caudal pole) (1.66 cm in length); with a slightly irregular shape. The parenchyma is mildly heterogenous with loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature appear normal.

The **right adrenal gland** is enlarged (0.84 cm at cranial pole) (0.86 cm at caudal pole); with a slightly irregular shape. The parenchyma is subtly heterogenous with some loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The **spleen** is normal in size (0.94 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 vasculature is normal.

Liver

The **liver** is prominent in size with normal curvilinear peripheral contours. The parenchyma is slightly mottled 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. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The **gastric lumen** is not distended. The gastric wall thickness is difficult to determine due to excessive rugal folds, but is subjectively thickened, with retention of the 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 ileocecocolic junction and colonic wall are 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 slightly 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.

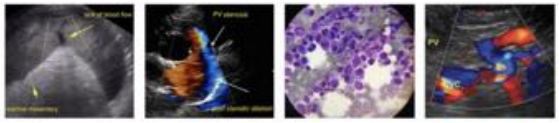
Other

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

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.



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- Subjective, mild gastric wall thickening. This may be a normal variant for this patient, artifactual due to excessive rugal folds or indicative of underlying pathology (i.e., inflammatory or less likely, infiltrative neoplasia).

Secondary Findings

- The bilateral adrenomegaly is consistent with the previous diagnosis of pituitary-dependent hyperadrenocorticism.
- The hepatic parenchymal changes are nonspecific and may be secondary to concurrent hepatopathy, regenerative nodular hyperplasia, age-related remodeling or some combination thereof. Infiltrative neoplasia is possible but considered less likely. Correlation with the patient's liver values is recommended.
- Bilateral, chronic age-related renal changes with pyelectasia, more pronounced in the left kidney.

*An obvious cause for the patient's clinical signs is not identified in this study. Considerations include primary gastrointestinal disease (i.e., inflammatory bowel disease, food allergy/intolerance, infectious/parasitic disease), underlying metabolic issue, mild pancreatitis, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the history of recent NSAID administration, continued empirical treatment for GI ulceration is recommended.

Also consider the following:

1. A fecal evaluation for ova/Giardia
2. Prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.
3. Administration of a probiotic with a high colony count (i.e., Proviable Forte)

If the patients GI signs are chronic and/or intermittent, the following diagnostics/treatments may be warranted:

1. Serum cobalamin, folate, PLI and TLI
2. 6-week limited antigen diet trial to assess for food allergies.
3. 4-week course of Tylosin as empirical treatment for small intestinal bacterial overgrowth.
4. +/- Endoscopic or surgical gastrointestinal biopsies. Three-view thoracic radiographs should be performed prior to any anesthetic event.

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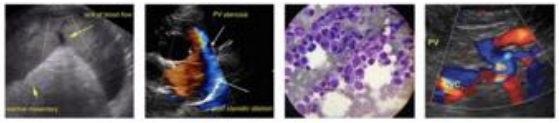

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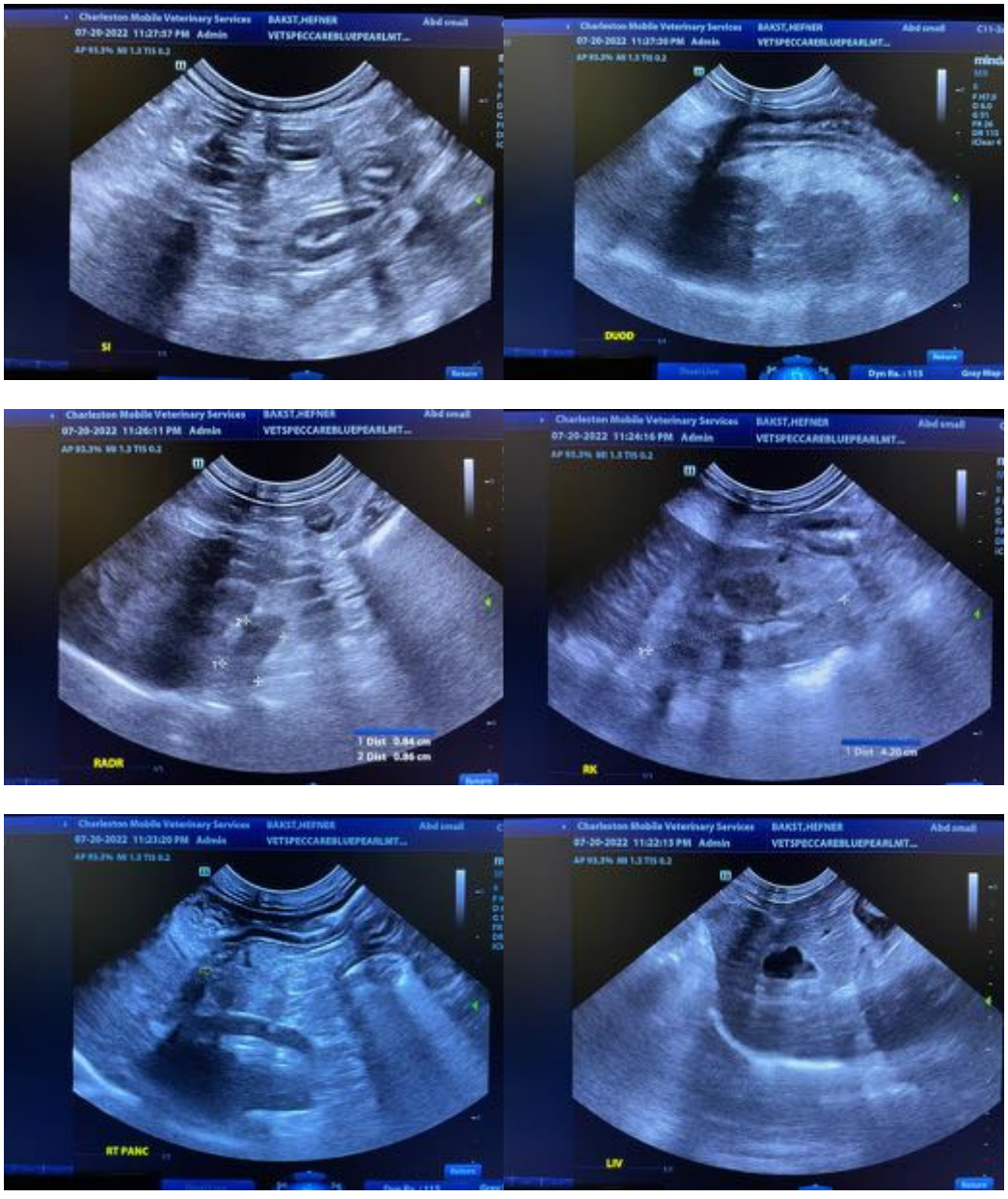

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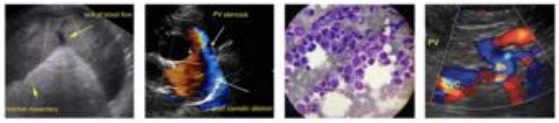

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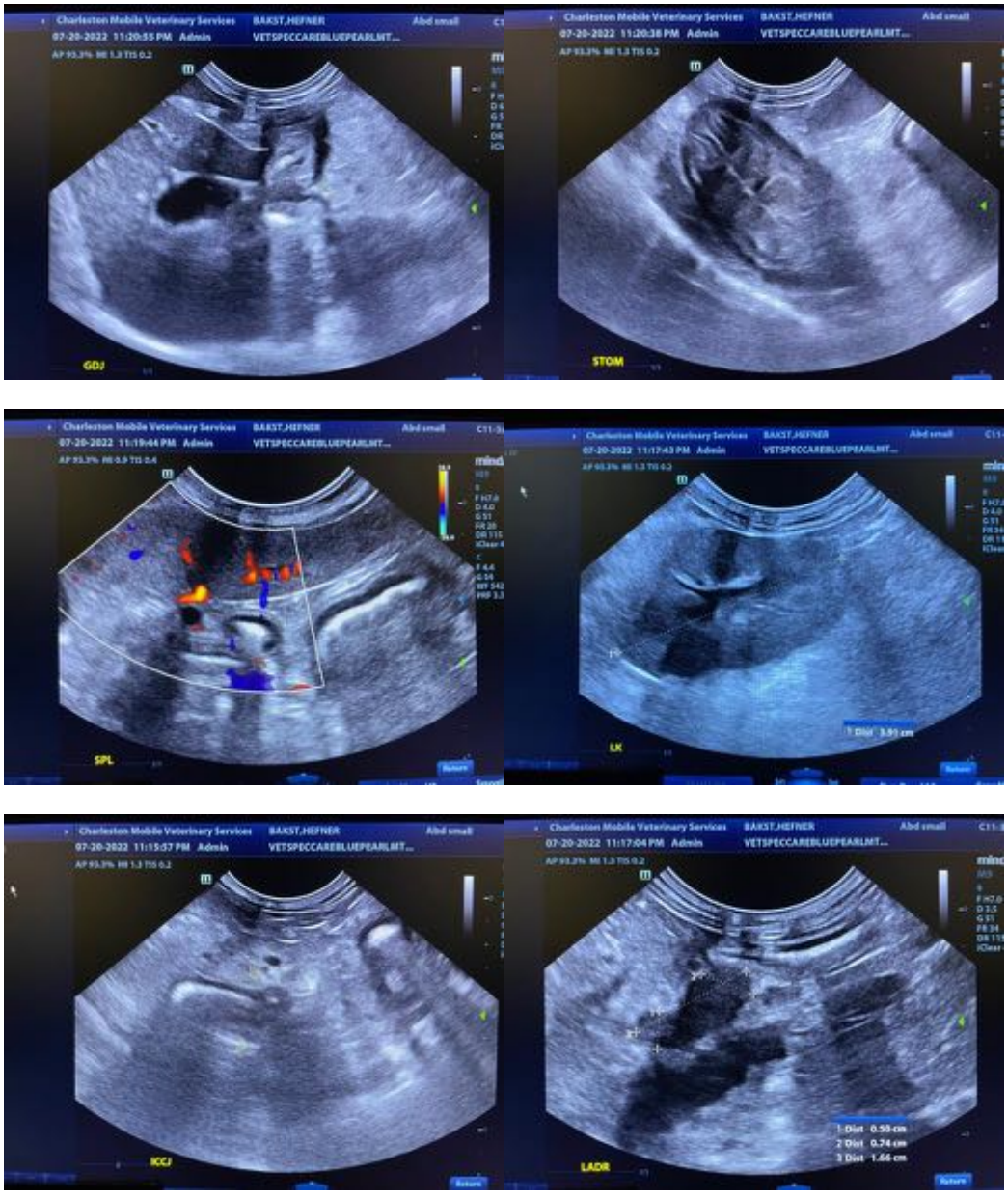

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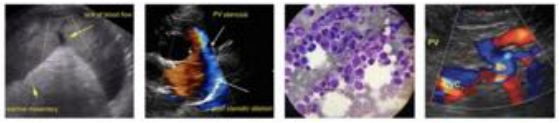

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com