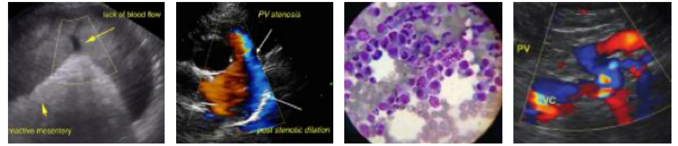
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Haiti Llompart

SPECIES

Canine

BREED

Medium size mixed breed

SEX

Female, spayed

AGE

14 Yrs.

WEIGHT

51 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Ferrer

HOSPITAL NAME

Paseos VC

REFERRING VET

Dr. Ortiz

INVOICE

13853

DATE
8/22/22

PRESENTING CLINICAL SIGNS

History: Presented for an abdominal ultrasound to evaluate on and off anorexia, and chronic diarrhea. Pt has a history of spindle cell tumor on the left forelimb antibrachium area.
Abnormal PE/Chem/CBC/UA Results: BW: July 28 2022 CBC: Hematocrit 41.3 37.3 - 61.7 % MCV 55.5 (61.6 - 73.5 fL) MCH 18.7 21.2 - 25.9 pg RDW 22.4 13.6 - 21.7 % Chem: BUN 52 (7 - 27 mg/dL) Globulin 4.8 (2.5 - 4.5 g/dL) ALT 165 (10 - 125 U/L) Cholesterol 346 (110 - 320 mg/dL)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is mildly distended with anechoic urine. The wall is of appropriate thickness for the level of repletion. The mucosal surface in the region of the apex is mildly irregular. No cystic calculi are observed. The cystourethral junction and the visible portion of the proximal urethra are normal.

The left kidney is normal size (5.98 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal size (6.48 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal size (0.53 cm at cranial pole) (0.59 cm at caudal pole) (2.67 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 (0.69 cm at cranial pole) (0.45 cm at caudal pole) (2.88 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.

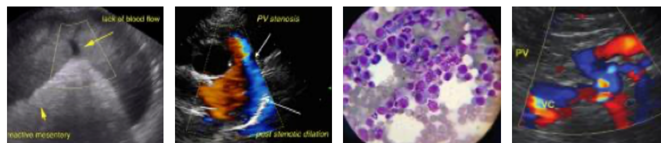
Spleen

The spleen is normal in size (1.84 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A 1.32 x 0.80 cm slightly hypoechoic nodule is observed at the caudomedial aspect. A few small, ill-defined myelolipomas are also observed in the region of the hilus. The lesion does not cause capsular expansion. 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. 1-2 small hyperechoic nodules are visualized near the diaphragm, the largest measuring 1.24 cm in length. The remaining parenchyma is homogeneous. Vascular and 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 to moderate amount of gravity-dependent echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal



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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 ileocecocolic junction is normal. The wall of the transverse colon is mildly thickened (up to 0.39 cm) with retention of the normal layering pattern. The remaining colonic wall is normal. No obstructive disease is noted.

Pancreas

The left limb and base of the pancreas is 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 peritoneal cavity is normal. There is no evidence of inflammation or effusion. A few mesenteric lymph nodes are visible, the largest measuring 0.76 cm in length. The nodes are normal in shape and echogenicity.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The colonic wall changes are most consistent with an inflammatory process with a lower possibility of an emerging malignancy.

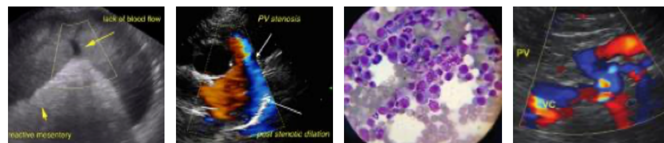
Secondary Findings:

- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.
- Mild age-related pancreatic remodeling.
- The hyperechoic hepatic nodule(s) are most likely associated with a benign process (i.e., regenerative nodular hyperplasia) with a low possibility of emerging neoplasia.
- The splenic nodule trends toward the benign (i.e., a focus of lymphoid hyperplasia, extramedullary hematopoiesis or similar) with a lower possibility of an emerging tumor.
- Mild bilateral, age-related degenerative renal changes.

*An obvious cause for the patient's gastrointestinal signs is not identified in this study. Top considerations include microscopic gastrointestinal disease (i.e., food allergy, infectious/parasitic disease, inflammatory bowel disease), underlying metabolic issue (i.e., hypoadrenocorticism), mild pancreatitis, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the patient's gastrointestinal signs, consider the following:



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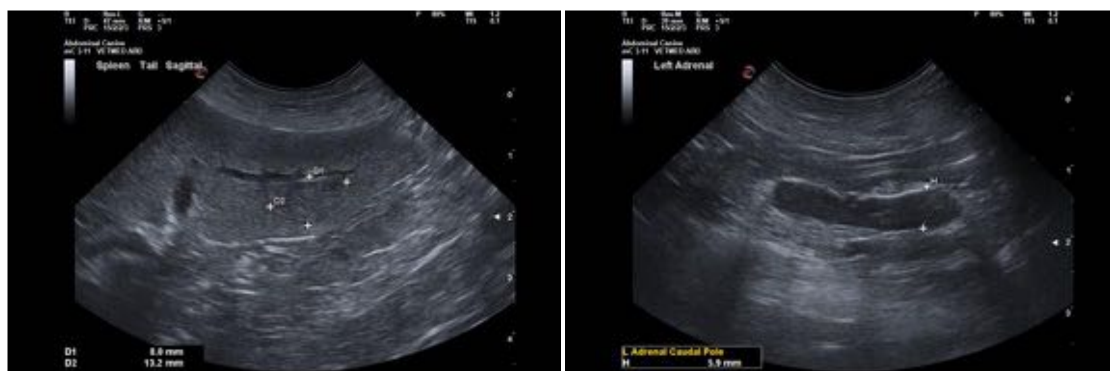
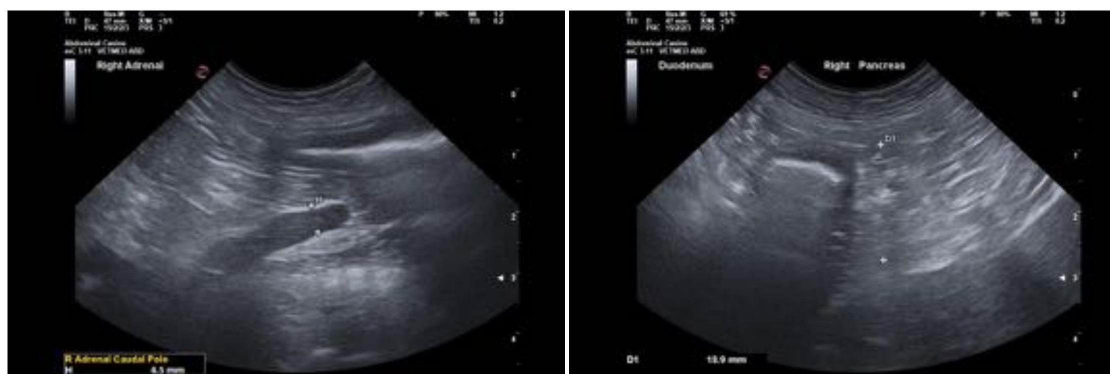
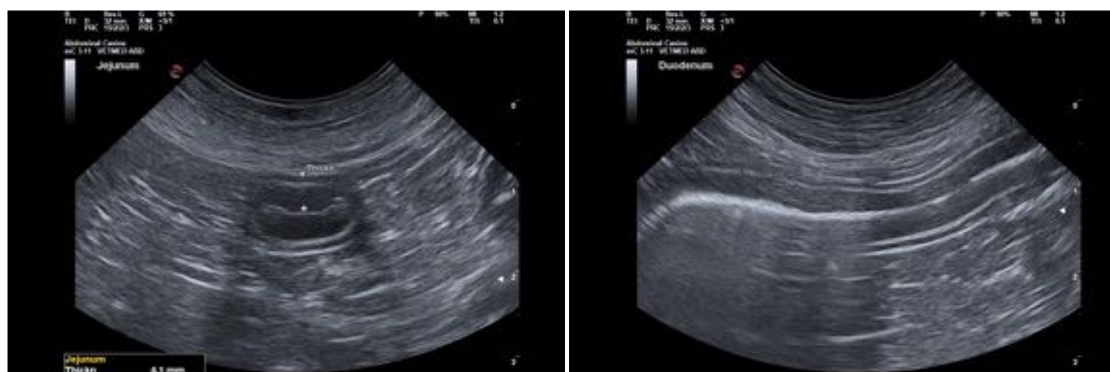
1. A fecal evaluation for ova/Giardia, if not already performed.
2. Prophylactic deworming with Fenbendazole
3. GI panel (send to Texas A&M).
4. 6-week novel protein diet trial.
5. Consider a resting cortisol level to screen for hypoadrenocorticism.
6. Also consider empirical treatment for small intestinal bacterial overgrowth with a 4-week course of Tylosin. In addition, supplementation with a probiotic with a high colony count may be beneficial.
7. If the above diagnostics are inconclusive and the patient's clinical signs do not improve, GI biopsies (i.e., endoscopic or surgical) may be warranted.







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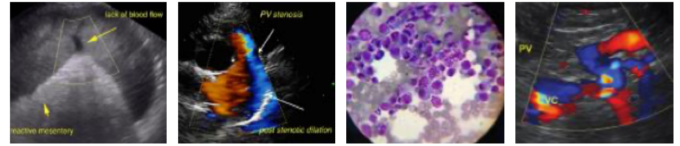

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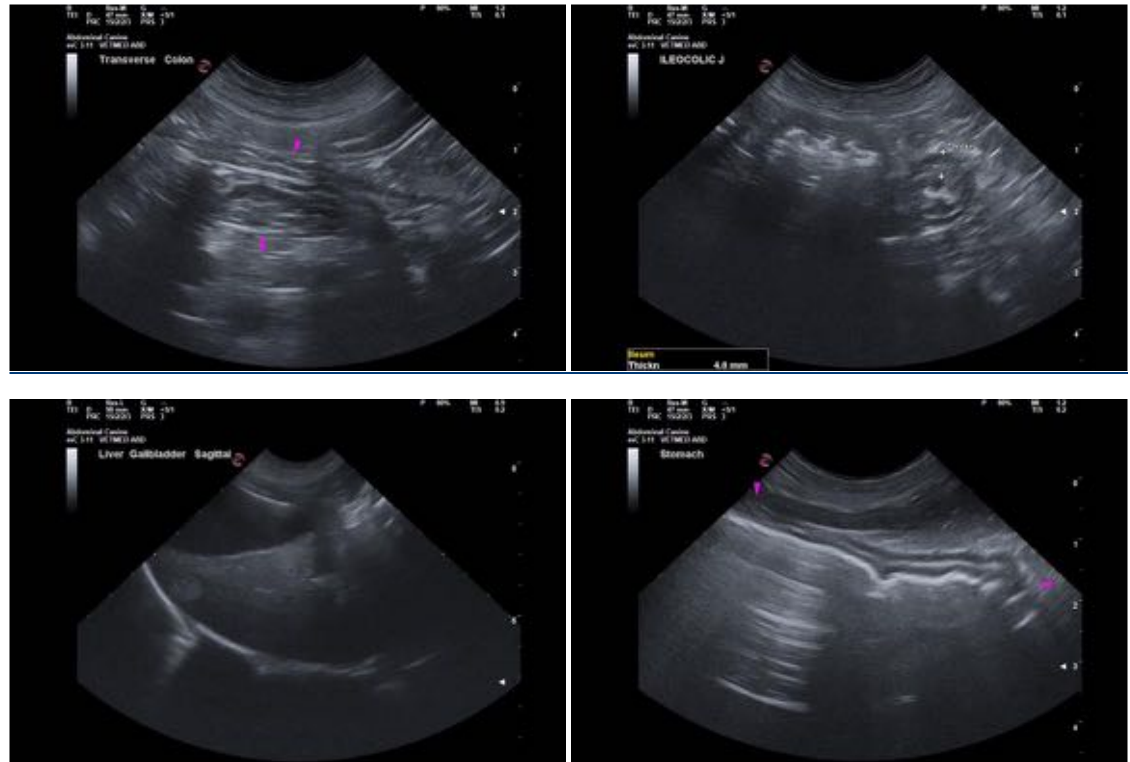

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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