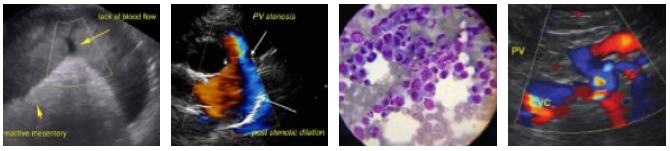

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1-800-838-4268 info@sonopath.com

PATIENT
Kini Del Valle

SPECIES
Canine

BREED
Toy Poodle

SEX
Female, intact

AGE
11 Yrs.

WEIGHT
7.4 lbs.

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

IMAGING PERFORMED BY
Dr. G. Ferrer

HOSPITAL NAME
Paseos VC

REFERRING VET
Dr. Fonseca

INVOICE
13500

DATE
7/6/22

PRESENTING CLINICAL SIGNS

History: Presented as a referral for an abdominal ultrasound. P presented to the EC with a 24-hour hx of vomit/bloody diarrhea + not as active as usual at home + currently on tx for Addison's dz. Lack of appetite in the past 48 hours. Hx of anal sac impaction (bilateral). Owner gave food with coconut oil + pumpkin and broccoli yesterday. Spoke with owner regarding the guarded/poor prognosis given renal values Tx: Hospitalization + IV Fluids + Unasyn + Metronidazole + Famotidine + Cerenia. PT is also on Zycortal and Prednisone
Abnormal PE/Chem/CBC/UA Results: Previous BW: CBC : NEU elevated WBC's total : wnl CHEM: BUN: elevated BUN/CREA ratio: high SDMA: elevated CHEM on 7-6-22 Ca+: 7.4 (7.9-12) TP: 4.3 (5.2-8.2) ALB: 1.8 (2.2-3.9) Chol: 99 (110-320) Amy: 358 (500-1500) Lipa: 354 (200-1800) CPL: normal

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. The region of the trigone and the visible portion of the proximal urethra are normal.

The left kidney is normal size (3.64 cm in length); normal 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. Pinpoint mineralized foci are visualized. Trace pyelectasia is present. There is no evidence of infarcts or hydroureter.

The right kidney is normal size (3.95 cm in length); normal 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The caudal pole of left adrenal gland is visualized and is small in size (0.23 cm in width) with a normal shape, glandular echogenicity and detail. Surrounding vasculature appears normal.

The caudal pole of the right adrenal gland is visualized and is small in size (0.22 cm in width) with a normal shape, glandular echogenicity and detail. Surrounding vasculature appears normal.

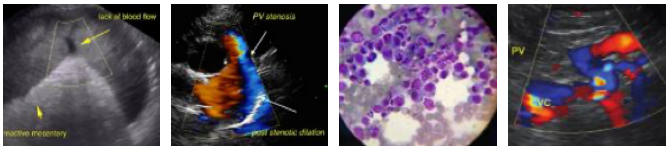
Spleen

The spleen is normal in size (0.98 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.

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 thickened (up to 0.15 cm) and hypoechoic with a “double-walled” effect. A small to moderate amount of aggregated partially dependent-to-suspended, echogenic debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal



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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 ileocecocolic junction and colonic wall are normal. The lumen of the descending colon contains shadowing fecal material. No obstructive disease is noted.

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

Trace free fluid is observed. The medial iliac lymph nodes are visualized, both measuring 0.87 cm in length. A 1.13 cm mesenteric lymph node is also seen.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The gallbladder wall changes could be secondary to hypoalbuminemia, increased hydrostatic pressure (i.e., secondary to congestive heart failure), anaphylaxis, cholecystitis, other. Given the patient's albumin, hypoalbuminemia is the most likely cause for this finding.

Secondary Findings:

- Bilateral, chronic, age-related renal changes with left non-obstructive nephrolithiasis.
- The small adrenal glands bilaterally are consistent with a previous diagnosis of hypoadrenocorticism.
- The splenic parenchyma changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, antigenic stimulation or splenitis with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.

*An obvious cause for the patient's clinical signs is not identified in this study. Considerations include primary gastrointestinal disease (i.e., dietary indiscretion, hemorrhagic gastroenteritis, infectious/parasitic disease, Addisonian crisis (less likely if patient has been given medications consistently), inflammatory bowel disease, food allergy/intolerance, other), low-grade pancreatitis, underlying metabolic issue, other.

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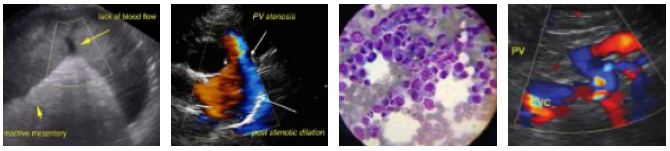

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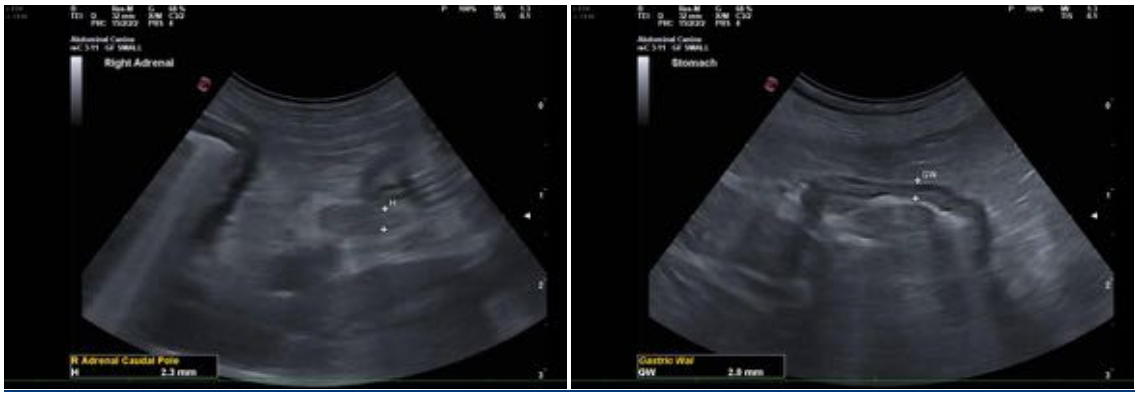
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A fecal evaluation for ova/Giardia
- Prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.
- Consider a malabsorption panel including serum cobalamin, folate, TLI and PLI.
- Consider Parvovirus testing, particularly if the patient is not vaccinated for the disease.
- Consider thoracic radiographs to assess cardiopulmonary status, particularly in light of the hypoalbuminemia and the risk of third-spacing fluids.
- Given the low albumin, consider pre- and post-prandial serum bile acids to assess for occult hepatic dysfunction as well as a UPC (if proteinuria is present).
- While awaiting test results, supportive care for hemorrhagic gastroenteritis is recommended. If the above diagnostics are inconclusive and the patient does not respond to supportive care within 48-72 hours, endoscopic or surgical gastrointestinal biopsies may be warranted.



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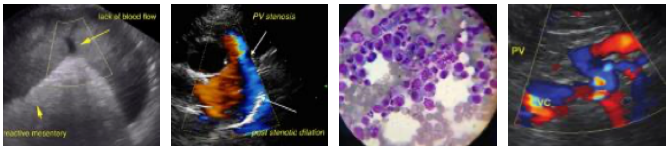

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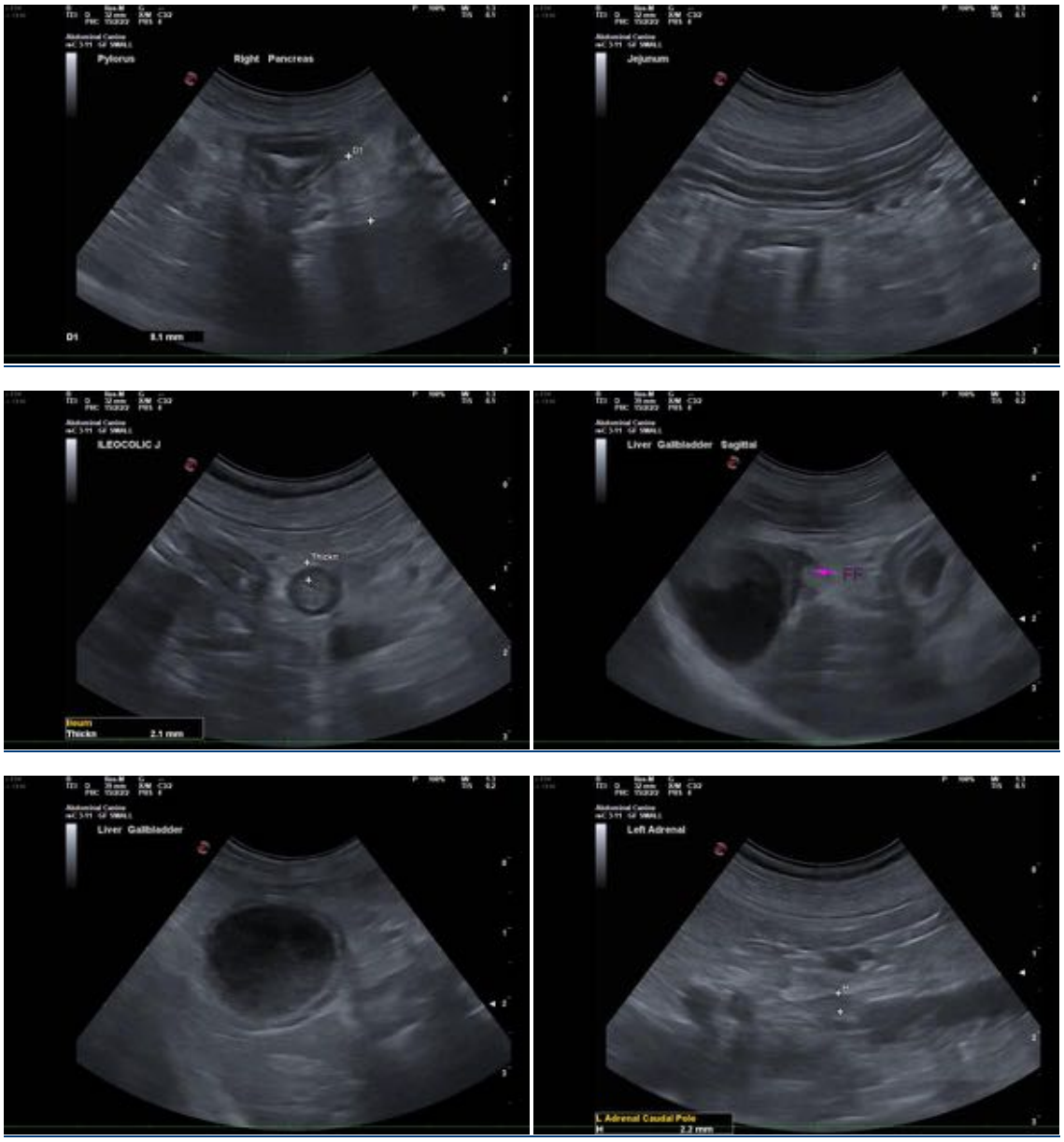

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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 ACVIM (*Small Animal Internal Medicine*)

Andrea.nicastro@sonopath.com