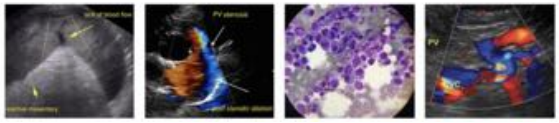


PATIENT

Princess Winn

SPECIES

Canine

BREED

Toy Poodle

SEX

Spayed Female

AGE

1.25.2006

WEIGHT

12.14 lbs

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

Flowertown AH

REFERRING VET

Dr. Kline

INVOICE

11274

DATE

7.28.22

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Suspected IBD previously well managed on HA, but lately has been having more intermittent vomiting/diarrhea. Baseline lab-work is unremarkable. PSL is elevated. USG 1.019. No proteinuria.

Radiographic Conclusions/Recommendations from 7/2:
1. Mild diffuse small intestinal dilation, most suggestive of enteritis and functional ileus. Although it is considered much less likely, partial mechanical obstruction from radiolucent foreign material cannot entirely be excluded.
2. The appearance of the colon is consistent with diarrhea/colitis and reported history.
3. The amorphous soft tissue opacity within the stomach may represent residual ingesta or nonobstructive foreign material.
4. Normal thorax including the cardiac silhouette. An echocardiogram is recommended to further evaluate the reported cardiac murmur if not recently performed.
5. Multifocal mineralized nodular changes within the dorsal subcutaneous space. Benign etiology is likely.
6. Spondylosis deformans at L7-S1, likely incidental.

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 **left kidney** is normal size (3.72 cm in length); with a slightly irregular shape. The cortex is thickened. There is moderate loss of corticomedullary distinction. Hyperechoic shadowing diverticular foci are visualized. Mild trace pyelectasia is present (0.21 cm in the longitudinal plane). There is no evidence of hydroureter. Renal vasculature is normal.

The **right kidney** is normal size (4.03 cm in length); normal shape and with smooth peripheral contours. The cortex is thickened. There is moderate loss of corticomedullary distinction. Hyperechoic shadowing diverticular foci are visualized. Mild trace pyelectasia is present (0.19 cm in the longitudinal plane). There is no evidence of hydroureter. Renal vasculature is normal.

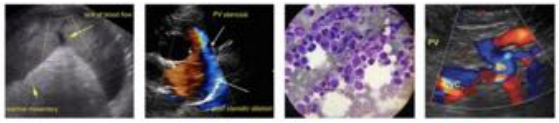
Adrenal Glands

The **left adrenal gland** is enlarged (0.81 cm at cranial pole) (0.78 cm at caudal pole) (1.78 cm in length); with a slightly irregular shape. The parenchyma is slightly heterogenous with some loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature are normal.

The **right adrenal gland** is enlarged (2.04 cm at cranial pole) (1.00 cm at caudal pole) (3.18 cm in length); with an irregular shape; heterogenous parenchyma. A 1.16 cm hyperechoic nodule is observed at the cranial pole. There is loss of glandular detail. Surrounding vasculature are normal.

Spleen

The **spleen** is normal in size (1.10 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A 0.97 x 0.88 cm irregular, hypoechoic nodule is observed approximately mid-organ. A 0.61 cm irregular, cystic lesion is also observed at the lateral aspect.



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Liver

The **liver** is subjectively prominent in size with slightly irregular peripheral contours at the caudal aspect. The parenchyma is isoechoic relative to the spleen. A 1.78 cm cystic lesion is observed at the caudal aspect. The cyst causes capsular expansion. In addition, at least one, small, ill-defined hyperechoic nodule/area is observed. 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. 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 not 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 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 **pancreas** is diffusely prominent to enlarged with slightly irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and mottled in appearance. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated.

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

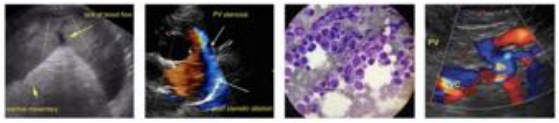
- The pancreatic changes are consistent with chronic +/- active pancreatitis.
- Bilateral adrenomegaly, more pronounced in the right adrenal gland. Differentials include bilateral hyperplastic change versus hyperplasia on the left with an emerging tumor on the right.
- The diffuse hepatic changes are 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.
- Bilateral, chronic, age-related renal changes with dystrophic mineralization and mild pyelectasia

Secondary Findings

- The splenic nodules could be consistent with benign processes. Alternatively, emerging tumors are possible.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the patient's worsening GI signs, consider the following:



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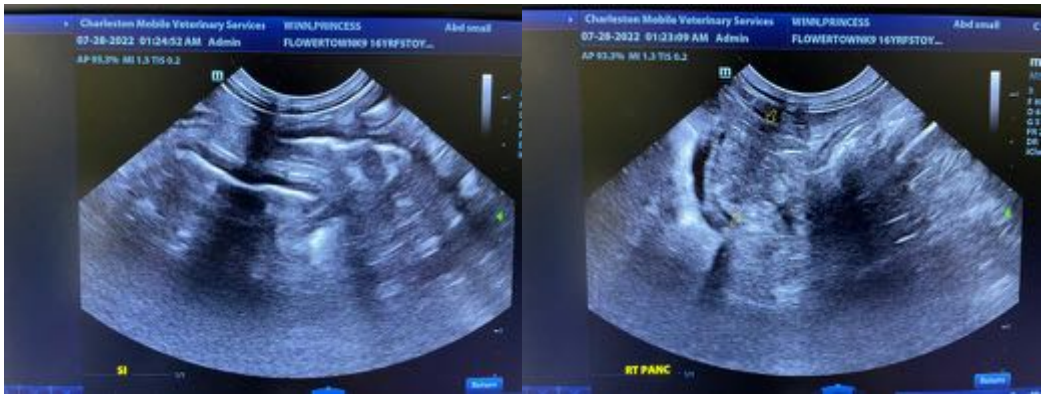
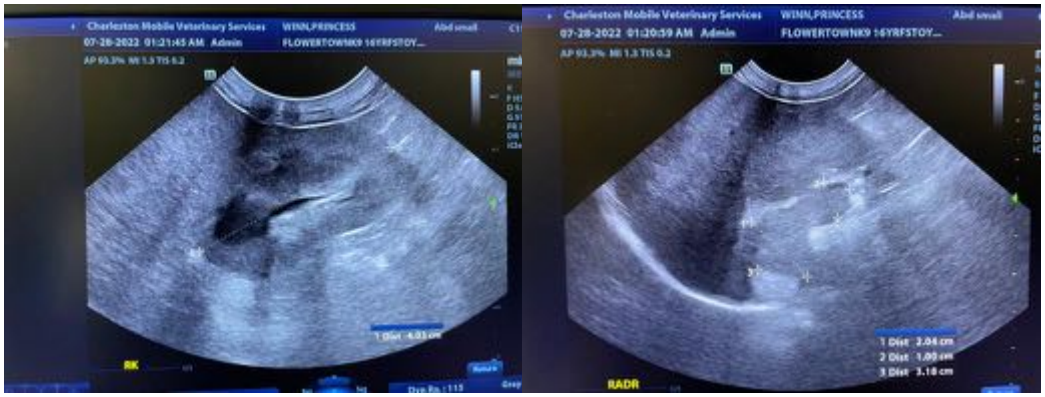
1. Fecal evaluation for ova and Giardia
2. Prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.
3. Malabsorption panel, including serum cobalamin and folate, TLI and PLI
4. Consider switching to a different hypoallergenic diet in case the patient has developed an allergy to the current food.
5. Consider empirical treatment for small intestinal bacterial overgrowth with a 4-week course of Tylosin, along with initiation of a probiotic with a high colony count (i.e., Proviable Forte or Visbiome).
6. Ultimately, endoscopic, or surgical gastrointestinal biopsies may be necessary to get a definitive diagnosis. However, the patient's age and the benefits of the procedure should be weighed against the risks. Thoracic radiographs should be considered be performed prior to any anesthetic event.

Consider testing for hyperadrenocorticism with a low-dose dexamethasone suppression test or ACTH stimulation test if clinical signs (i.e., PU/PD) develop.

Also consider a recheck sonogram in 4-6 weeks to reassess the splenic nodules.





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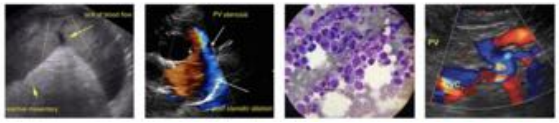

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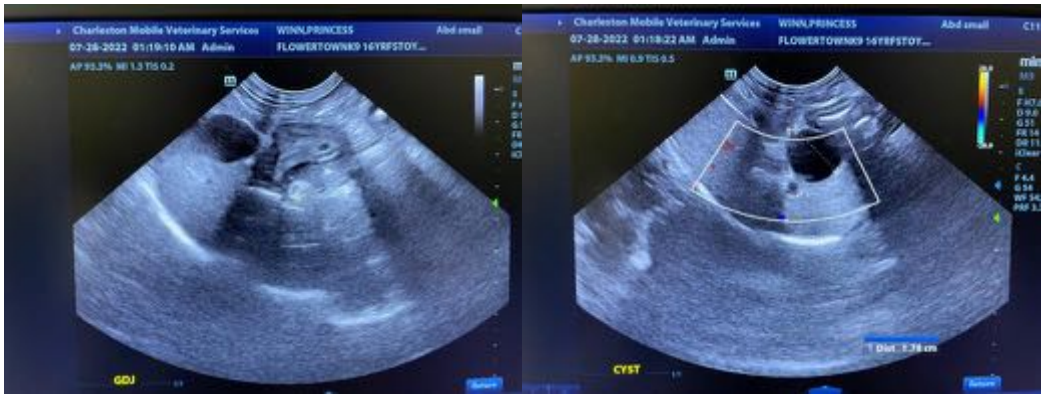

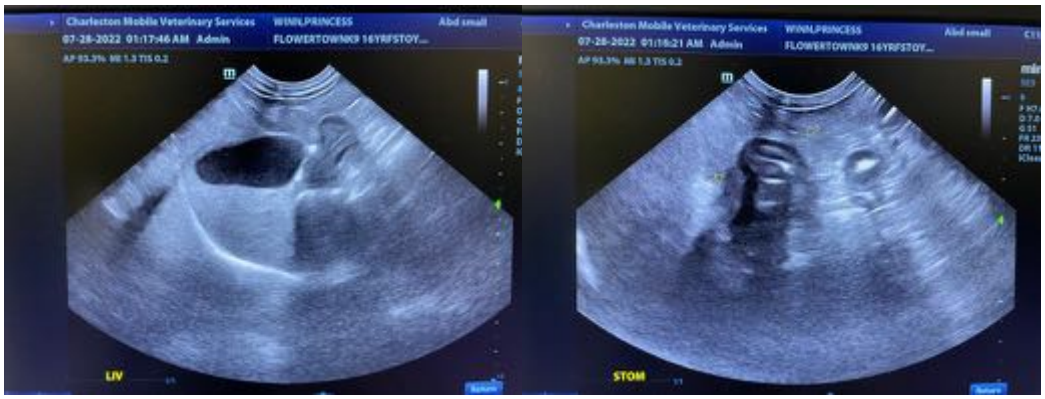

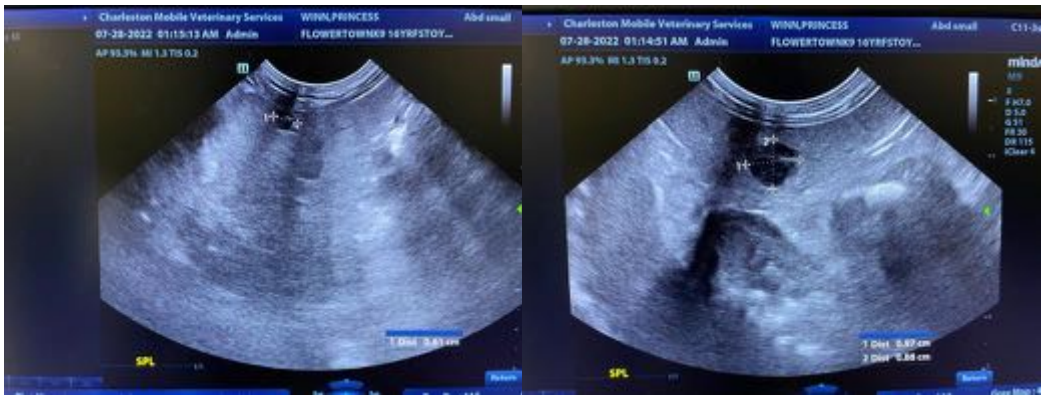

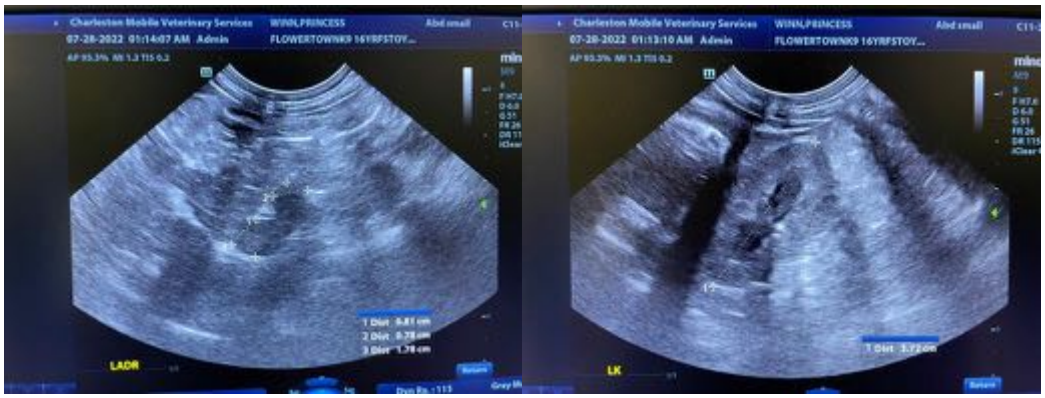

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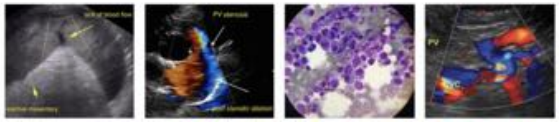

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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