



## PATIENT

Dakota Cordrey

## SPECIES

Canine

## BREED

Chihuahua

## SEX

Neutered Male

## AGE

7 years

## WEIGHT

5.94 kg

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Dr. Laura De Cordon

## HOSPITAL NAME

Mason Dixon Animal  
ER

## REFERRING VET

Dr. Laura De Cordon

## INVOICE

11532

## DATE

8.31.22

## PRESENTING CLINICAL SIGNS

History: Presented 8.30.22 for not eating and vomiting/diarrhea for several days. Diagnosed with DM and pancreatitis early 2022. Since then, has had several flare ups of pancreatitis and has continued to lose weight. Difficulty managing diet as Dakota very picky eater and is often enticed to eat by using treats or table food

Abnormal PE/Chem/CBC/UA Results: Chem: Phos 6.2, TP high normal, Alb 4.6, BG 593, chol >450, ALP >993, Lytes: WNL CBC: Mild neutrophilia, Hct 53% CPLi: Not done, expected to be positive Serum ketones: 80

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The **urinary bladder** wall is normal in thickness and the mucosal surface is smooth. The bladder is distended. A small amount of suspended, echogenic debris is observed within the lumen. 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 visualized portion of the **prostate** appears normal in size with smooth peripheral contours and homogenous parenchyma. The prostatic urethra is not overtly dilated.

The **left kidney** is subjectively normal size with a normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. A hyperechoic medullary band is observed adjacent to corticomedullary junction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The **right kidney** is normal size (4.59 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. A hyperechoic medullary band is observed adjacent to corticomedullary junction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

### Adrenal Glands

The **left adrenal gland** is normal size (0.50 cm at cranial pole) (0.53 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.

The **right adrenal gland** is normal size (0.71 cm at cranial pole) (0.48 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 (0.72 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 enlarged with slightly swollen peripheral contours. The parenchyma is isoechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular 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. A small to moderate amount of aggregated, echogenic, mostly gravity dependent debris/sludge 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 is normal in thickness with a normal layering pattern. 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. The lumen of the descending colon contains shadowing fecal material. There is no evidence of an obstructive pattern.

### ***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 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.
- Gall bladder debris/sludge, non-mucocele
- Minor degenerative renal changes

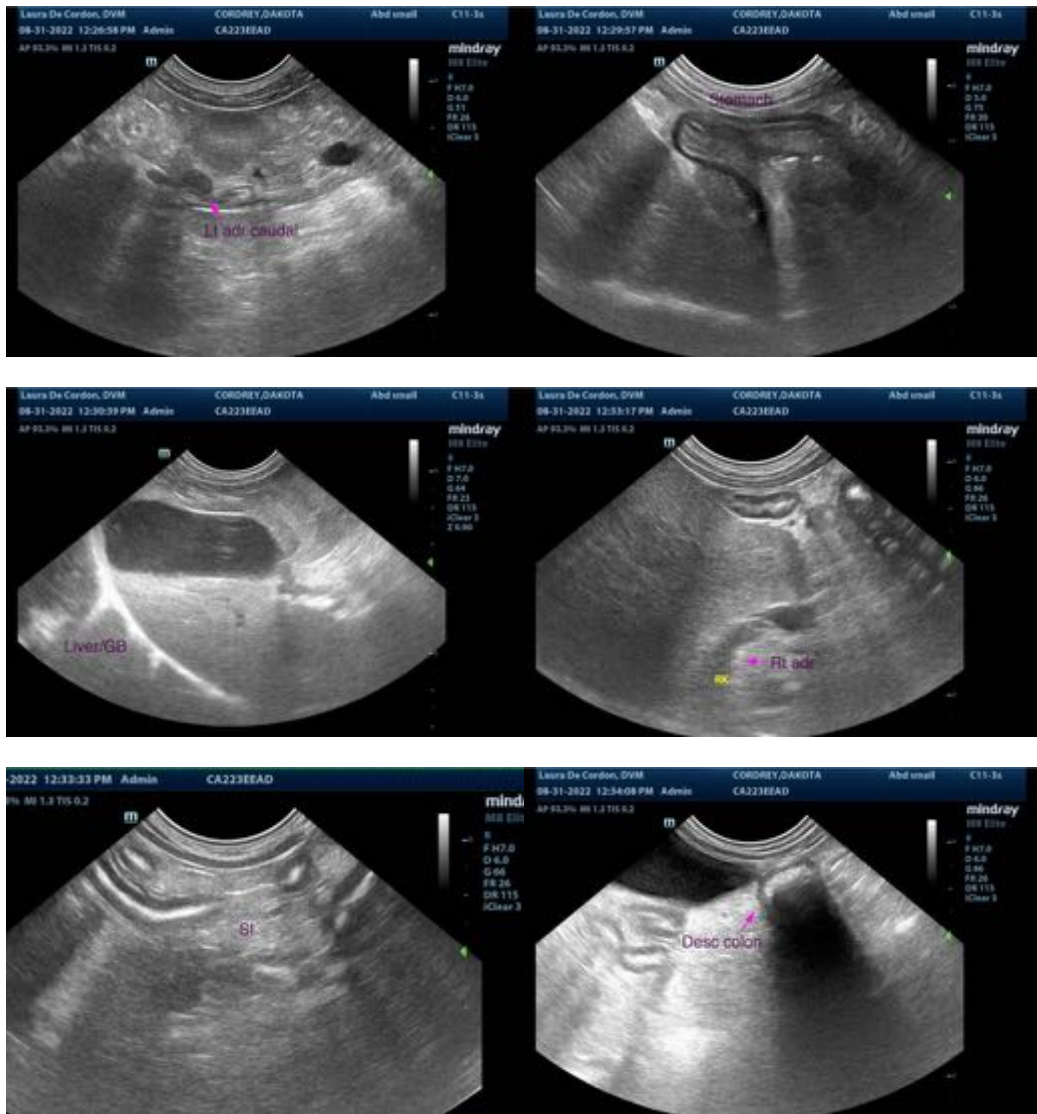
\*An obvious cause for the patient's clinical signs is not identified in this study. Considerations include microscopic gastrointestinal disease (i.e., food allergy/intolerance, inflammatory bowel disease, infectious/parasitic disease), pancreatic disease, underlying metabolic issue, other.

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

The following diagnostics/treatment recommendations can be considered:

1. Serum cobalamin, folate, PLI and TLI
2. Fecal evaluation for ova/Giardia
3. Prophylactic deworming with Fenbendazole
4. A 6-week hydrolyzed or limited antigen diet trial to assess for food allergies.
5. Consider a 4-week course of Tylosin as empirical treatment for small intestinal bacterial overgrowth.
6. A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended.

7. Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be warranted. Three-view thoracic radiographs should be performed prior to any anesthetic event.
8. While awaiting test results, supportive care for diabetic ketoacidosis is recommended, including regular insulin, fluid therapy, gastric protectants, antiemetics and pain medication as needed.



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.

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