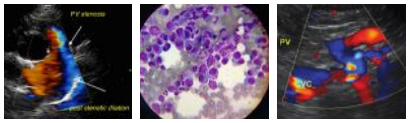
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
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DATE

8.2.2022

PATIENT

Teddy Connolly

SPECIES

Canine

BREED

Coton de Tulear

SEX

Neutered Male

AGE

6/2/2011

WEIGHT

6.7kg

INTERPRETED BY

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

HOSPITAL NAME

Nexus Veterinary Specialists

REFERRING VET

Dr. Steele

INVOICE

11306

PRESENTING CLINICAL SIGNS

April 2022 owners noted polydipsia, polyphagia, diarrhea, weight loss. Lab work showed albumin 2.3, ALP 505, ALT 155, BUN 5, GGT 20, normal T4/FT4, unremarkable CBC, negative fecal, negative 4DX (no urine). Seen again in July for progressive signs, ALP normalized, ALT 200, albumin 12.9. Trialed steroids on a taper, owner felt minimal improvement. Continued weight loss, yellow diarrhea, defecating large volumes at least 6x daily. TLI in "gray zone" at 3.6, B12 low at 217, folate increased at 31.8, normal PLI. History of IBD diagnosed on biopsy in 2013, has been maintained on hydrolyzed diet since with mild signs of gassiness and loud borborygmi.

Current Medications: Prednisone 2.5mg once daily (tapering off)
Tylosin 1/16th tsp BID (stopping today), Proviable forte once daily, Cobalequin once daily
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** is mildly distended. The wall is of appropriate thickness for the level of repletion. The mucosal surface is irregular in the region of the apex. A small amount of suspended, aggregated, echogenic debris is observed within the lumen. No cystic calculi are observed. The cystourethral junction and the visible portion of the proximal urethra are normal.

The **prostate** is not definitively visualized due to its pelvic location.

The **left kidney** is normal size (4.42 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The **right kidney** is normal size (4.65 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The **left adrenal gland** is normal size (0.51 cm at cranial pole) (0.48 cm at caudal pole) (1.75 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 (0.44 cm at cranial pole) (0.54 cm at caudal pole) (2.13 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 normal in size (1.56 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. An 0.69 x 0.64 cm irregular, hypoechoic to slightly heterogenous nodule is observed near the cranial aspect. In addition, a few, small, ill-defined myelolipomas are seen in the region of the hilus. Splenic vasculature is normal.

Liver
The **liver** is prominent in size with normal curvilinear peripheral contours. The parenchyma is hyperechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion.

The **gall bladder** is moderately distended. The wall is normal to mildly thickened (up to 0.23 cm), is hyperechoic to mineralized and slightly irregular in appearance. A small amount of aggregated, echogenic debris/sludge is adhered to the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal
The **gastric lumen** is not distended. The gastric wall is normal in thickness with a normal layering pattern. The small intestinal lumen is segmentally dilated with gas and chyme. The small intestinal wall is normal in thickness with retention of the normal layering pattern. There is slight disruption in the normal 1:3 muscularis: mucosal ratio in a few segments. Discreet masses are not identified. The colonic wall is normal. The colonic lumen contains shadowing fecal material. 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 ascites is present. The abdominal **lymph nodes** are normal/not visible.

Other
A brief echocardiogram reveals no obvious evidence of pericardial effusion.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The clinical history, in conjunction with the sonographic changes are consistent with a chronic enteropathy. Top differentials include inflammatory bowel disease, food allergy/intolerance, infectious/parasitic disease, emerging neoplasia.
- The gall bladder wall changes (aka, “porcelain gall bladder”) are most consistent with cholecystitis. However, in rare instances, this finding can progress to biliary adenocarcinoma.
- Trace ascites. Differentials include low oncotic pressure, increased hydrostatic pressure or increased vascular permeability.

Secondary Findings

- The hepatic parenchymal changes are most consistent with a steroid hepatopathy. However, other differentials (i.e., idiopathic vacuolar hepatopathy, inflammatory disease, or less likely, infiltrative neoplasia) are possible.
- The splenic nodule could be consistent with a benign process (i.e., focus of lymphoid hyperplasia, extramedullary hematopoiesis, or similar). Alternatively, an emerging tumor is possible.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommendations regarding this exam to be implemented by Dr. Cara Steele.

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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