

**DATE PRESENTING CLINICAL SIGNS**

8/30/21

History: Presented for chronic intermittent diarrhea, pruritus, and dermatitis along with acute vomiting and hematochezia. Diarrhea responsive to bland diet and metronidazole but returns once medications are stopped. Physical exam largely unremarkable.

**PATIENT**

Scout Wetzel

Current Medications: Metronidazole 250 mg PO q12hr x 7 days, started 8/16.

**SPECIES**

Canine

Lab Results: CBC/chemistry/urinalysis: largely unremarkable, alb 3.6.

IPS: negative, baseline cortisol: 1.4. ACTH stim: normal, not diagnostic for Addison's disease.

Radiographs: Not provided by the veterinarian.

**BREED**

Labrador Mix

Date of Previous IntraPet Ultrasound: No previous IntraPet scans.

Sedation: Gabapentin 300mg PO 2-3 hours prior to scan.

**SEX**

Female Spayed

Stat Report: not needed

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN****AGE**

10/16/20

**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.

**WEIGHT**

45.8 lbs.

The left kidney is normal size (5.64 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. Renal vasculature is normal.

The right kidney is normal size (5.41 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. Renal vasculature is normal.

**INTERPRETED BY**

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

**HOSPITAL NAME**

Eastern Animal  
 Hospital

**Adrenal Glands**

The left adrenal gland is normal size (0.52 cm at cranial pole) (0.56 cm at caudal pole) (2.62 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.

**REFERRING VET**

Dr. Michelotti

The right adrenal gland is normal size (0.58 cm at cranial pole) (0.49 cm at caudal pole) (2.48 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.

**INVOICE**

11725kk

**Spleen**

The spleen is normal in size (1.89 cm in width at the level of the hilus) with a normal capsular contour. A light micronodular pattern is present throughout the parenchyma. No focal lesions are observed. Splenic vasculature is normal.

### *Liver*

The liver is subjectively normal in size with normal contours and structure. 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 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 ileocolic junction and colonic wall are normal. The colonic lumen contains granular-appearing fecal material. There is no evidence of obstruction.

### *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 1.96 cm medial ileac lymph node is visualized. In addition, 1-2 prominent mesenteric lymph nodes are seen.

## **ULTRASONOGRAPHIC FINDINGS**

### **Primary Findings:**

\*\*An obvious cause for the patient's clinical signs is not identified in this study. Considerations include primary gastrointestinal disease (i.e., food intolerance/allergy, inflammatory bowel disease, other), low grade pancreatitis, underlying metabolic issue, and other.

### **Secondary Findings:**

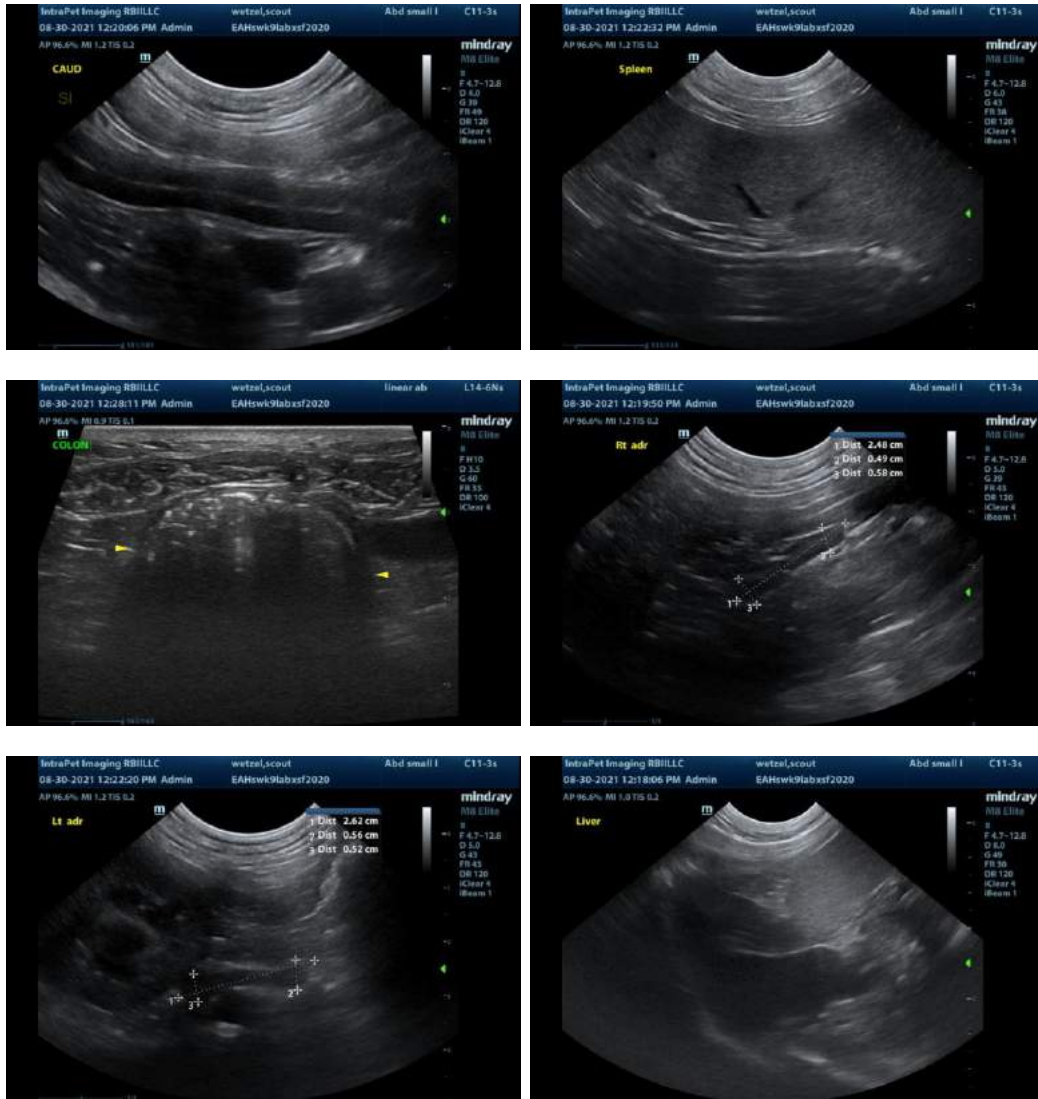
- The splenic parenchyma changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis or splenitis with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

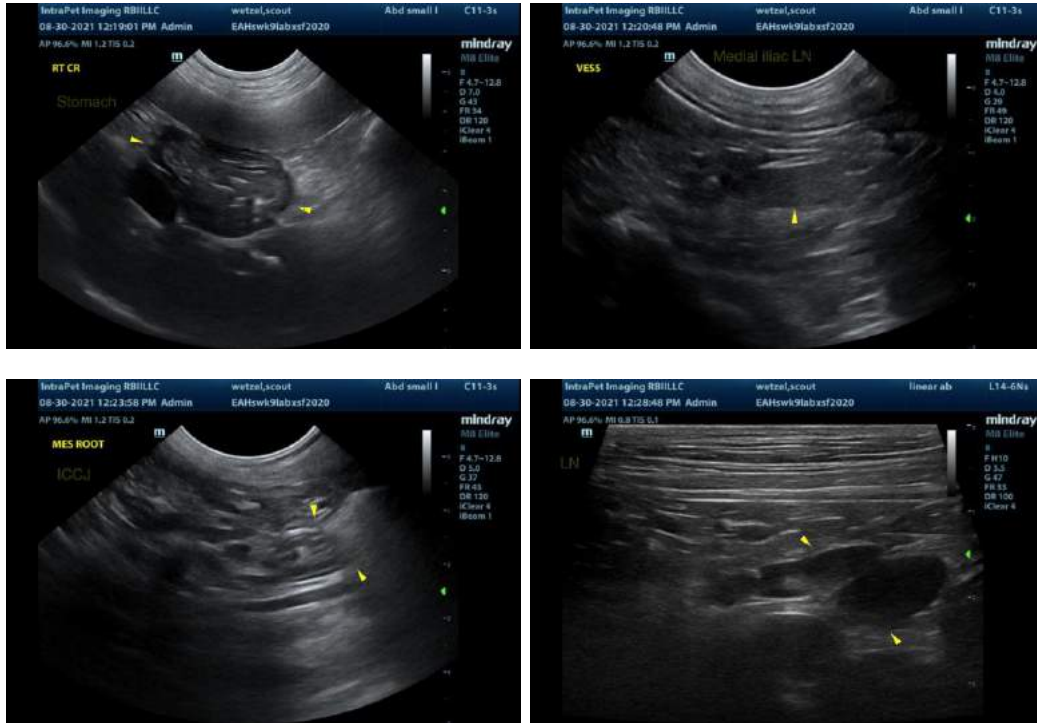
## **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The following diagnostics/treatment recommendations can be considered:

1. Serum cobalamin, folate, PLI and TLI
2. Despite a negative fecal evaluation, consider a prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.
3. A 6-week limited antigen diet trial to assess for food allergies.
4. Consider pre- and post-prandial serum bile acids to assess for occult hepatic dysfunction.

5. Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be warranted.
6. Three-view thoracic radiographs should be performed prior to any anesthetic event.





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.

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