

**DATE PRESENTING CLINICAL SIGNS**

8/30/2021

History: Presented originally on 7/19/2021 for lethargy, vomiting, diarrhea, panting at ER. CBC/CHEM was performed & wnl- treated for pancreatitis. Since visit- P has been PU/PD: urinalysis was performed UA- pH 8- cocci seen on sedivue, SG 1.011, glucose 50, negative for protein, IPS all negative. Placed on cefpodoxime- but no improvements in clinical signs.

PATIENT

Hope Hoerl

Current Medications: Cefpodoxime 100 mg- 1 tab PO SID 7 days.

Lab Results: SG 1.011- O to drop off first morning urine sample.

Radiographs: Not provided by the veterinarian.

Date of Previous IntraPet Ultrasound: No previous IntraPet scans.

Sedation: Gabapentin 100mg PO 2-3 hours prior to scan.

Stat Report: not requested

SPECIES

Canine

BREED

Sheltie

SEX

Female, spayed

AGE

3/30/2012

WEIGHT

20.7 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Eastern Animal
 Hospital

REFERRING VET

Dr. Haviland

INVOICE

11969

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

The urinary bladder, trigone, and pelvic urethra are 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 (5.16 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. Trace pyelectasia is present (0.21 cm in the longitudinal plane). There is no evidence of infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal in size (4.89 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. Trace pyelectasia is present (0.13 cm in the longitudinal plane). There is no evidence of infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.70 cm at cranial pole) (0.67 cm at caudal pole) (2.58 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 (0.66 cm at cranial pole) (0.65 cm at caudal pole) (2.34 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 (1.27 cm in width at the level of the hilus) with a normal capsular contour. The parenchyma is subtly mottled in appearance. 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 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 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. No obstructive disease is noted.

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

There is no evidence of free fluid. A 1.45 x 1.42 cm hypoechoic rounded lymph node is observed adjacent to the ileocecal colic junction. Surrounding mesentery is hyperechoic.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The enlarged colic lymph node could be consistent with infiltrative neoplasia (i.e., lymphoma), lymphoid hyperplasia or reactive lymphadenitis.
- The pancreatic changes may be a normal variant for this patient or could be consistent with mild, chronic pancreatitis. Correlation with clinical findings is recommended.

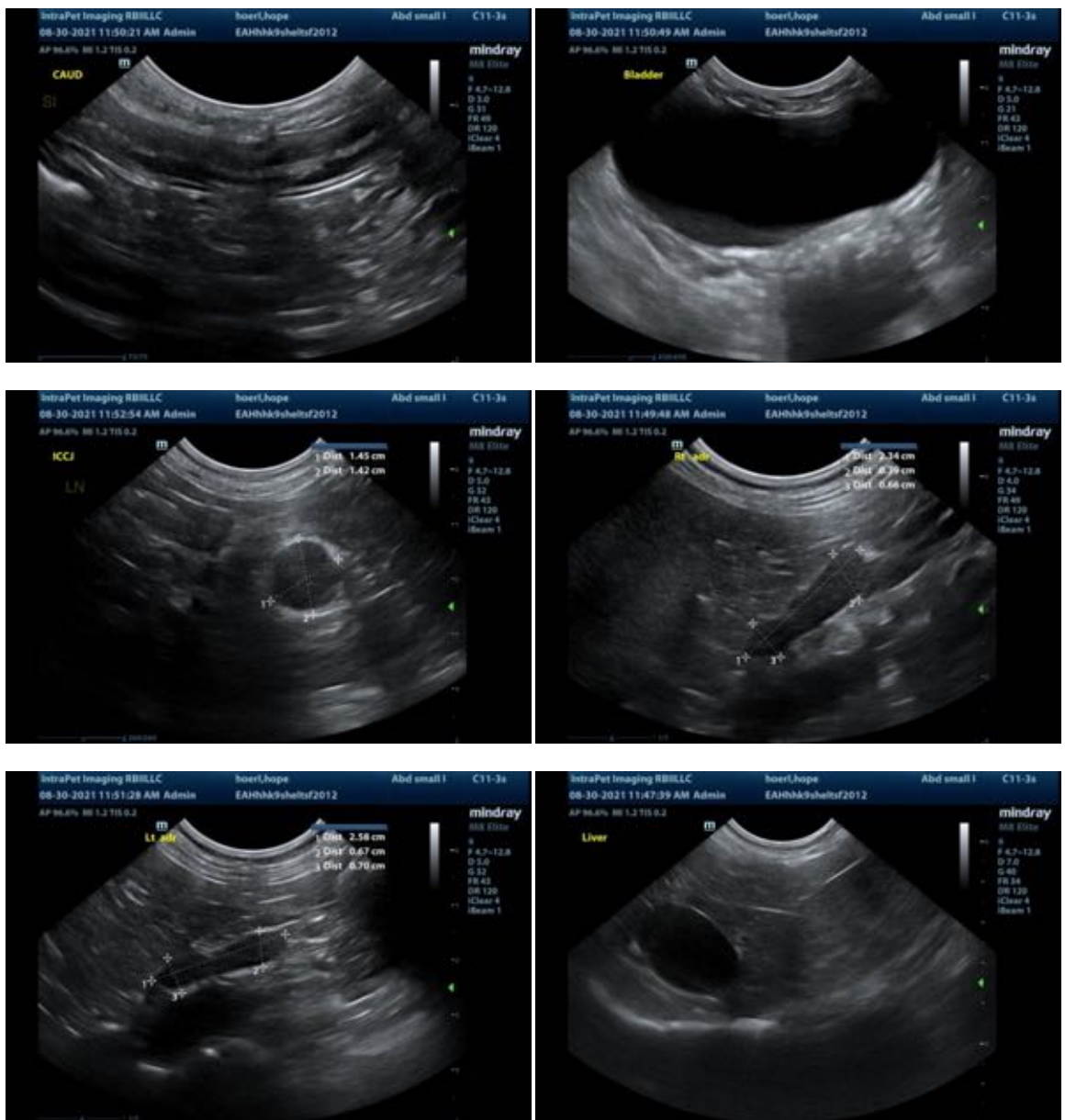
Secondary Findings:

- The hepatic changes are consistent with age-related parenchymal remodeling and are not considered clinically significant at this time.
- The splenic parenchyma changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis or splenitis with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).
- Mild bilateral age-related renal changes with dystrophic mineralization and trace pyelectasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- If accessible, a fine needle aspirate of the enlarged abdominal lymph node is recommended (if clotting status is appropriate). A 25-gauge needle should be used for aspiration.
- Three-view thoracic radiographs are recommended to assess for lymphadenopathy in the chest.
- Given the presence of the urinary tract infection, a urine culture and sensitivity is recommended 5-7 days after the last dose of antibiotics to determine if the infection has cleared.
- Other diagnostic considerations for the GI signs include the following:
 1. A fecal evaluation for ova/Giardia (if not already performed).

2. Serum cobalamin, folate, PLI and TLI
3. A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended
4. If clinical signs persist and the above diagnostics are inconclusive, endoscopic or surgical gastrointestinal biopsies could be considered.







The information and recommendations provided are based on the images presented by the referring veterinarian. 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, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)
Andrea.nicastro@sonopath.com