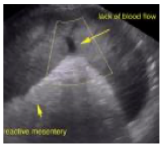
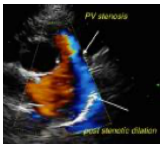
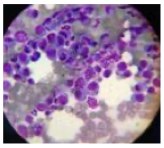
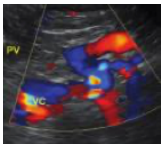
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT
Buddy Vranizan

SPECIES
Canine

BREED
Labradoodle

SEX
Neutered Male

AGE
10 years

WEIGHT
52 lbs

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

IMAGING PERFORMED BY
Christina Sutton

HOSPITAL NAME
Sherwood Family PC

REFERRING VET
Dr. Christina Sutton

INVOICE
11311

DATE
8.3.22

PRESENTING CLINICAL SIGNS

History: weight loss, vomiting, intermittent loose stool, dry/dull coat seizures dx in 2/2022 - started on phenobarb, then transitioned to keppra + KBr; currently seizures are somewhat stable

Abnormal PE/Chem/CBC/UA Results: Sodium 154 (142-152) Calcium 7 (8.4-11.8) chloride 133 (108-119) AG 7 (11-26) TP 3.3 (5.5-7.5); was 5 Albumin 1.2 (2.7-3.9); was 2.4 Globluin 2.1 (2.4-4) A/G ratio 0.6 (0.7-1.5) AST 67 (16-55) Cholesterol 113 (337-131-345) Amylase 1827 (337-1469) Lipase 559 (0-250) CK 659 (10-200) glucose 90 (63-114) T4 1.2 (1-4) CBC MCV 78 (59-76) MCH 27 (21.9-26.1) Neutrophils 13022 (2940-12670) UA USG 1.008 pH 8.5 blood 1+ 2+ protein ketones, bacteria, crystals negative trace glucose UPC test pending today Bile acids and GI panel planned for tomorrow on fasted blood sample

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. A scant amount of suspended, echogenic debris is observed within the lumen. 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 **prostate** is normal in size (1.56 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The **left kidney** is normal size (6.44 cm in length); with a slightly irregular shape. The cortex is variably thickened and heterogenous in appearance. The cortex is mildly heterogenous in appearance. A cortical infarct is observed at the caudal pole. Trace pyelectasia is present. There is no evidence of nephroliths, or hydroureter.

The **right kidney** is normal size (7.57 cm in length); with a slightly irregular shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. Trace pyelectasia is present. A cortical infarct is suspected at the caudolateral aspect. There is no evidence of nephroliths or hydroureter.

Adrenal Glands

The caudal pole of the **left adrenal gland** is visualized and is normal in size (0.54 cm in width) with a normal shape, glandular echogenicity and detail. Surrounding vasculature are normal.

The **right adrenal gland** is normal size (1.21 cm at cranial pole) (0.53 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.

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. 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 isoechoic relative to the spleen with minor changes consistent with age-related remodeling. No focal lesions are observed. Hepatic vasculature 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. Luminal contents are anechoic. 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 intestinal lumen is segmentally dilated with chyme. 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. The lumen of the descending colon contains liquid-appearing 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

The **peritoneal cavity** is normal. There is no evidence of inflammation or effusion. The abdominal **lymph nodes** are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Given the clinical history, a protein-losing enteropathy is suspected. Top differentials include inflammatory bowel disease, lymphangiectasia, infectious/parasitic disease or infiltrative neoplasia (less likely). If the patient was fasted for this study, the presence of ingesta within the gastric lumen would suggest delayed gastric emptying.

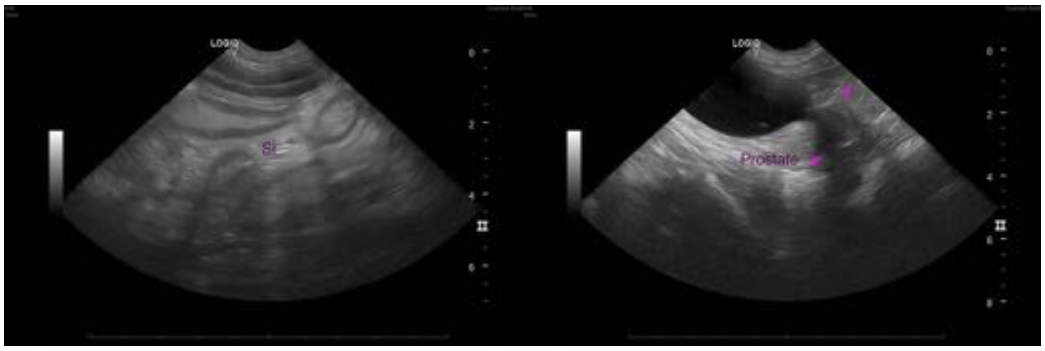
Secondary Findings

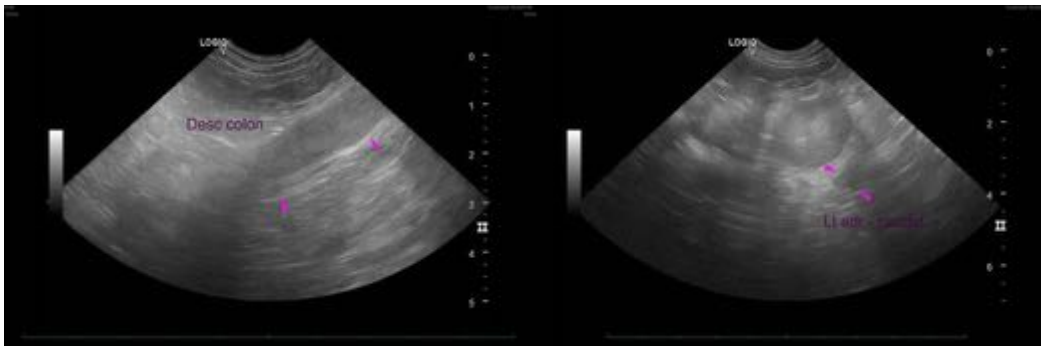
- Bilateral chronic, age-related renal changes with cortical infarcts.
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory and infiltrative disease are considered less likely.

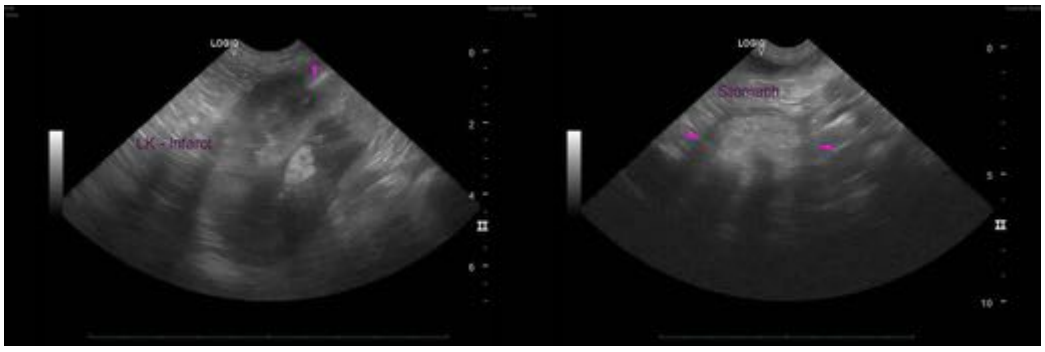
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

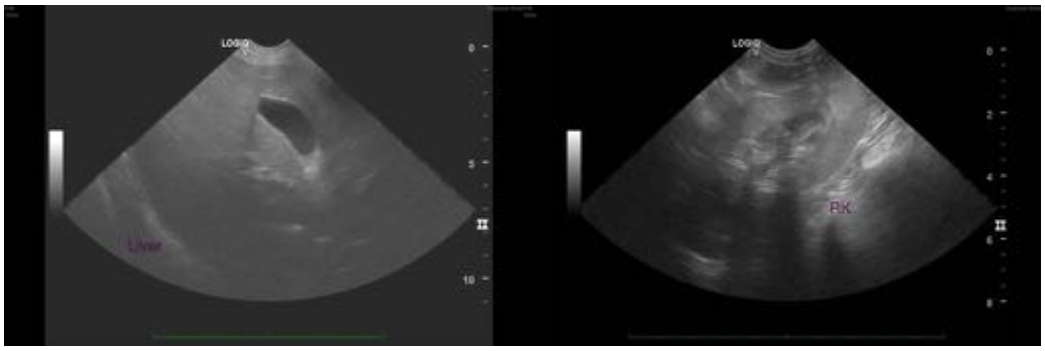
In addition to the pending diagnostics, consider a resting cortisol level to screen for hypoadrenocorticism, a fecal evaluation for ova and Giardia, prophylactic deworming with fenbendazole and a low-fat hypoallergenic diet trial.

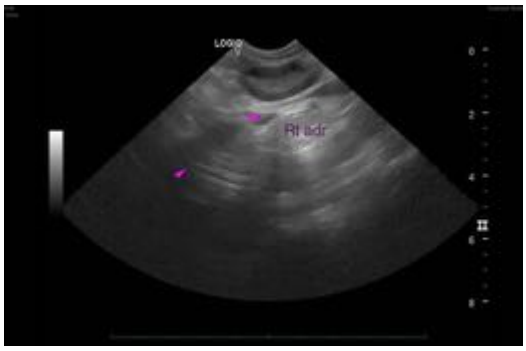
Ultimately, endoscopic or surgical gastrointestinal biopsies may be necessary to get a definitive diagnosis. If pursued, thoracic radiographs (three-view) are recommended to assess cardiopulmonary status prior to anesthesia.


SI
Prostate


Desc colon


LK - infarct
Stomach


Liver
RK



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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