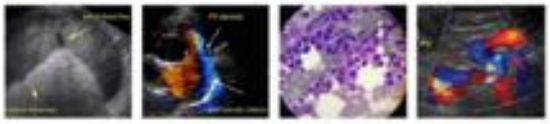

PATIENT

Remi Lax

SPECIES

Canine

BREED

Border Collie

SEX

Neutered Male

AGE

10 years, 4 mos

WEIGHT

61 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT LVT

HOSPITAL NAME

Grass Valley VH

REFERRING VET

Dr Kristi Cortright

INVOICE

11327

DATE

8.4.22

PRESENTING CLINICAL SIGNS

History: tense abdomen- History: Long involved hx started with hard swallowing. Empiric tx failed. Endoscopy showed ulcerations in stomach. Bx results: Stomach: Gastritis, lymphoplasmacytic and eosinophilic, multifocal, chronic, moderate with erosions and edema. 2. Duodenum: Enteritis, lymphoplasmacytic and eosinophilic, multifocal, chronic, moderate with minimal lymphocytic epitheliotropism. Started on Purina HA diet, budesonide, abx to cover H. pylori infection, gastric protectants. Remi slowly improved clinically over about 6 weeks but has had a couple of relapses of vomiting/not eating much. This may be due to dietary indiscretion but highly rec abdominal u/s to r/o comorbidities, o has postponed until today.

Physical exam findings: Quiet, ARH, BCS 4/9, CV-HR 120, no murmurs. Resp-eupneic, RR 20. GI-No reaction to palpation anywhere. MS-suspect OA of hips/stifles. All else wnl. Reason for Ultrasound: To assess for any comorbities

Abnormal PE/Chem/CBC/UA Results: endoscopy report attached- Abnormal CBC values: Mild neutrophilia r/o inflammation. Abnormal Chemistry Values: Mod increase in alkphos Abnormal UA Values: N/A

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 **prostate** is normal in size (0.75 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 (5.95 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.

The **right kidney** is normal size (5.85 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.

Adrenal Glands

The **left adrenal gland** is small in size (0.45 cm at cranial pole) (0.47 cm at caudal pole); (2.38 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 small in size (0.96 cm at cranial pole) (0.43 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 (2.03 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.

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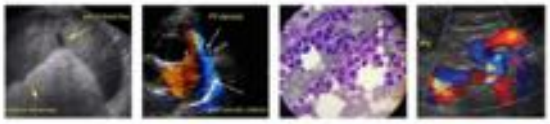

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Liver

The **liver** is normal to slightly prominent in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and exhibits subtle heterogeneity and a coarse echotexture. No distinct focal lesions are observed. Hepatic vasculature and intrahepatic 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 scant amount of gravity dependent, echogenic debris is observed within the lumen. 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 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 ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

The right limb 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. The abdominal **lymph nodes** are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The presence of ingesta in the gastric lumen despite fasting is suggestive of delayed gastric emptying.
- The bilaterally small adrenal glands may be a normal variant for this patient or may be secondary to early atrophy (i.e., due to hypoadrenocorticism).

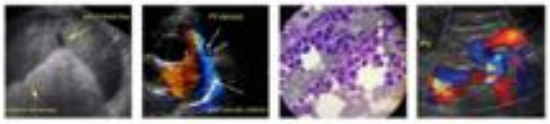
Secondary Findings

- Age-related pancreatic remodeling/fibrosis. Chronic pancreatitis may also be present, particularly if the patient exhibits pain on cranial abdominal palpation.
- Nonspecific, mild, diffuse hepatopathy, likely benign/age-related

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the patient's clinical history of inflammatory bowel disease, consider the following:

1. Malabsorption panel, including serum cobalamin and folate, TLI and PLI, is recommended.
2. A fecal evaluation for ova and Giardia is also recommended.
3. Resting cortisol level to screen for hypoadrenocorticism
4. Three-view thoracic radiographs are recommended to assess for occult esophageal disease.



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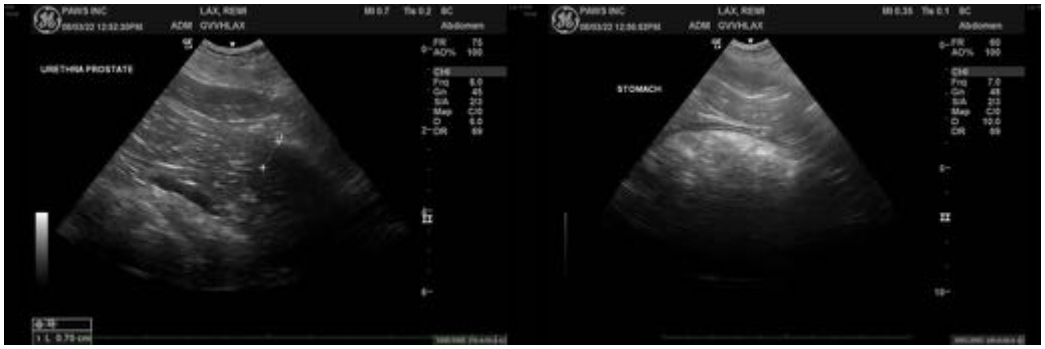
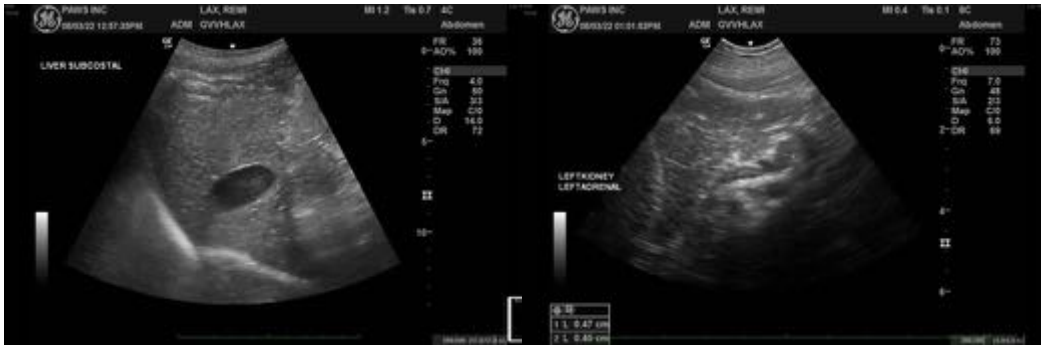
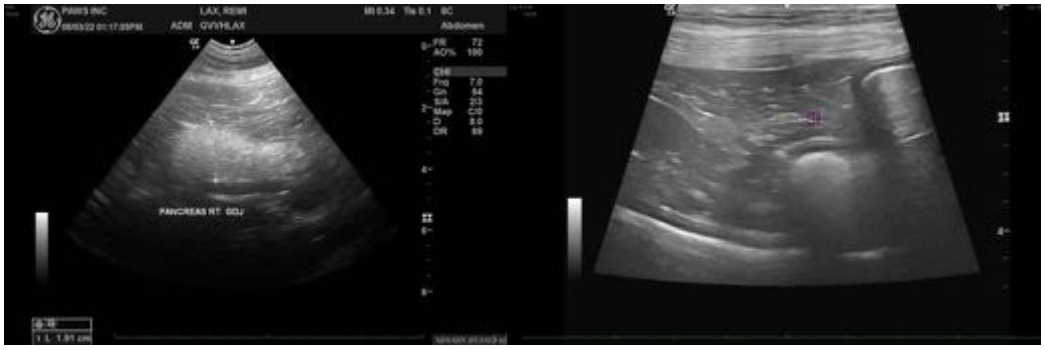
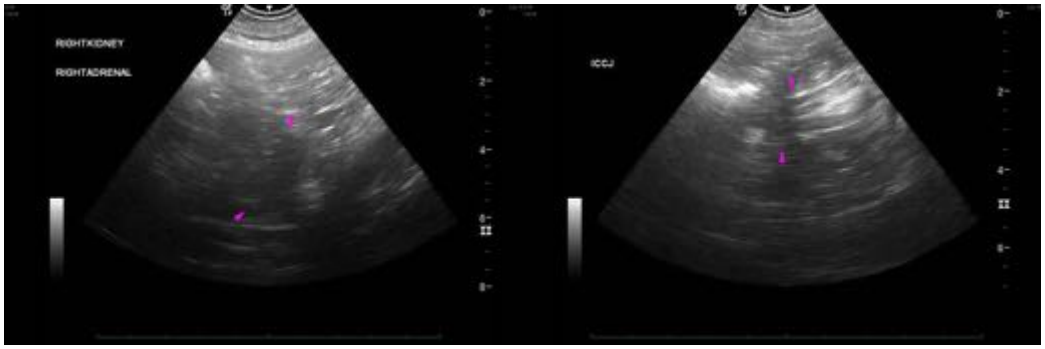
5. Consider referral to a board-certified internist to discuss medical management of the inflammatory bowel disease. The patient may require prednisone in lieu of budesonide, as it tends to be the more potent option.









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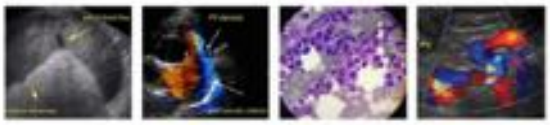

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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