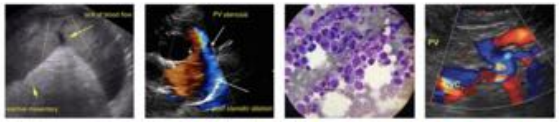


PATIENT

Bella Smith

SPECIES

Canine

BREED

Pitbull Mix

SEX

Spayed Female

AGE

9.16.2010

WEIGHT

50.5 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

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

HOSPITAL NAME

Flowertown AH

REFERRING VET

Rebecca Hawk

INVOICE

11684

DATE

9.23.22

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Chronic vomiting or diarrhea intermittently for ~1 yr per O but has gotten much worse and more frequent over past 4 months. Pt has lost a large amt of weight in combo with that (approx 15-20 lbs) Pt does eat chicken feces in yard or cat feces. Both cats in household eat raw pork and beef for meals. PE findings- BCS 3.5/9, soft smelly stool with thickening on rectal, muscle atrophy, QAR

Abnormal lab-work values: CBC unremarkable. Chemistry panel shows an ALT of 123. Urinalysis specific gravity is 1.040. 3+ proteinuria inactive sediment. T4 is normal.

Current Medications: Simparica Trio
Radiographic Findings: not performed

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** wall is 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 2-3 cm, are normal.

The **left kidney** is normal size (6.06 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The **right kidney** is normal size (6.84 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild 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 enlarged (1.06 cm at cranial pole) (1.03 cm at caudal pole) (3.44 cm in length); with a slightly irregular shape. A 1.05 x 0.82 cm hyperechoic to mildly heterogenous nodule is observed at the cranial pole. The parenchyma in the mid- to caudal aspect is heterogenous with loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature are normal.

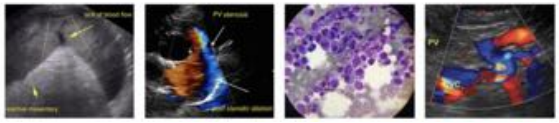
The **right adrenal gland** is borderline enlarged (1.16 cm at cranial pole) (0.72 cm at caudal pole); normal shape and smooth peripheral contours. The parenchyma is mildly heterogenous with some loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature appear normal.

Spleen

The **spleen** is normal in size (1.89 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 portal vein to caudal vena cava ratio is approximately 1: 1.



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The **gall bladder** lumen is moderately distended. The wall is thin and smooth. A small to moderate amount of gravity dependent, echogenic debris is observed within the lumen. 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 mildly distended with ingesta. 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. 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

There is no evidence of free fluid. A 1.94 cm medial iliac **lymph node** is visualized. A few prominent mesenteric lymph nodes are also seen, the largest measuring 1.60 cm in length.

Other

A **brief echocardiogram** reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- If the patient was fasted for this study, the presence of ingesta within the gastric lumen could suggest delayed gastric emptying.

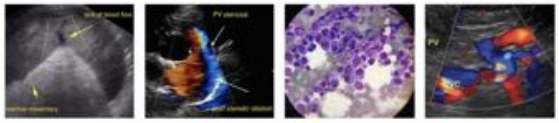
Secondary Findings

- The bilateral adrenomegaly is most consistent with hyperplastic change. The left adrenal nodule trends toward the benign (i.e., nodular hyperplasia). However, an emerging tumor cannot be completely excluded.
- Minor bilateral degenerative renal changes

*An obvious cause for the patient's chronic gastrointestinal signs is not identified in this study. Considerations include food allergy/intolerance, infectious/parasitic disease, inflammatory bowel disease, underlying metabolic issue, mild chronic pancreatitis, occult neoplasia, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A fecal evaluation for ova and Giardia is recommended.
- Consider prophylactic deworming with Fenbendazole, if not already performed.
- Given the weight loss, three-view thoracic radiographs are recommended to assess for occult neoplasia in the chest.



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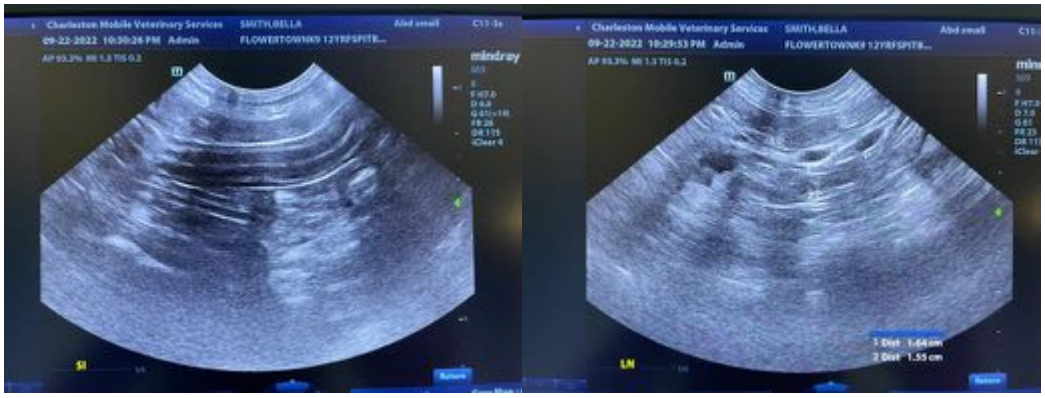
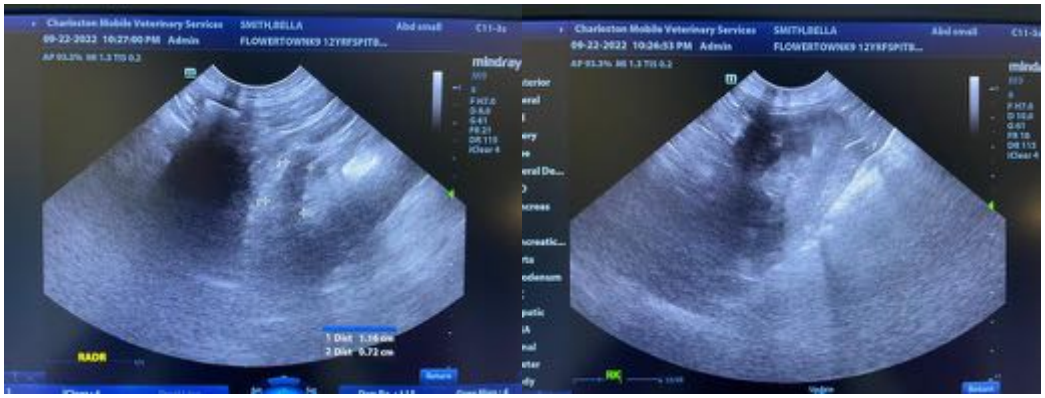
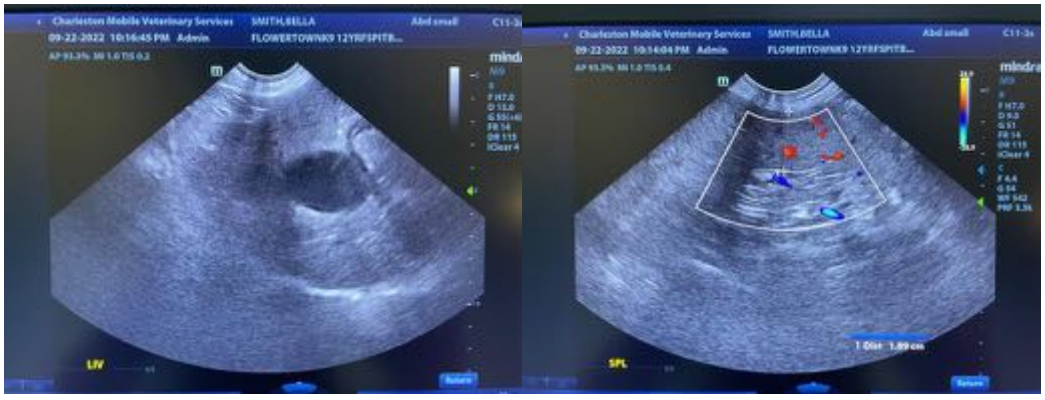
- Consider supplementation with a probiotic (i.e., Proviable Forte or Visbiome).
- A GI panel including serum cobalamin and folate, TLI and PLI, is also recommended (send to Texas A&M).
- Also consider empirical treatment for small intestinal bacterial overgrowth with a 4-week course of Tylosin.
- A 6-week hydrolyzed protein or limited antigen diet trial should also be considered.
- Ultimately, endoscopic or surgical biopsies may be necessary to get a definitive diagnosis.
- Given the proteinuria, a UPC is recommended.







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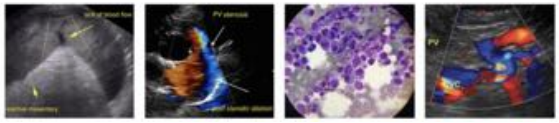

Charleston Mobile Veterinary Services
IMAGING PERFORMED BY
CharlestonMobile.Net 800.403.5408

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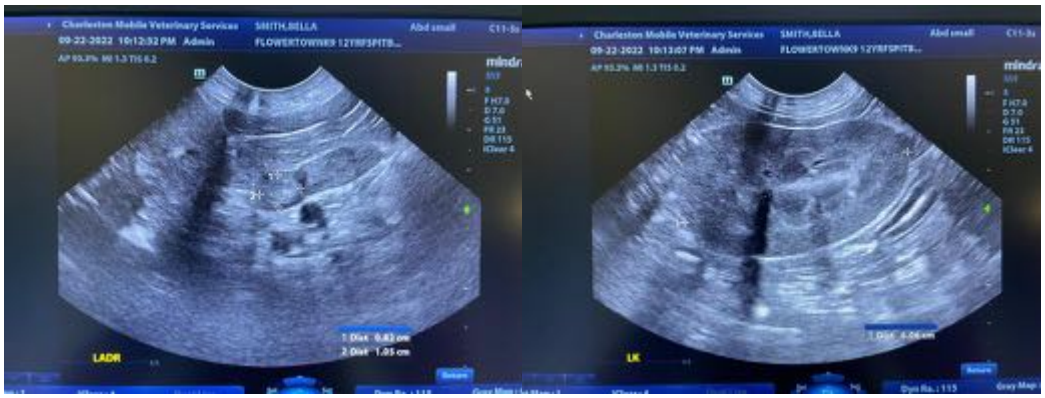

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com