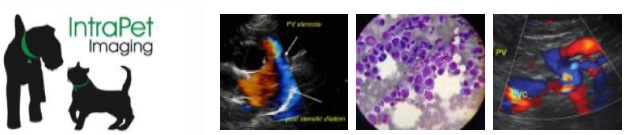
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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DATE

8/12/21

PATIENT

Daisy Jones

SPECIES

Canine

BREED

Yorkie

SEX

Female, spayed

AGE

2012

WEIGHT

10.8 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Banfield Towson

REFERRING VET

Dr. Lewis

INVOICE

11874

PRESENTING CLINICAL SIGNS

History: Presented 8/3/21 for distended abdomen.
PE: mm pink, slightly tacky; distended and tense on abdominal palpation with palpable fluid wave.
Current Medications: None
Lab Results: Chemistry: albumin 1.4; alkp < 10; CA 6.5; chol 55; TP 3.3. Panhypoproteinemic
CBC: platelet count 611. CPL WNL.
Radiographs: Thoracic and abdominal radiographs: thorax clear.
Abdomen: diffuse poor abdominal detail, free fluid present.
Date of Previous IntraPet Ultrasound: No previous
Sedation: Not needed.
Stat Report: Not requested/declined.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are 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 (3.59 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (3.66 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The region of the left adrenal gland is evaluated. No obvious pathology is observed.

The right adrenal gland is normal size (0.39 cm at cranial pole) (0.40 cm at caudal pole) (1.74 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 (1.04 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 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 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 is normal to mildly thickened (up to 0.44 cm) with a normal layering pattern. There is evidence of mucosal fogging and occasional

linear striations in some segments. Discreet masses are not identified. The colonic wall is normal. No obstructive disease is noted.

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 large amount of free fluid is present within the abdomen. A scant amount of echogenic debris is suspended within the fluid. The mesentery throughout the abdomen is hyperechoic and irregular. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

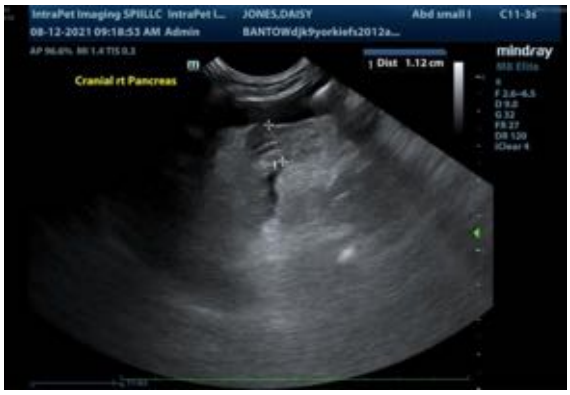
- The clinical history and sonographic changes are most consistent with a protein-losing enteropathy. Top differentials include inflammatory bowel disease, lymphangiectasia, infectious/parasitic disease and/or lymphoma.
- The ascites is likely secondary to low oncotic pressure.

Secondary Findings:

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the protein-losing enteropathy, consider the following:
    1. Serum cobalamin, folate, PLI and TLI
    2. A fecal evaluation for ova/Giardia
    3. Transition to a low-fat, hypoallergenic diet.
    4. Ultimately, endoscopic or surgical gastrointestinal biopsies would be necessary to get a definitive diagnosis.
- To assess for concurrent causes of hypoalbuminemia, consider the following:
    1. Pre- and post-prandial serum bile acids (to evaluate hepatic function).
    2. UPC
    3. A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended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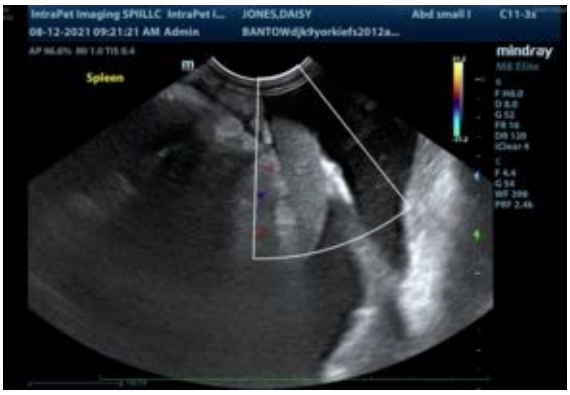
Cranial rt Pancreas
Dist 1.12 cm
mindray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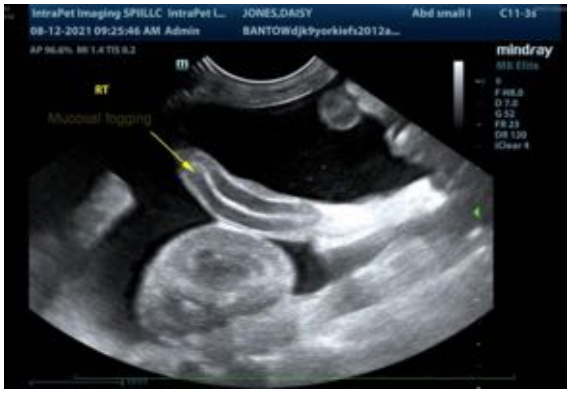
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RT
Mucosal tagging
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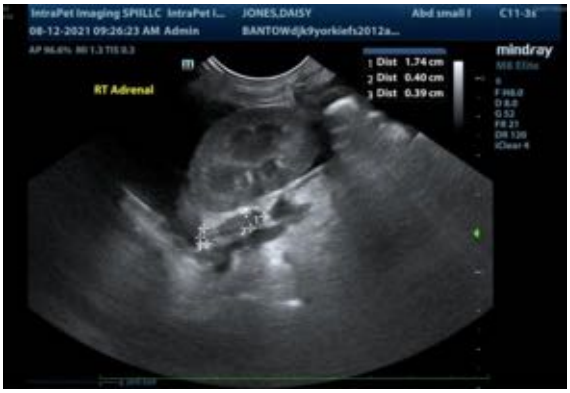
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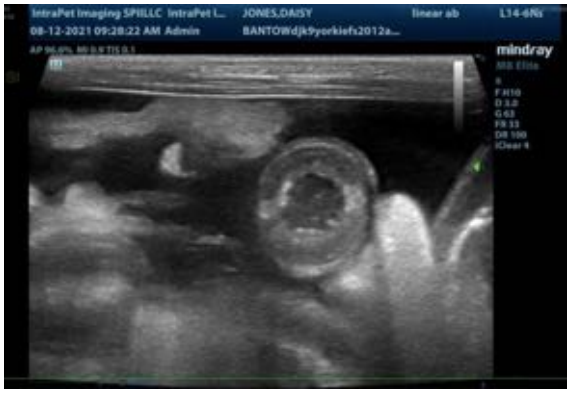
RT Adrenal
Dist 1.74 cm
Dist 0.40 cm
Dist 0.39 cm
mindray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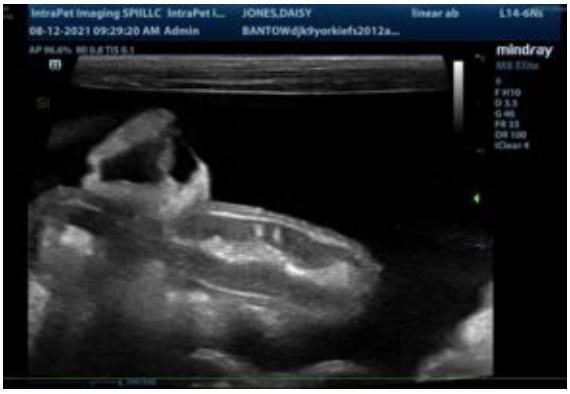
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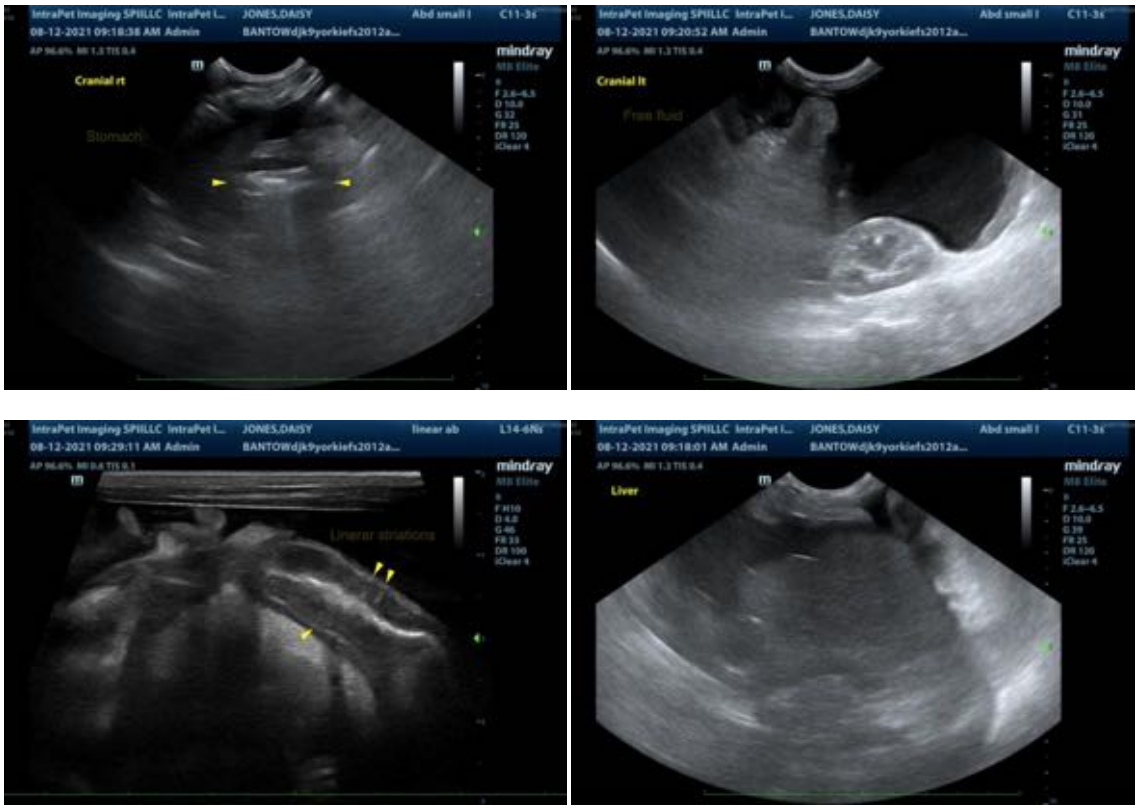

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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