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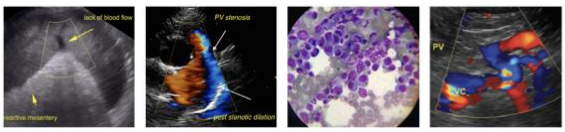

Charleston Mobile Veterinary Services
IMAGING PERFORMED BY
CharlestonMobile.Net 800.403.5408

PATIENT
Jake Smith

SPECIES
Canine

BREED
Labrador Retr

SEX
Neutered Male

AGE
12/6/2013

WEIGHT
82 lbs

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

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

HOSPITAL NAME
Flowertown AH

REFERRING VET
Nawa

INVOICE
14178

DATE
8.19.23

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: 8/18 acute lethargy; acute vomiting; acute anorexia
open to severe enteritis/colitis, partial obstruction, GI disease
8/19discussed all abnormalites on the bloodwork and concern for PLE vs hepatic disease/failure. Discussed that P does not seem to be making much of an improvement besides that he is interested in eating i/d. At this time, I highly recommend to move forward with an abdominal ultrasound due to severity of the panhypoproteinemia and ongoing clinical signs

Abnormal lab-work values: Blood was drawn from the left lateral saphenous vein for inhouse BW
leukocytosis 26.65
monocytosis 2.17
neutrophilia 20.61
eosinophilia 1.28
hypoalbuminemia 1.6
hypoglobulinemia 2.2
hypoproteinemia 3.8
decreased ALP <10
decreased BUN 6
hypochlorestoralemia 86

Current Medications: Gabapentin

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. Luminal contents are mostly anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, appear normal.

The prostate is normal in size (0.52 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal in size (7.77 cm in length) with a normal shape, architecture and 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 appears normal.

The right kidney is normal in size (7.78 cm in length) with a normal shape, architecture and 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 appears normal.

Adrenal Glands

The left adrenal gland is normal in size (0.65 cm at cranial pole) (0.76 cm at caudal pole) 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 appear normal.

The right adrenal gland is in normal size (0.86 cm at cranial pole) (0.65 cm at caudal pole) 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 appear normal.

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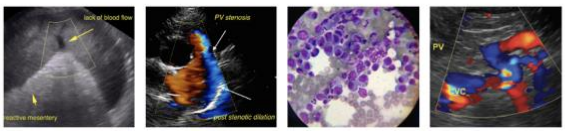

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Spleen
The spleen is normal in size (1.88 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature appears normal.

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 portal vein to caudal vena cava ratio is approximately 1: 1.

The gall bladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal/not seen.

Gastrointestinal
The gastric lumen is mildly to moderately 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 intestine is segmentally dilated with chyme. Several small intestinal segments are moderately to severely thickened and hypoechoic (up to 1.26 cm) with loss of the normal layering pattern. The mesentery effacing the serosal surface of these segments is hyperechoic. The remaining small intestinal segments are normal in thickness with a normal layering pattern and appropriate mural detail. The ileocecocolic junction and colonic wall are normal. There is no obvious evidence of an obstructive pattern.

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. Several enlarged, irregular, hypoechoic mesenteric lymph nodes are visualized (one of the larger measuring 3.01 x 1.09 cm.

Other
A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.

ULTRASONOGRAPHIC FINDINGS

- Given the patient's clinical history and bowel changes, a protein-losing nephropathy is considered likely. Gastrointestinal lymphoma is the top differential. However, other protein-losing nephropathies (i.e., fungal disease (i.e., pytheosis, histoplasmosis)) cannot be completely excluded.
- The mesenteric lymphadenopathy could be consistent with infiltrative neoplasia (i.e., lymphoma) or reactive change.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for lymphadenopathy in the chest.
- Consider fine-needle aspirates of the thickened bowel segments (if clotting status is appropriate). Twenty-five gauge-needles should be used. Depending on the results, consultation with a board-certified oncologist may be warranted.

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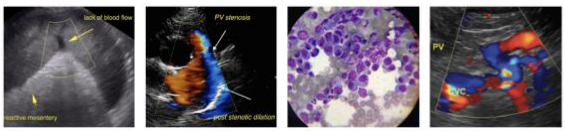

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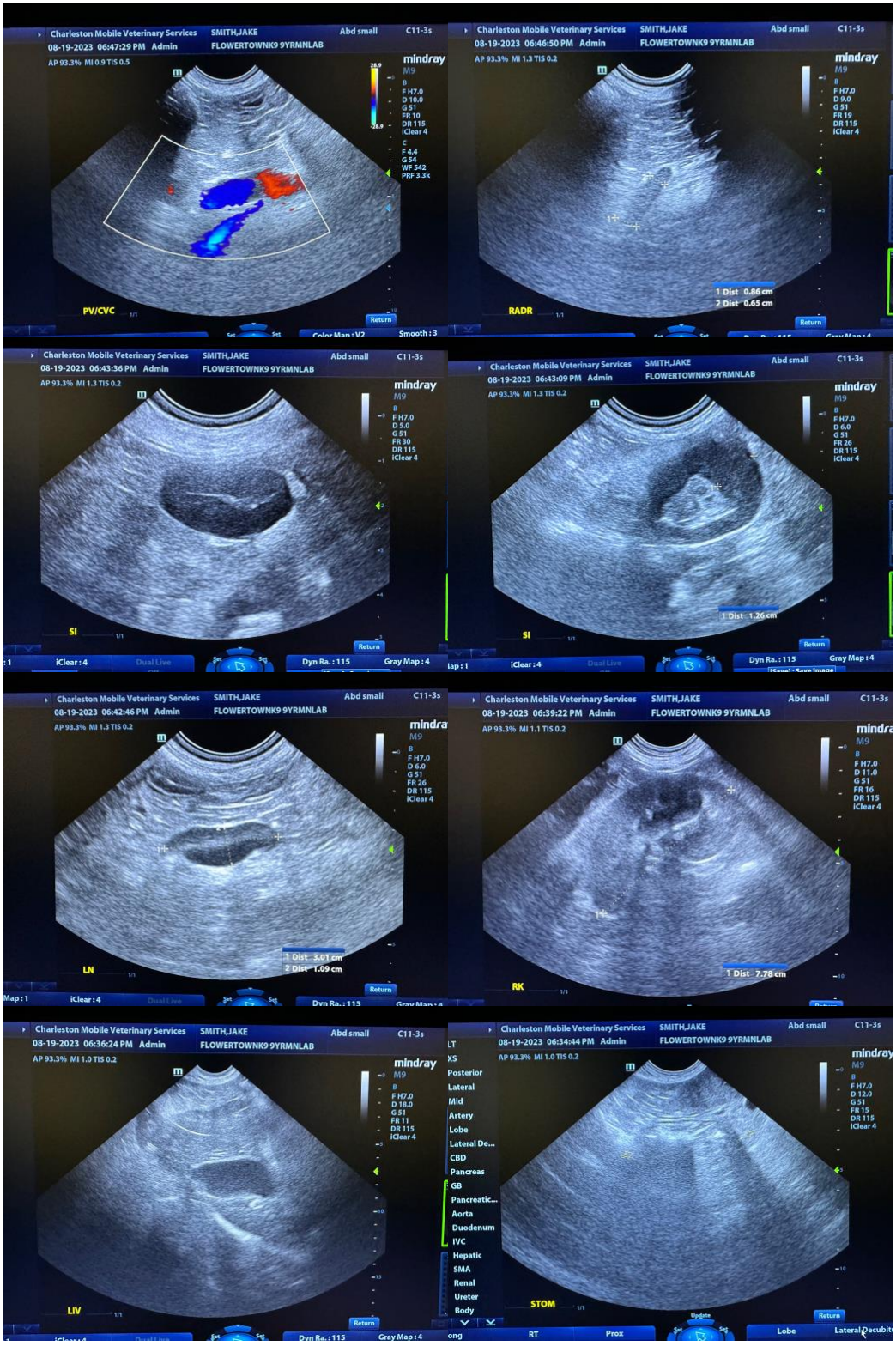

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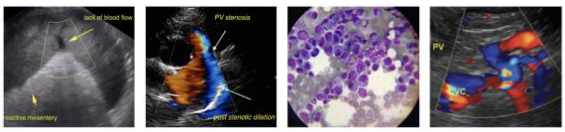

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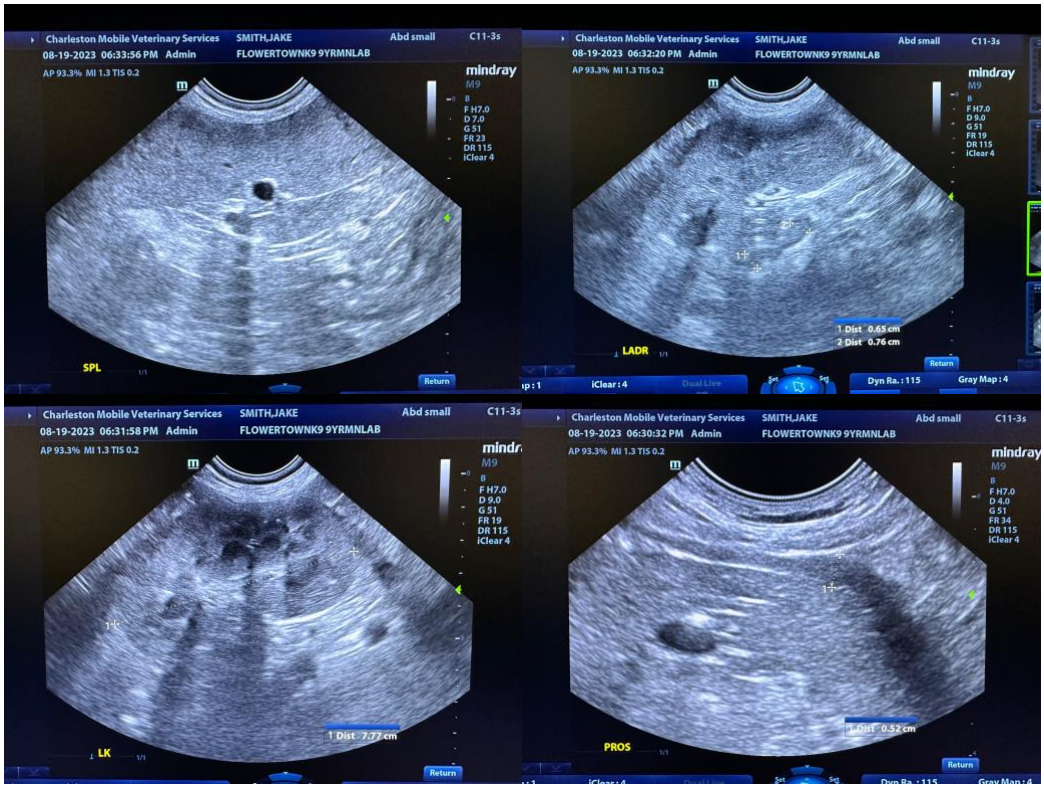

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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