

PATIENT

Aspen Montalvo

SPECIES

Canine

BREED

Labrador Retr

SEX

Spayed Female

AGE

11 years, 11 mos

WEIGHT

73 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques,
RVT LVT

HOSPITAL NAME

MountainView AH

REFERRING VET

Dr. Sarah Kalivoda

INVOICE

11503

DATE

8.26.22

PRESENTING CLINICAL SIGNS

History: Chief Concern / Provisional Diagnosis: Panting, PD

Relevant Medical History and Physical Exam findings: Aspen is a diabetic which based on blood work has been poorly managed. She has been panting and restless at night and drinking more water at night. She recently had a GDV and surgical correction. She has severe OA. She has suspected IBD. The other concern is potential for Cushing's Disease. MEDS: Gabapentin 100mg 1-3 caps PO q8-12h: 2 pills q 8 hours Prozac insulin 20U SQ AM & 18U PM Adequan injections 1.3ml q3-4weeks Amantadine 100mg 1 cap PO SID Cobalamine supp Galliprant 60 mg: 1 tab PO q 24 hours Melatonin 6 mg 1 tab PM GasX 125 mg: 1/2 tab PO q 24 hours
Abnormal PE/Chem/CBC/UA Results: Urine cortisol: creatinine ratio 70

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** wall is normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended with anechoic urine. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The **left kidney** is normal size (7.04 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 (7.08 cm in length); normal shape and architecture with 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 is normal.

Adrenal Glands

The **left adrenal gland** is normal size (0.66 cm at cranial pole) (0.68 cm at caudal pole); 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.

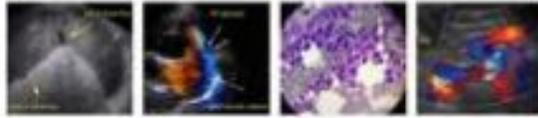
The **right adrenal gland** is normal size (1.43 cm at cranial pole) (0.58 cm at caudal pole) (2.46 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The **spleen** is normal in size (1.59 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 is normal.

Liver

The **liver** is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and subtly mottled in appearance with a coarse echotexture. A few, small, ill-defined hypoechoic nodule/areas are observed. There is a subtle increase in portal markings. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.



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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.

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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. There is no evidence of an obstructive pattern.

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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

The **peritoneal cavity** is normal. There is no evidence of inflammation or effusion. A few prominent sublumbar **lymph nodes** are visualized, the largest measuring 1.76 cm in length.

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Other

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

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ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Minor, bilateral, age-related renal changes
- The sublumbar lymphadenopathy is likely reactive with a lower possibility of emerging neoplasia.
- 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. Correlation with the patient's liver values is recommended.

*An obvious cause for the patient's clinical signs is not identified in this study.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the poor diabetic control, consider the following:

1. Baseline labwork including a CBC, chemistry panel, T4 and urinalysis, if not already performed.
2. Urine culture and sensitivity
3. Three-view thoracic radiographs are recommended to assess for occult disease in the chest.
4. Despite the normal-sized adrenal glands, further testing for Cushing's Disease (i.e., low-dose dexamethasone suppression test) can be considered if the clinical suspicion for disease is high and if baseline lab work is supportive of the diagnosis (i.e., elevated ALP)
5. If the above diagnostics are inconclusive and the patient is deemed insulin resistant, switching of insulin types may be warranted.

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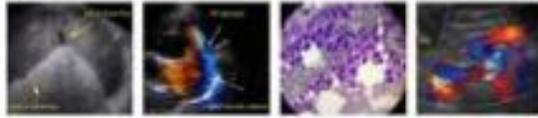
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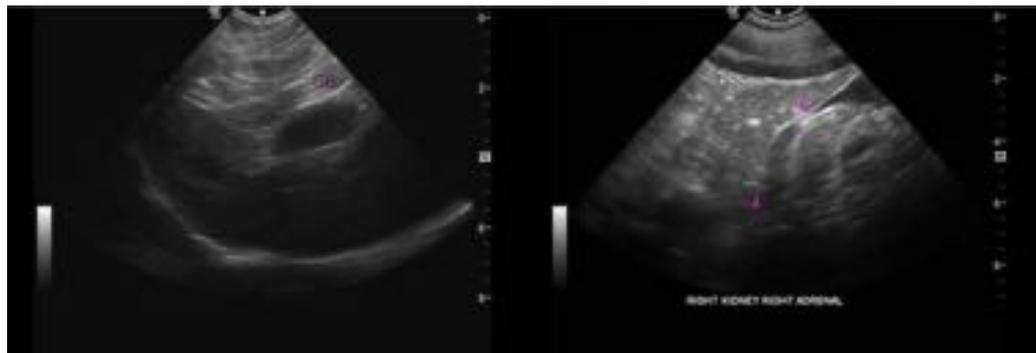
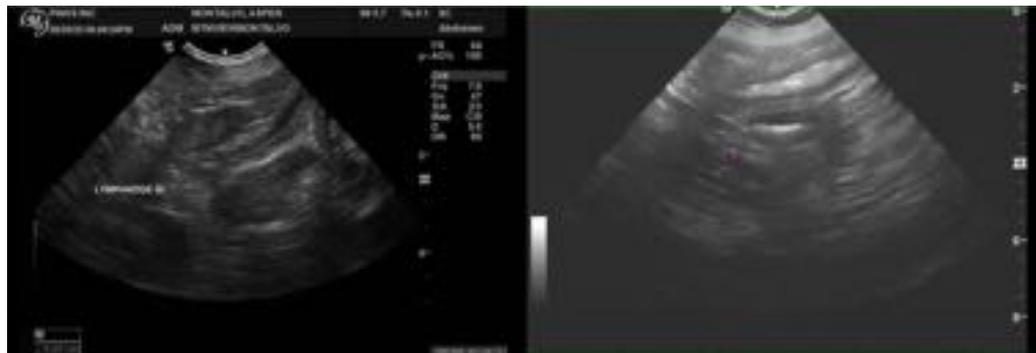
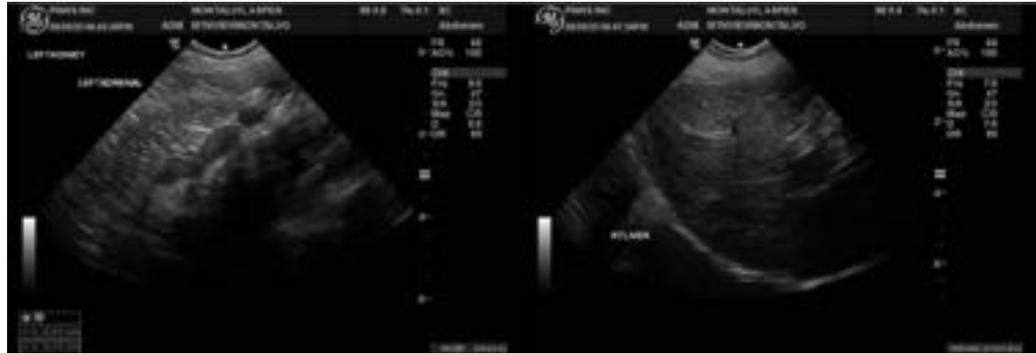
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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