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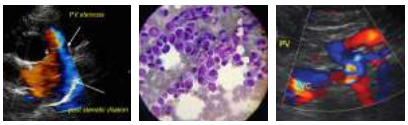

SonoPath
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DATE

8/13/21

PATIENT

Maya Koch

SPECIES

Canine

BREED

English Pointer

SEX

Female Spayed

AGE

6/27/13

WEIGHT

47.5 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Timonium Animal Hospital

REFERRING VET

Dr. Falkowski

INVOICE

11639kk

PRESENTING CLINICAL SIGNS

History: 8/10/21: Weight loss of 10.5lb since May. Vomiting for 2 weeks usually twice at night and once during the day. Having urinary accidents in house recently. No diarrhea. PE: BCS 4/9; severe muscle atrophy overhead, spine and hindlimbs bilaterally.

Current Medications: No current medications.

Lab Results: CBC: Mild normocytic, normochromic non-regenerative anemia (HCT 39.2%), Mild neutrophilia 14.34K/uL Ddx: inflammation, infection, neoplasia, stress, Severe eosinopenia 0K/uL Ddx: normal, stress, acute inflammation, Mild thrombocytosis 452K/uL Ddx: inflammation, rebound, stress. Chemistry: Mild hypocalcemia 8.2mg/dL Ddx: pancreatic disease, hypoparathyroidism, Cushing's, artifact, intestinal malabsorption. Moderate hypoproteinemia 4.4g/dL Ddx: maldigestion/malabsorption, liver disease, PLE, PLN, Severe hypoalbuminemia 1.5g/dL Ddx: liver disease, maldigestion/malabsorption, PLN, PLE, Albumin: Globulin Ratio 0.5 Ddx: liver disease, maldigestion/malabsorption, PLN, PLE. UA (cysto): USG 1.010, pH 6.5, inactive sediment. T4: 1.8ug/dL

Radiographs: Not provided by the veterinarian.

Date of Previous IntraPet Ultrasound: No previous IntraPet scans.

Sedation: Sedation not required for scan.

Stat Report: STAT report not requested by the veterinarian.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

The bowel examination is severely limited due to excessive gas and stool.

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 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 (6.74 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. At least two small cortical cysts are present. Hyperechoic, shadowing, diverticular foci are visualized. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (7.12 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.61 cm at cranial pole) (0.73 cm at caudal pole) (1.78 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 caudal pole of the right adrenal gland is well visualized and is normal size (0.75 cm in width) with a normal shape, glandular echogenicity, and detail. Surrounding vasculature appears normal.

Spleen
The spleen is normal in size (2.74 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. A small amount of suspended, echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal
The gastric lumen is moderately gas-distended. The gastric wall is normal in thickness with a normal layering pattern. The small intestinal lumen is diffusely distended with gas and chyme. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. The colonic lumen contains shadowing fecal material. There is no obvious evidence of obstruction.

Pancreas
The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

Free Abdomen
Trace free fluid is observed. One to two prominent mesenteric lymph nodes are visualized. The largest measures 2.97 cm in length.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

**An obvious cause for the patient's clinical signs is not identified in this study. Considerations include protein-losing enteropathy, hepatic dysfunction, and protein-losing nephropathy (less likely).

Secondary Findings:

- Minor, bilateral, age-related renal changes with dystrophic mineralization.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The trace ascites is likely secondary to low oncotic pressure.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. Further work up for protein-losing enteropathy is recommended including the following:
    a. A fecal evaluation for ova/Giardia
    b. A malabsorption panel including serum cobalamin, folate, PLI and TLI +/- endoscopic or surgical gastrointestinal biopsies.

c. Also consider transitioning to a low-fat hypoallergenic diet.

2. To further assess for other causes of hypoalbuminemia, the following diagnostics can be considered:

   a. Pre- and post-prandial serum bile acids to assess hepatic function.

   b. UPC (if proteinuria is present).

   c. A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended.

3. Three-view thoracic radiographs should be performed prior to any anesthetic event, particularly given the patient's low oncotic pressure and potential for third spacing of fluids.

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.

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