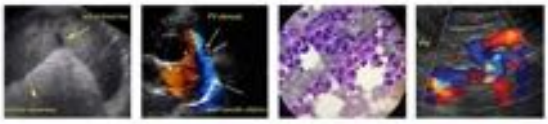


PATIENT

Lux Moran

SPECIES

Canine

BREED

Labrador Retriever

SEX

Female, spayed

AGE

11 Years

WEIGHT

57 Pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT

HOSPITAL NAME

Alpine AH

REFERRING VET

Dr. Sjloin

INVOICE

13858

DATE

8/22/22

PRESENTING CLINICAL SIGNS

History: No sedation. Evaluate for cause of murmur and safety of anesthesia. Grade 2/6 L systolic. Hx mild elevation liver enz - see previous ultrasound. Now is vomiting a few times a week, large amounts of food several hours after eating.
Abnormal PE/Chem/CBC/UA Results: February 2022 - ALP-229, all else WNL- Blood Pressure-Systolic 148. CBC unremarkable, SDMA 18, ALP 206, spec cPL 919, USG 1.012, no proteinuria. Pyuria and Bacteriuria are present.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is moderately distended. The wall in the region of the apex is thickened (up to 0.54 cm) and irregular. The wall tapers to a normal thickness as it extends toward the cystourethral junction. A small amount of suspended echogenic debris is observe within the lumen. No cystic calculi are observed. The region of the trigone is normal. The proximal urethral wall is slightly thickened (up to 0.31 cm). The urethral lumen is not overtly dilated.

The left kidney is normal size (6.20 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.

The right kidney is normal size (6.17 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.

Adrenal Glands

The left adrenal gland is normal size (0.69 cm at cranial pole) (0.68 cm at caudal pole) (2.55 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.

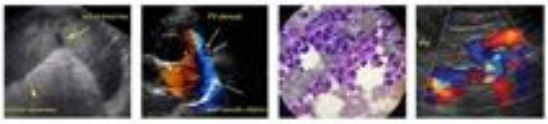
The right adrenal gland is normal size (0.95 cm at cranial pole) (0.60 cm at caudal pole) (2.32 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (2.34 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A 0.74 cm slightly heterogeneous nodule is observed at the lateral aspect. In addition, a 0.44 x 0.36 cm hypoechoic nodule is seen. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. 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 gall bladder lumen is moderately



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distended. The wall is thin and smooth. A small to moderate amount of mostly gravity-dependent echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

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 is normal to borderline thickened (up to 0.48 cm). There is retention of the normal layering pattern with disruption of the normal 1:3 muscularis: mucosal ratio in most segments. There is also thickening at the submucosal layer in several regions. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. No obstructive disease is noted.

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

There is no evidence of free fluid. A few prominent mesenteric lymph nodes are visualized, the largest measuring 1.60 cm in length. In addition, a 0.73 cm gastric lymph node is observed.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

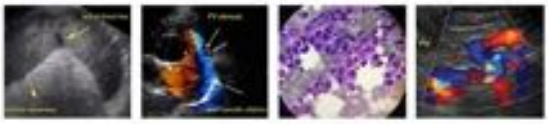
- The small intestinal wall changes are consistent with inflammatory bowel disease with some potential for emerging lymphoma.

Secondary Findings:

- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.
- 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.
- The splenic nodules trend toward the benign (i.e., foci of lymphoid hyperplasia, extramedullary hematopoiesis or similar). However, emerging tumors cannot be completely excluded.
- The urinary bladder wall and urethral changes are most consistent with cystitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the clinical history and urinary bladder wall changes, a urine culture and sensitivity is recommended.
- Regarding the GI signs, consider the following:
  1. A fecal evaluation for ova/Giardia
  2. GI panel (send to Texas A&M)



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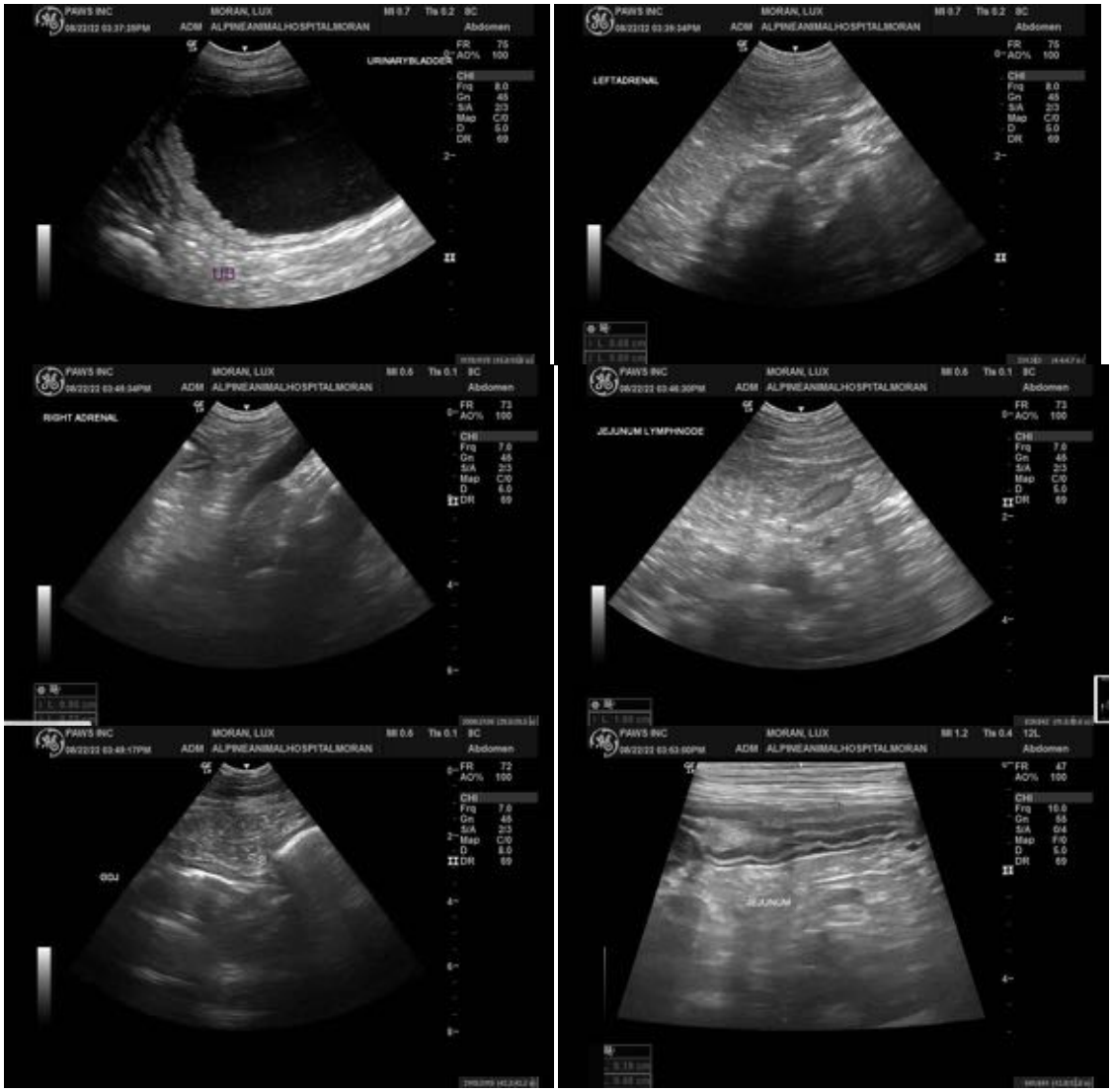
3. 6 week limited antigen diet trial to assess for food allergies
4. A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended
5. Depending on the results of the above diagnostics, gastrointestinal biopsies (i.e., endoscopic or surgical may be necessary to get a definitive diagnosis). If pursued, three-thoracic radiographs should be performed prior to anesthesia.

- Regarding the splenic nodules, serial sonographic monitoring (i.e., every 1-2 months) is recommended to assess for progression.



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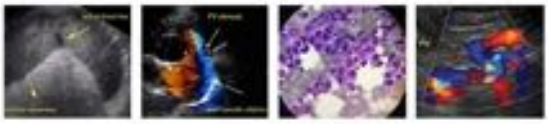

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pawsonography@gmail.com 530-786-8340

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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)
info@SonoPath.com