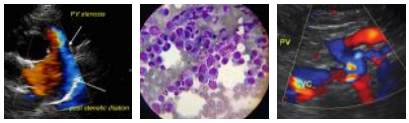
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
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DATE

8.13.23

PATIENT

Blaze Carbone

SPECIES

Canine

BREED

American Staffordshire Terrier

SEX

Female Spayed

AGE

1/7/13

WEIGHT

34.8 lbs

INTERPRETED BY

Andrea Nicastro, DMV, Diplomate DACVIM (Small Animal Internal Medicine)

HOSPITAL NAME

Animal EH

REFERRING VET

Dr. Roper

INVOICE

14078

PRESENTING CLINICAL SIGNS

Couple of months ago P was acting abnormal and bloodwork showed low proteins and then P was diagnosed with PLE. P had an abdominal ultrasound performed a month ago and PLE was diagnosed. Monday rDVM - pancreatitis diagnosed via bloodwork P has been vomiting and not had interest in food. P is having soft serve diarrhea. O gave Cerenia yesterday and P vomited afterword. P has been on prednisone which was increased from SID to BID on Monday.

Current Medications: Vitamin B12, Maropitant Citrate, Pantoprazole, Butorphanol.
Lab Results: No proteinuria evident.
Radiographs: Abdomen 2 view; Idexx consult attached.
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 wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. A small amount of suspended echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The left kidney is normal in size (5.81 cm in length) with a normal shape, architecture and 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.

The right kidney is normal in size (5.87 cm in length) with a normal shape, architecture and 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 left adrenal gland is normal in size (0.58 cm at cranial pole) (0.65 cm at caudal pole) (2.44 cm in length) with a normal shape and 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 in normal size (0.64 cm at cranial pole) (0.52 cm at caudal pole) (2.61 cm in length) with a normal shape and 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 is not definitively visualized in the available images.

Liver

The liver is normal to slightly prominent in size with swollen peripheral contours. The parenchyma exhibits mild heterogeneity. 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 small amount of aggregated, echogenic debris is observed within the lumen (some of which is gravity-dependent and some of which is stranding). The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is not distended. The gastric wall in the region of the fundus is normal to moderately thickened (up to 0.77 cm) with retention of the normal layering pattern. The small intestinal lumen is segmentally dilated with fluid and gas. The small intestinal wall is mildly thickened (up to 0.53 cm). There is disruption in the normal 1:3 muscularis: mucosal ratio in several segments. There is evidence of mucosal fogging. Discreet masses are not identified. The colonic wall is normal. The colonic lumen contains diarrheic stool. There is no obvious evidence of an obstructive pattern.

Pancreas

The base and right limb of the pancreas are 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

The mesentery throughout the abdomen is hyperechoic. A moderate amount of anechoic free fluid is present. A 1.13 x 1.02 cm lymph node is observed in the cranial abdomen.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Given the patient's clinical history and sonographic changes, a protein-losing nephropathy (i.e., inflammatory bowel disease, lymphangiectasia, infectious/parasitic disease, emerging lymphoma) is suspected.
- The gastric wall changes could be consistent with inflammation, hypertrophy, or less likely, emerging neoplasia.
- Diffuse peritonitis is present, likely secondary to bowel pathology.
- The ascites may be secondary to low oncotic pressure (most likely), increased vascular permeability or increased hydrostatic pressure.

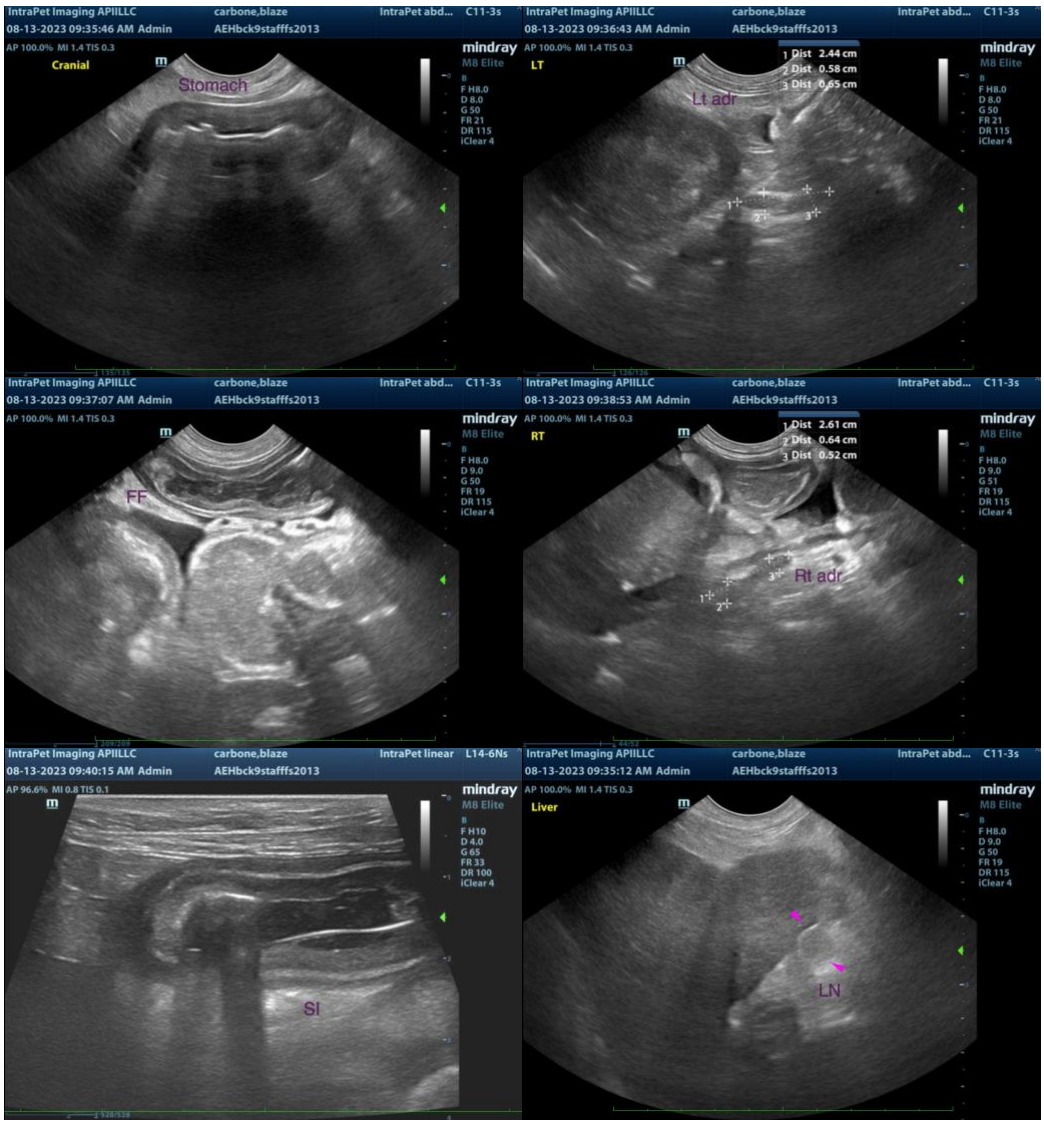
Secondary Findings

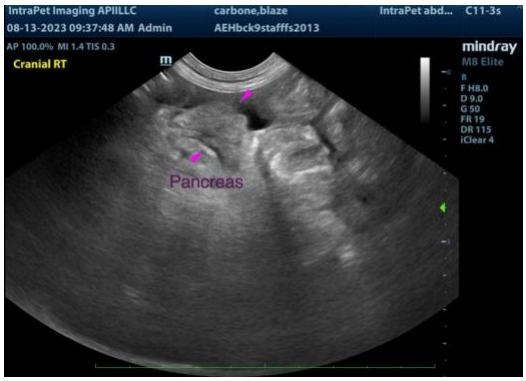
- Bilateral chronic age-related renal changes
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory and infiltrative disease are considered less likely. However, correlation with the patient's liver values is recommended.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Fecal evaluation for internal parasites
- Consider prophylactic deworming with Fenbendazole (if not already performed).
- Consider rechecking baseline lab work, including a CBC, chemistry panel, urinalysis and T4 to assess overall metabolic function.

- Texas GI panel including serum cobalamin and folate, TLI, PLI and resting cortisol level is recommended.
- Also consider initiation of a probiotic with a high colony count, as well as a fiber supplement (i.e., psyllium).
- Ultimately, endoscopic or surgical GI biopsies would be necessary to get a definitive diagnosis. If pursued, three-view thoracic radiographs should be performed prior to anesthesia.





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.

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