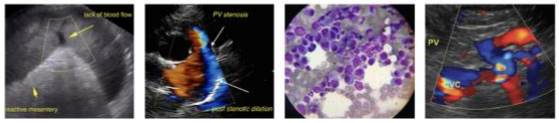


PATIENT

Keegan Harvey

SPECIES

Canine

BREED

Lab

SEX

Spayed Female

AGE

2.11.2011

WEIGHT

35.5 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

Courtenay Freeman

INVOICE

11287

DATE

7.29.22

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Keegan was transferred to the Neurology/Neurosurgery service on the 29th of July for evaluation of pelvic limb weakness. She has a long history of mild pelvic limb weakness. Keegan was acutely weak in her right pelvic limb yesterday. She was evaluated by her veterinarian and referred for further evaluation. She has a history of diabetes for about 5 years, a right TL birth defect, arthritis, and possible early glaucoma. She is partially blind in the left eye.

She is currently on the following medications: Vetsulin 27 units (0.77 u/kg BID), Carprofen, Dasuquin, Apoquel, Fish Oil SID, Dorzolamide OU, Latanoprost in left eye BID. She is otherwise healthy.

Mentation: bright, alert, responsive
Gait: ambulatory without assistance, paraparetic with pseudohypermetria (reduced hock flexion)
Postural reactions: mildly delayed in both PL
Reflexes: reduced withdrawal in both PL
Cranial nerves: reduced menace response OS (historical)
Sensory: nonpainful
Neuroanatomic localization: L6-S1 myelopathy

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 mostly 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 (7.84 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. Pinpoint hyperechoic foci are observed within the cortex. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The **right kidney** is normal (7.95 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. Pinpoint hyperechoic foci are observed within the cortex. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

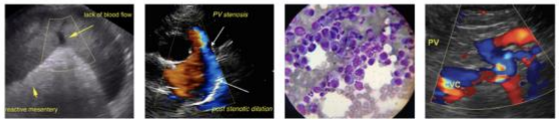
Adrenal Glands

The **left adrenal gland** is normal size (0.59 cm at cranial pole) (0.69 cm at caudal pole) (2.28 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 normal size (1.01 cm at cranial pole) (0.80 cm at caudal pole) (2.94 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.

Spleen

The **spleen** is subjectively normal in size (0.99 cm in width at the level of the hilus) with normal curvilinear peripheral contours. The parenchyma is of appropriate echogenicity. Pinpoint hyperechoic foci are observed throughout the organ. A few, ill-defined myelolipomas are observed in the region of



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the hilus. Splenic vasculature appears normal with no evidence of thrombosis.

Liver

The **liver** is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen with minor changes consistent with age-related remodeling. No focal lesions are observed. Hepatic vasculature and biliary tracts are of normal volume with no evidence of congestion.

The **gall bladder** is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. 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. The colonic lumen contains hard, shadowing fecal material throughout the organ. 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

A focal area of reactive mesentery is observed in the left cranial to midabdominal. Trace free fluid is observed. The abdominal **lymph nodes** are normal/not visible.

Other

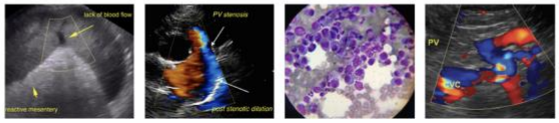
A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.

ULTRASONOGRAPHIC FINDINGS

- Mild focal peritonitis in the left cranial to midabdominal, the cause of which is unclear. It may be secondary to mild or resolving pancreatitis, low-grade gastroenteritis, other.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Minor, age-related/geriatric renal and hepatic changes
- Dystrophic mineralization of the spleen, likely secondary to diabetes mellites. This is a benign incidental finding.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Regarding the hind limb signs, further diagnostics and treatments are to be implemented by the overseeing neurologist.



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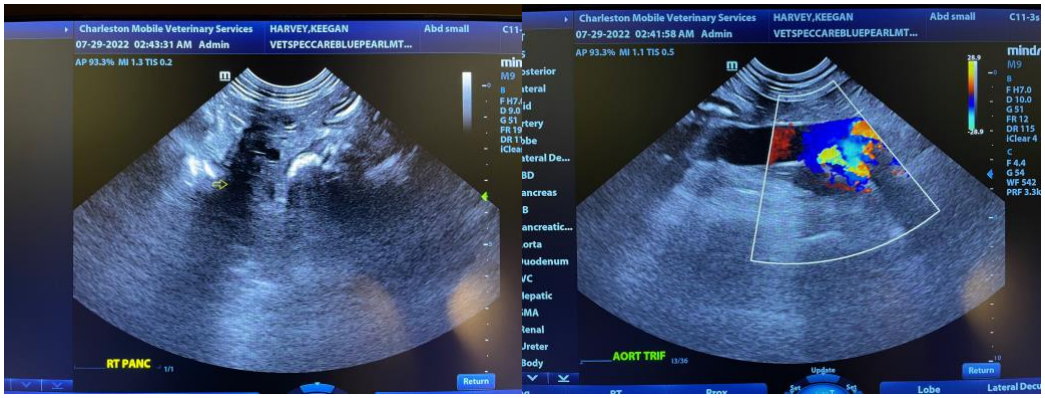
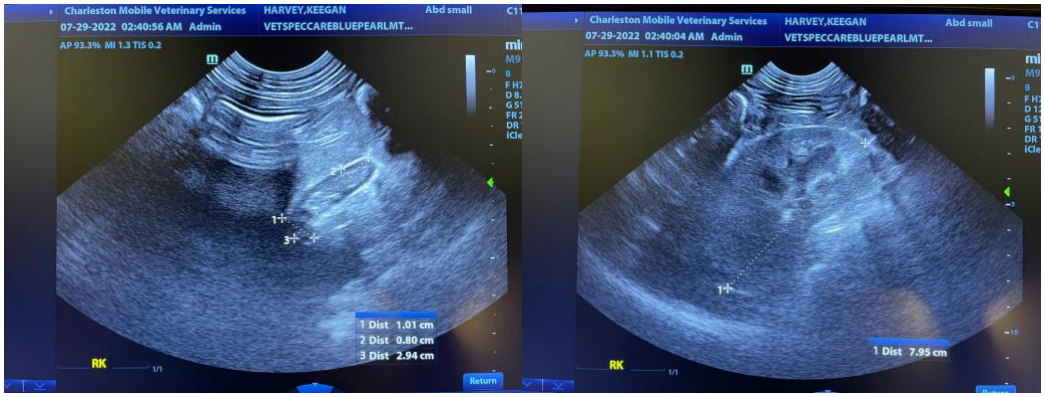
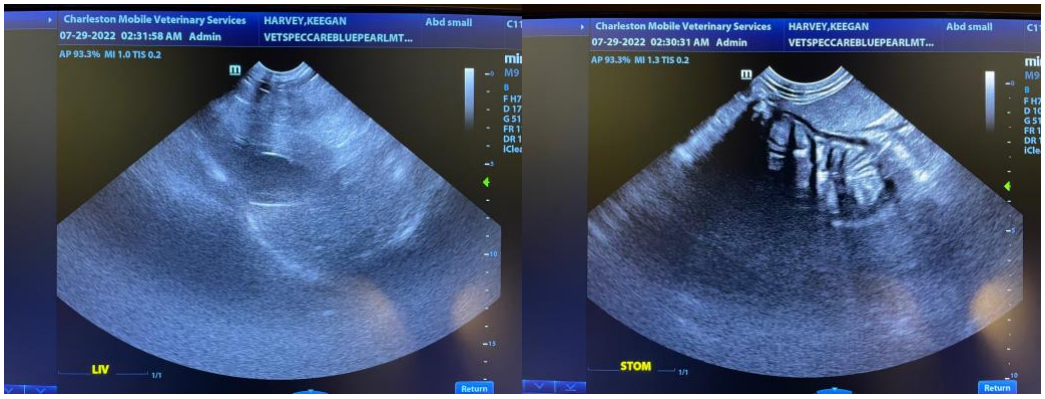
If the patient develops gastrointestinal signs, repeat abdominal imaging +/- further work-up may be warranted.







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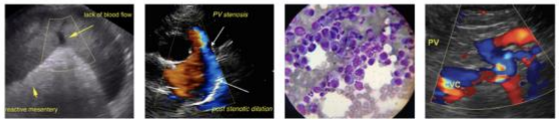

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IMAGING PERFORMED BY
CharlestonMobile.Net 800.403.5408

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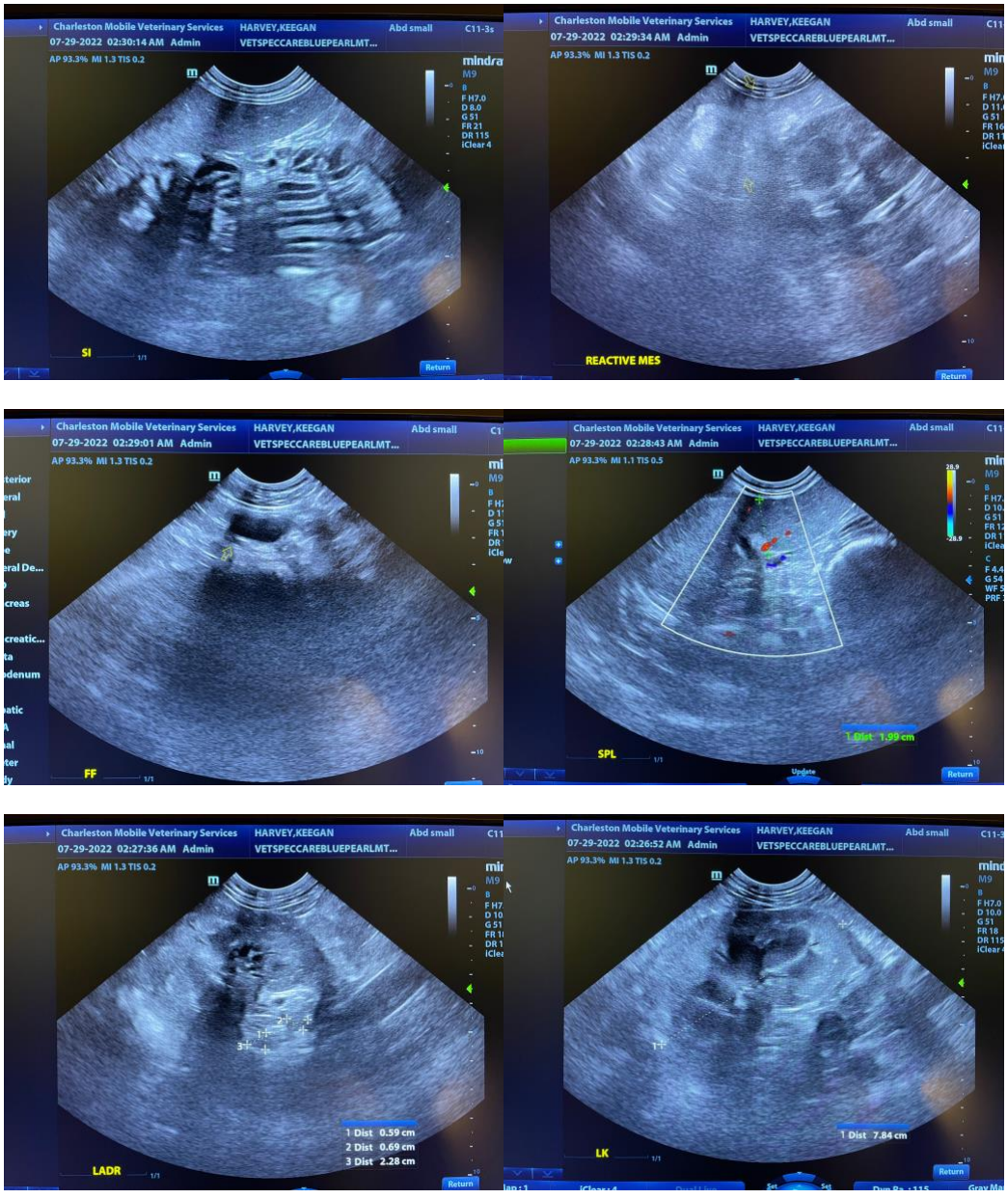

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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