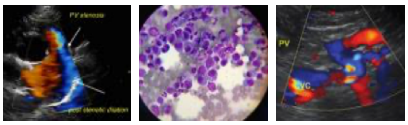
IMAGING PERFORMED BY

IntraPet.com



SonoPath
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DATE

8/10/22

PATIENT

Bruce Johnson

SPECIES

Canine

BREED

Chihuahua

SEX

9.6 lbs.

AGE

11/13/2008

WEIGHT

9.6 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Banfield Towson

REFERRING VET

Dr. Chadha

INVOICE

13817

PRESENTING CLINICAL SIGNS

Pet was presented for belly breathing and panting all day. Eating/drinking fine.

Current Medications: Trazodone, Gabapentin.
Lab Results: Mildly increased ALKP.
Radiographs: Chest- showed tall cardiac silhouette. Abdomen- show hepatomegaly and small linear foreign material in ventral abdomen.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Andi Parkinson BS, RDMS

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly to moderately distended. The wall is normal in thickness with a smooth mucosal surface. A small amount of gravity-dependent mineralized debris vs tiny calculi is observed within the lumen. The region of the trigone and the visible portion of the proximal urethra are normal.

The prostate is normal in size (0.76 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 (3.92 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. A hyperechoic medullary band is observed at the corticomedullary junction. A few small non-obstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (3.90 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. A hyperechoic medullary band is observed at the corticomedullary junction. Several small non-obstructive nephroliths are visualized. A small cortical cyst is observed at the medial aspect. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.49 cm at cranial pole) (0.48 cm at caudal pole) (1.97 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 borderline enlarged (0.55 cm at cranial pole) (0.53 cm at caudal pole) (1.27 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 normal in size (1.00 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 subjectively prominent in size with slightly swollen peripheral contours. The parenchyma is isoechoic relative to the spleen and subtly heterogeneous in appearance. A 1.65 x 1.28 cm ill-defined cystic area is observed on the left side. 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. A small amount of aggregated echogenic debris is observed within the lumen, most of which is adhered and some of which is suspended. 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. No obstructive disease is noted.

Pancreas

The base/right limb of the pancreas is visible with minimal deviation from the normal peripheral contours. The parenchyma is slightly hypoechoic relative to surrounding omental fat and subtly mottled in appearance. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated. The mesentery effacing the serosal surface is mildly hyperechoic.

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 could be consistent with mild acute or chronic active pancreatitis with age-related remodeling +/- fibrosis.
- 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. The left cystic lesion trends toward the benign with a lower possibility of an emerging vascular tumor.
- Gallbladder debris, non-mucocele.
- Mineralized urinary bladder sand vs tiny calculi.

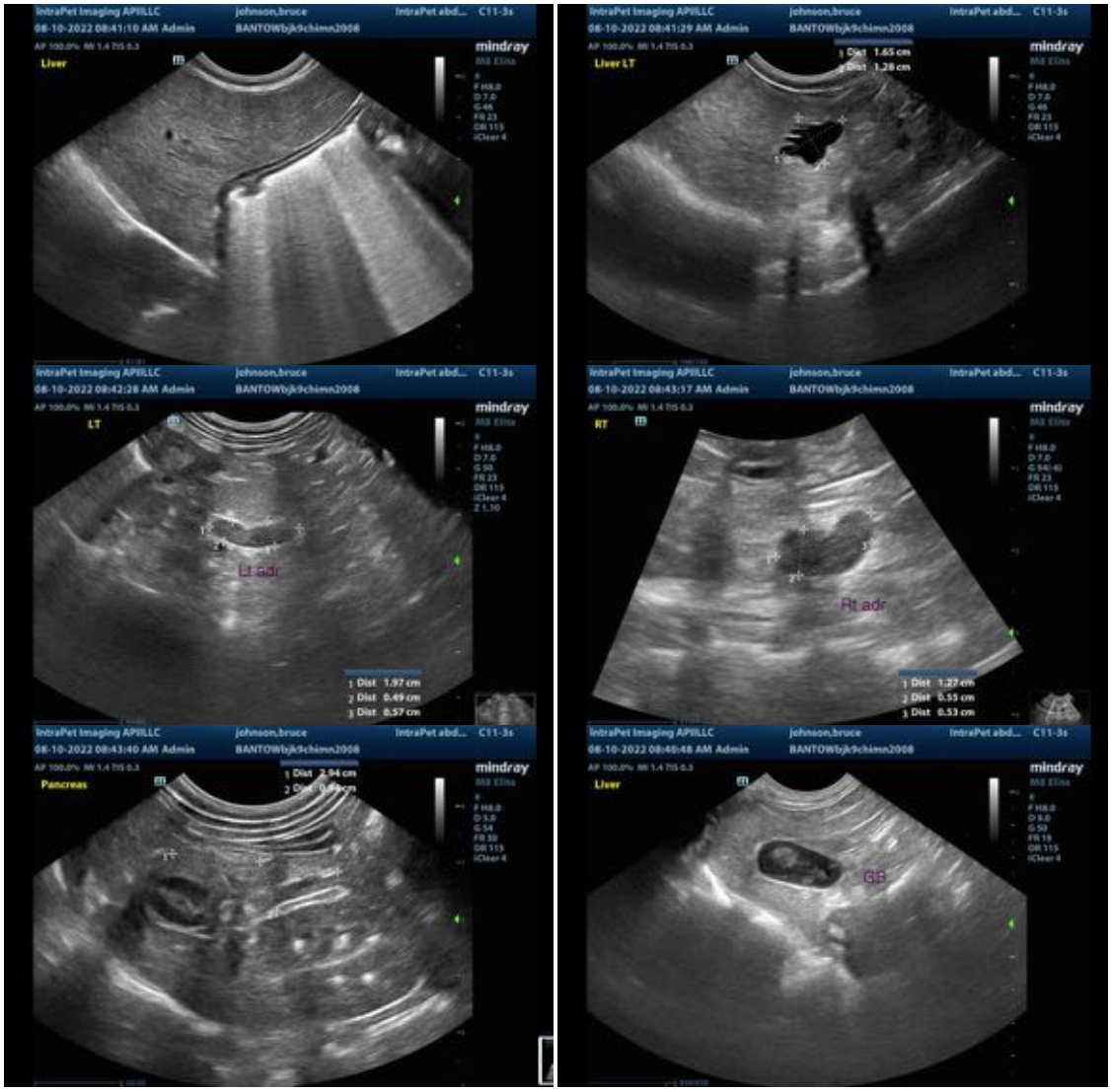
Secondary Findings:

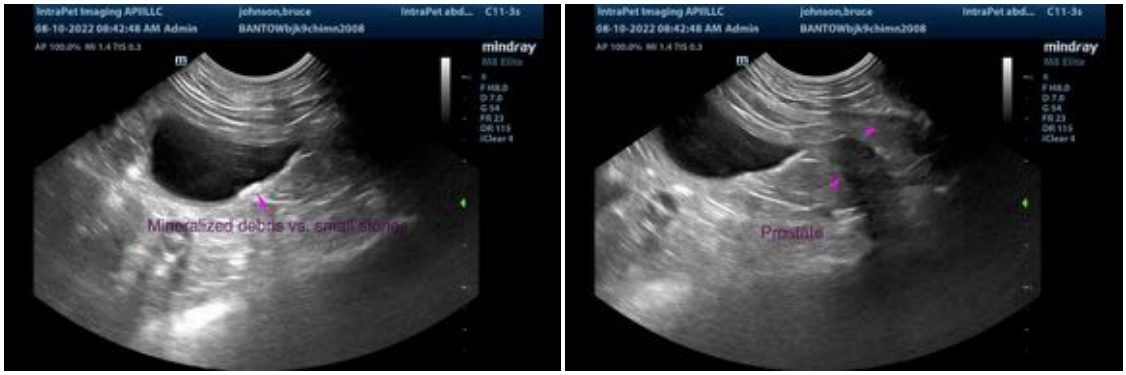
- Bilateral age-related degenerative renal changes with non-obstructive nephrolithiasis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the pancreatic changes, consider a cPLI to further assess for pancreatitis.
- Given the dyspnea and reported cardiac changes, consider an echocardiogram.
- Thorough orthopedic and neurologic examinations are also recommended to assess for non-metabolic causes of discomfort.

- Given the bilateral nephrolithiasis, a urinalysis +/- urine culture and sensitivity should be considered.
- While awaiting test results, supportive care for pancreatitis is recommended including fluid therapy (as needed), gastric protectants and pain medication.
- Given the mineralized debris in the urinary bladder, consider review of the abdominal radiographs for distinct calculi. If present, a cystotomy with stone removal analysis and culture can be considered when the patient's current condition has stabilized. Alternatively, an attempt at medical dissolution with prescription urinary diet and broad spectrum antibiotics can be considered.





The information and recommendations provided are based on the images presented by the referring veterinarian. 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)
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