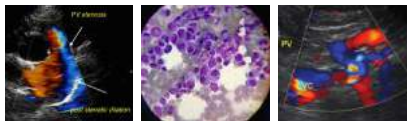
IMAGING PERFORMED BY

IntraPet.com



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DATE

8/13/21

PATIENT

Ouzo Oliphant

SPECIES

Canine

BREED

Labrador Retriever Mix

SEX

Male Neutered

AGE

3/18/09

WEIGHT

107.9 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Northwind Animal Hospital

REFERRING VET

Dr. Jones

INVOICE

11643kk

PRESENTING CLINICAL SIGNS

History: Patient has been having intermittent diarrhea since spring. Patient has loose stool for 3-4 days in a row then is fine and it resolves on its own. owner concerned about something more significant going on due to patient age

Current Medications: Carprofen 100mg PRN.

Lab Results: CBC/CHEM/T4: ALP 440 T4 0.89

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

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 prostate is upper limits of normal in size, but likely normal for the patient's weight (2.04 cm in width) with a normal shape and smooth peripheral contours. The parenchyma is homogenous. No focal lesions are observed. The prostatic urethra is not overtly dilated.

The left kidney is normal size (7.84 cm in length) with a slightly irregular shape. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (8.75 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is enlarged at the cranial pole and normal in size at the caudal pole (1.62 cm at cranial pole) (0.93 cm at caudal pole) (3.33 cm in length). A 1.73 x 1.49 cm hypoechoic nodule/mass is observed at the cranial aspect. Glandular echogenicity and detail at the caudal aspect are normal. The phrenicoabdominal vein and surrounding vasculature appear normal.

The caudal pole of the right adrenal gland is visualized and is small in size (0.37 cm in width) with a normal shape, glandular echogenicity, and detail. Surrounding vasculature appears normal.

Spleen

The spleen is normal in size (1.86 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 curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and subtly heterogeneous in appearance. No distinct focal lesions are observed. Hepatic vasculature and intrahepatic 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 moderate amount of echogenic debris is observed within the lumen, most of which is gravity-dependent and some of which is suspended and/or adherent. The cystic and common bile ducts are normal/not seen.

Gastrointestinal
The gastric lumen is distended with ingesta. 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
A portion of the pancreas is obscured by the gastric distension. In the visualized portion, no obvious pathology is observed.

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 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.

- Left adrenal nodule/mass. Differentials include adenoma, early adenocarcinoma, regenerative nodule, other. The small right adrenal gland may be due to atrophy (if the left adrenal nodule is functional). Alternatively, the right adrenal size may be normal for this patient.

Secondary Findings:

- Minor, age-related renal pathology.

**An obvious cause for the patient's chronic, intermittent diarrhea is not identified in this study. Considerations include primary gastrointestinal disease (i.e., food allergy, inflammatory bowel disease, infectious/parasitic, and other), low-grade pancreatitis, underlying metabolic disease, and other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. Given the left adrenal changes, three-view thoracic radiographs are recommended to assess for pulmonary metastatic disease. A baseline blood pressure measurement is also recommended.

2. To further assess for a functional tumor, consider a low-dose dexamethasone suppression test and urine/blood catecholamine levels.

3. Regarding the diarrhea, consider the following:

a. A fecal evaluation for ova/Giardia

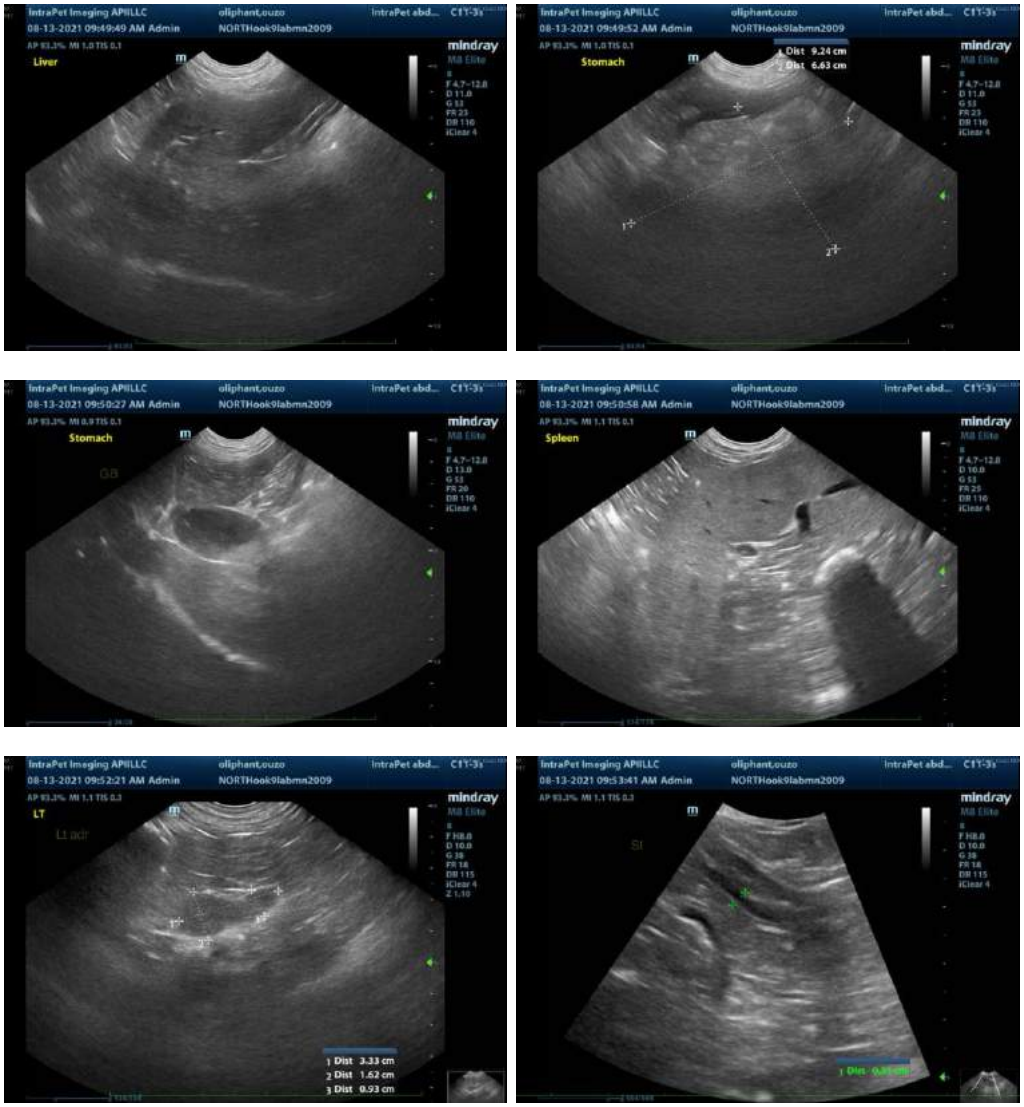
b. A malabsorption panel including serum cobalamin, folate, PLI and TLI.

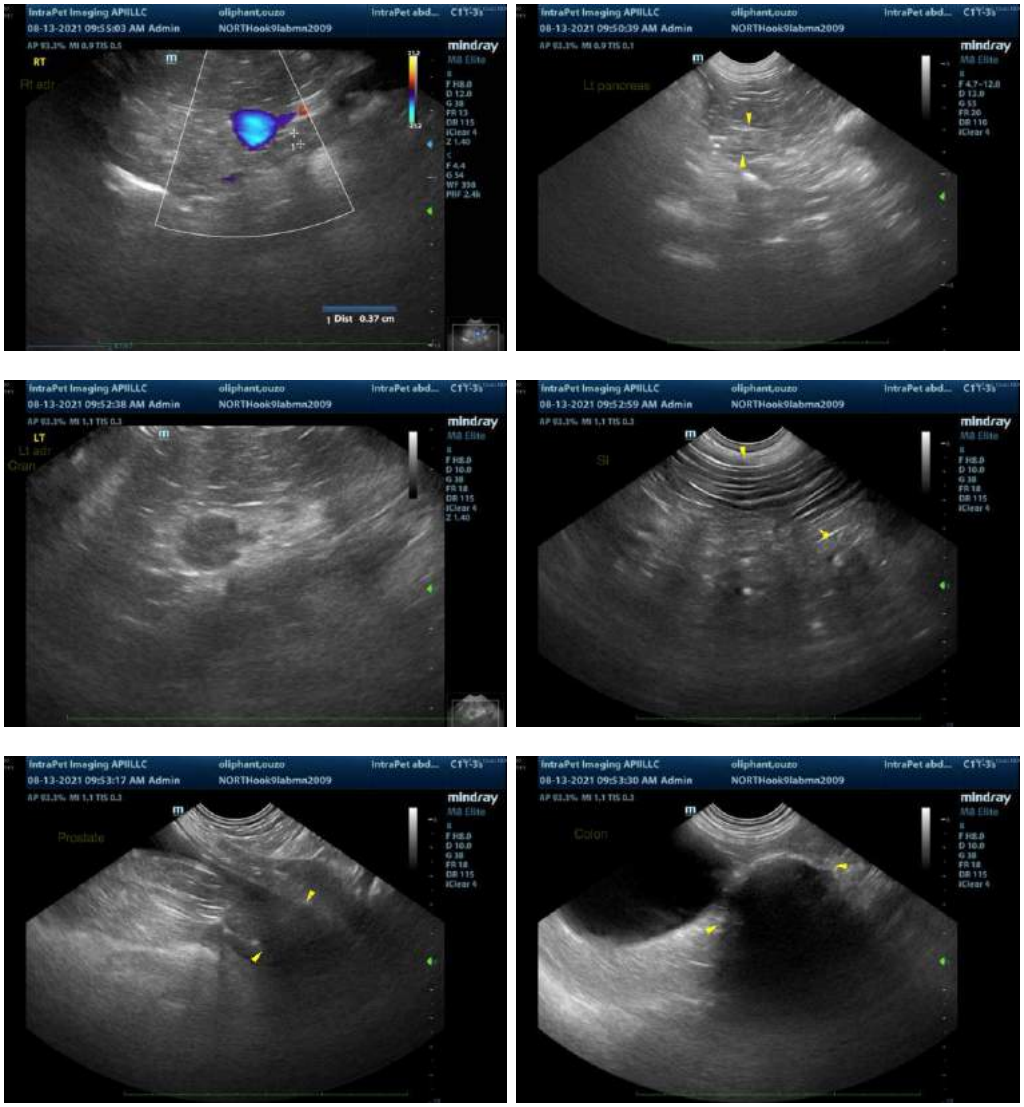
c. A 6-week limited antigen diet trial to assess for food allergies

d. Consider supplementation with a probiotic with a high colony count (i.e., Visbiome or Proviable Forte).

e. Consider empirical treatment for small intestinal bacterial overgrowth with Tylosin.

f. Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be necessary to get a definitive diagnosis.





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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