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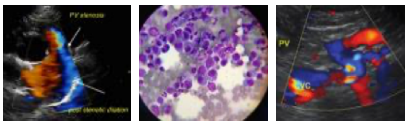

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DATE

8/30/2021

PATIENT

Zoya Hill

SPECIES

Canine

BREED

German Shepherd

SEX

Female, spayed

AGE

3/30/2014

WEIGHT

81 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Noah's Ark Veterinary & Boarding Resort

REFERRING VET

Dr. Martinez-Hernandez

INVOICE

11973

PRESENTING CLINICAL SIGNS

History: The patient was seen for lameness but during PE some appetite changes/fluctuations, as well as vomiting were noted. Lab work had some changes indicating some Renal and Potentially Pancreatitis concerns. Follow up CPL- confirmed pancreatitis. Still need to follow up with some additional lab work to determine renal. The following day Zoya also started having some diarrhea. Addendum: 8-21-21:
Follow up labs had Normal SDMA as well as CPL values and GI issues had resolved temporarily- Purina EN diet continued- last week had an episode of vomiting and diarrhea reoccurred. Started on Proviable and on 8-25-21 had multiple episodes of vomiting bile- seems to be responsive to Cerenia.

Current Medications: Initially- Cerenia/ Gabapentin /famotidine
added in metronidazole and Proviable once diarrhea began. Currently
Gabapentin 300 mg 1 BID, Dasuquin - 1 chew Daily, Cytopoint- 80 mg once daily, Douxo mousse/wipes as needed, Apoquel 16 mg 1 tab as needed, Cytopoint at needed, Cerenia 160 mg 1/2 PO SID as needed- may switch to Zolfran 8 mg SID- BID by the time US is performed, Famotidine 20mg - SID - evening.

Lab Results: SDMA- elevated, inappropriate SPG. Lipase/Ck/CPL- elevated. Updated labs attached separately – values WNL.
Radiographs: Not provided by the veterinarian.
Date of Previous IntraPet Ultrasound: No previous IntraPet scans.
Sedation: IV sedation utilized for AUS
Stat Report: not requested

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 (7.14 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.

The right kidney is normal size (7.07 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 length (0.55 cm at cranial pole) (0.56 cm at caudal pole) (3.12 cm in length) with flattened contour. 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 length (0.49 cm at cranial pole) (0.52 cm at caudal pole) (2.40 cm in length) with flattened contour. 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 (2.47 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 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 gallbladder 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.

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 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:

- The flattened adrenal glands may be a normal variant or could be consistent with early atrophy (i.e., secondary to hypoadrenocorticism)

Secondary Findings:

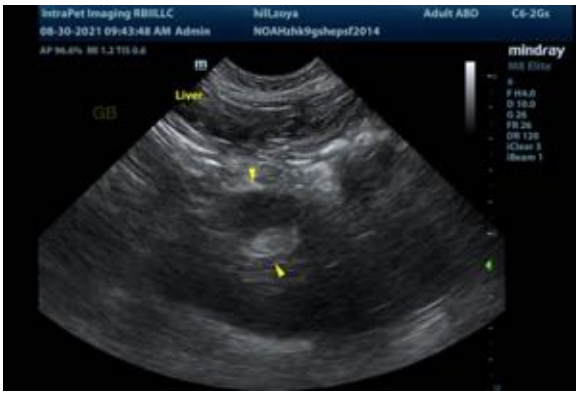
- Gallbladder debris- incidental.
- Minor chronic renal changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The following diagnostics/treatment recommendations can be considered:

1. Serum cobalamin, folate, PLI and TLI
2. A fecal evaluation for ova/Giardia
3. Prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.
4. A 6-week limited antigen diet trial to assess for food allergies.
5. A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended.
6. Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be warranted.

7. 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.

Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)
Andrea.nicastro@sonopath.com