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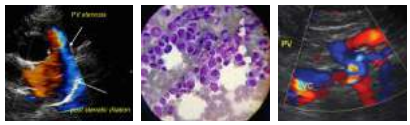

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DATE

8/19/21

PATIENT

Rooster Primm

SPECIES

Canine

BREED

Schnauzer

SEX

Male Neutered

AGE

10/9/10

WEIGHT

30.4 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Eastern Animal Hospital

REFERRING VET

Dr. Sole

INVOICE

11673kk

PRESENTING CLINICAL SIGNS

History: Progressive weight loss over 5 months with normal appetite, historically elevated liver values. LPL lameness.

Current Medications: Fluoxetine, Gabapentin (doses not provided by the veterinarian).

Lab Results: Historically elevated liver values, most recent 8/3/21. ALP 1568, CBC shows thrombocytosis; otherwise unremarkable.

Radiographs: Not provided by the veterinarian.

Date of Previous IntraPet Ultrasound: 3-5-2020.

Sedation: Gabapentin.

Stat Report: STAT report not requested by the veterinarian.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is distended. The wall is normal in thickness with a smooth mucosal surface. A small amount of suspended echogenic debris is present within the lumen. A 0.24 cm cystic calculus (versus accumulation of mineralized sand) is also observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The prostate is normal in size (0.73 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 (5.54 cm in length) with a normal shape and architecture and smooth peripheral contours. The cortex is hyperechoic and there is a normal 1:3 cortex to medulla ratio. There is minimal loss of corticomedullary distinction. Hyperechoic, shadowing diverticular foci are visualized. There is no evidence of pyelectasia, infarcts or hydroureter.

The right kidney is normal size (5.87 cm in length) with a normal shape and architecture and smooth peripheral contours. The cortex is hyperechoic and there is a normal 1:3 cortex to medulla ratio. There is minimal loss of corticomedullary distinction. Hyperechoic, shadowing diverticular foci are visualized. There is no evidence of pyelectasia, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal size (0.56 cm at cranial pole) (0.61 cm at caudal pole) (1.83 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 normal size (0.70 cm at cranial pole) (0.68 cm at caudal pole) (2.30 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 subjectively normal in size with a normal capsular contour. The parenchyma is subtly mottled in appearance. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits mild heterogeneity. No distinct focal lesions are observed. Hepatic vasculature and biliary tracts are of normal volume with no evidence of congestion. The gall bladder is moderately distended. The wall is normal in thickness. Excessive echogenic to mineralized partially dependent sludge is observed within the lumen. 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 left limb of the pancreas is visible with minimal deviation from the normal peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and subtly mottled in appearance. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated. There is no evidence of peripancreatic effusion.

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. A 2.55 x 1.54 cm cystic hepatic lymph node is visualized.

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.
- Excessive, mineralized gall bladder sludge, non-mucocele.
- Tiny cystic calculus (versus accumulation of mineralized sand).

Secondary Findings:

- Bilateral, age-related renal pathology with dystrophic mineralization.
- The splenic parenchyma changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis or splenitis with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis, or chronic pancreatitis.
- The enlarged hepatic lymph node is likely a benign, incidental finding. It was observed on the previous sonogram and is similar in size today.

**An obvious cause for the patient's weight loss is not identified in this study. Considerations include microscopic gastrointestinal disease, low-grade pancreatitis, underlying metabolic issue, primary neurologic disease (i.e., brain tumor), and other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

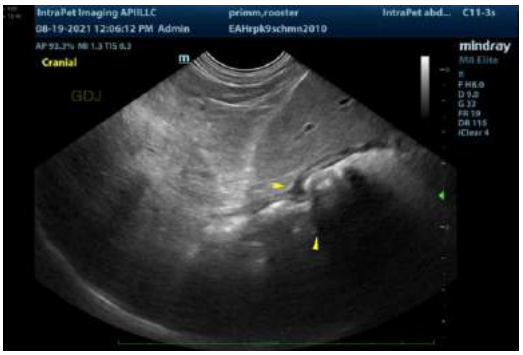
1. Three-view thoracic radiographs are recommended to assess for occult neoplasia.

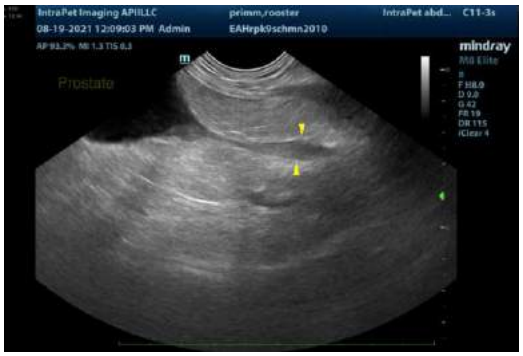
2. A malabsorption panel should also be considered to evaluate for underlying gastrointestinal and pancreatic disease. A fecal evaluation for ova and giardia is also recommended.

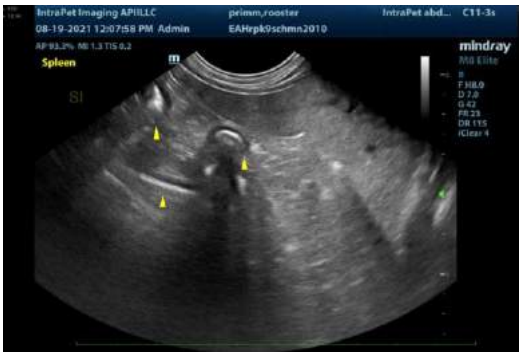
3. A thorough neurologic examination is also recommended as primary brain tumors can present with weight loss as the sole clinical sign.

4. Depending on the results of the above diagnostics, endoscopic or surgical gastrointestinal biopsies may be warranted. If surgery is pursued, a liver biopsy should also be obtained.

5. Regarding the possible cystic calculus, an abdominal radiograph is recommended to determine if a distinct stone (versus sand) is present.







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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