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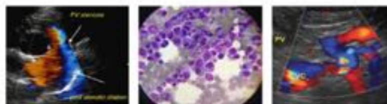
Potomac Mobile Veterinary Ultrasound



SonoPath

Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™

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

PATIENT

Jerry Pickett

SPECIES

Canine

BREED

Beagle Mix

SEX

Neutered Male

AGE

13 years

WEIGHT

34 lbs

INTERPRETED BY

Andrea Nicastro, DMV, Diplomate DACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Potomoc Mobile Vet US

HOSPITAL NAME

Silver Spring AH

REFERRING VET

Dr. Cathy Jarret

INVOICE

11523

DATE

8.30.22

PRESENTING CLINICAL SIGNS

History: Went to the ER last week. Diarrhea resolved yesterday and vomiting is resolving. The ER the patient went to recommend a follow up ultrasound.

Abnormal PE/Chem/CBC/UA Results:

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** is normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended with mostly 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 (1.02 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The **left kidney** is normal in size (5.25 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild loss of corticomedullary distinction. A hyperechoic medullary band is observed adjacent to the corticomedullary junction. Several hyperechoic shadowing diverticular foci are observed. Mild pyelectasia is present (0.32 cm in the transverse plane.) There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

The **right kidney** is normal size (5.27 cm in length); with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild loss of corticomedullary distinction. A hyperechoic medullary band is observed adjacent to the corticomedullary junction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronureter. Renal vasculature is normal.

Adrenal Glands

The **left adrenal gland** is normal size (0.59 cm at cranial pole) (0.66 cm at caudal pole); (2.28 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.

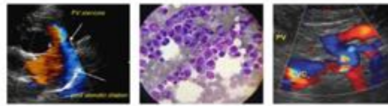
The **right adrenal gland** is normal size (0.72 cm at cranial pole) (0.58 cm at caudal pole); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The **spleen** is normal in size (1.22 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 prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits mild heterogeneity. No distinct focal lesions are observed. The parenchymal echotexture is coarse. Hepatic vasculature and biliary tracts are of normal volume with no evidence of congestion.



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The **gall bladder** lumen is moderately distended. The wall is thin and smooth. A small amount of aggregated, echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The **gastric lumen** is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness with a retention of the normal layering pattern. There is slight disruption in the normal 1:3 muscularis: mucosal ratio in some segments. Discreet masses are not identified. The colonic wall is normal. The colonic lumen contains shadowing fecal material. 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

There is no evidence of free fluid. A few prominent mesenteric **lymph nodes** are visualized, the largest measuring 0.72 cm in length).

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The small intestinal wall changes are suggestive of inflammatory bowel disease with minor potential for emerging lymphoma. (Changes are similar to the previous sonogram).

Secondary Findings

- 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. (Changes are similar to the previous sonogram).

- Bilateral degenerative renal changes with dystrophic mineralization and left pyelectasia. (Changes are similar to the previous sonogram).

- Age-related pancreatic remodeling +/- fibrosis. Mild chronic pancreatitis is also possible, particularly if the patient's clinical history is supportive of this diagnosis. (Changes are similar to the previous sonogram).

- 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

Given the patient's history of chronic GI signs, consider the following:

1. Consider fecal evaluation for ova and Giardia, if not already performed.
2. Also consider prophylactic deworming with Fenbendazole.

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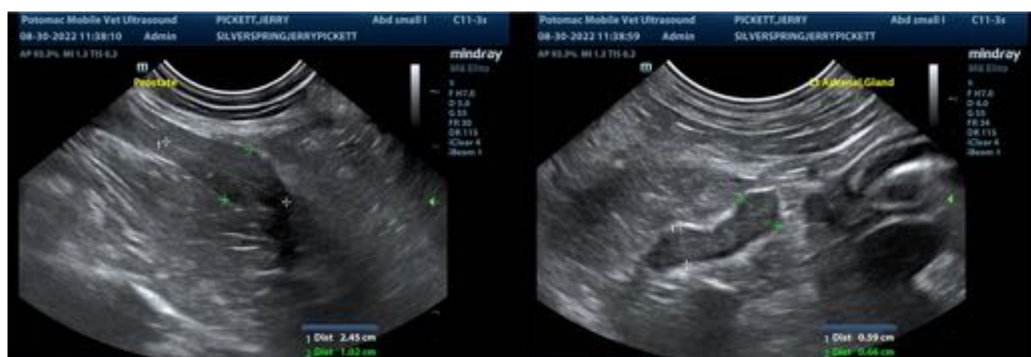
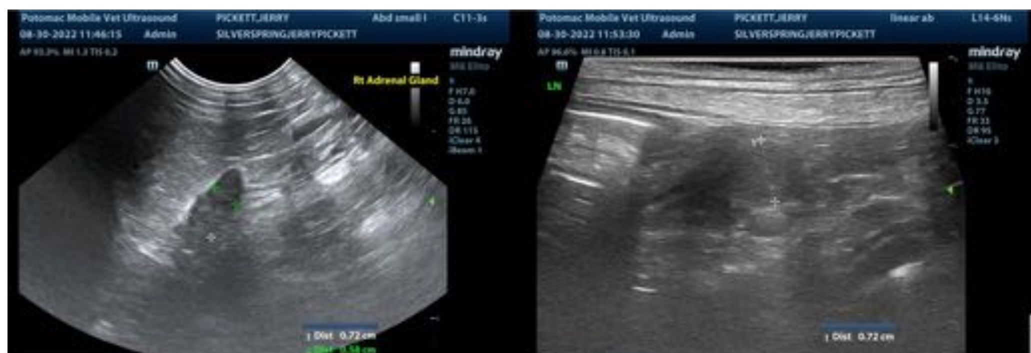
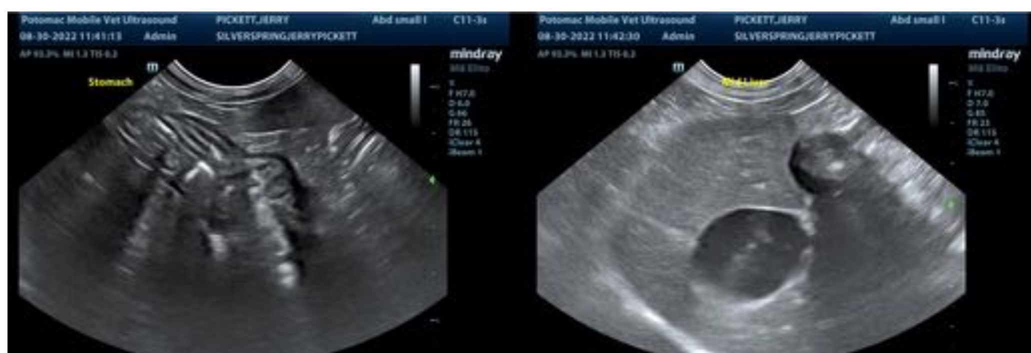
3. A malabsorption panel (serum cobalamin and folate, TLI and PLI) is recommended; send to Texas A&M
4. A resting cortisol level is recommended to screen for hypoadrenocorticism.
5. Consider a 6-week novel protein diet trial.
6. Also consider initiation of a probiotic with a high colony count (i.e., Proviable Forte or Visbiome), along with empirical treatment for small intestinal bacterial overgrowth (i.e., Tylosin).
7. If the above diagnostics are inconclusive and the patient's clinical signs persist, GI biopsies (i.e., endoscopic or surgical) can be considered.







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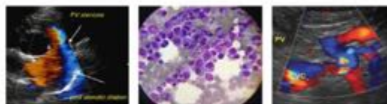

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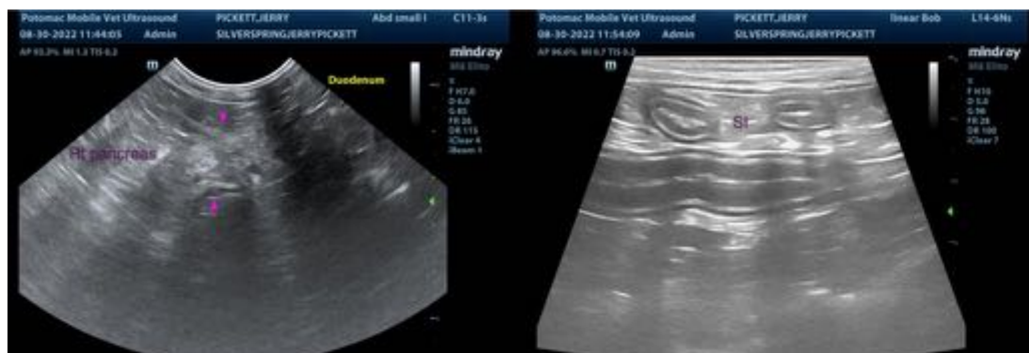

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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