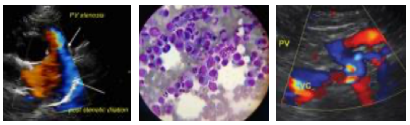
IMAGING PERFORMED BY

IntraPet.com



SonoPath
Clinical Sonography & Telecytology
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DATE

9/26/22

PATIENT

Taxi Maloney

SPECIES

Canine

BREED

Greyhound

SEX

Male, neutered

AGE

3/14/2013

WEIGHT

82.3 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Fullerton AH

REFERRING VET

Dr. Unger

INVOICE

14024

PRESENTING CLINICAL SIGNS

History of intermittent recurring diarrhea. Also has a history of proteinuria we are following. O notes diarrhea has been occurring on an off for a few weeks. It seems to be responsive to metronidazole and bland diet but recurs when diet is stopped, or meds finished. Had similar issue years ago than only was resolved with Tylan use. Other than needing a dental exam unremarkable.

Current Medications: Metronidazole 500mg BID started 9/22
Proviable capsules daily as Proviable paste PRN, I/D diet, Advantage Multi monthly.
Lab Results: Negative fecal and Giardia Elisa; last lab results in July NSF anf last UPC 0.5.
Date of Previous IntraPet Ultrasound: 11/2/21.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Rachel Brilhart, RDMS.

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. The region of the trigone and the visible portion of the proximal urethra are normal.

The prostate is not definitively visualized due to its pelvic location.

The left kidney is normal size (7.10 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (8.60 cm in length) with a slightly irregular shape. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. There is a questionable cortical infarct at the lateral aspect. There is no evidence of pyelectasia, nephroliths or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.80 cm at cranial pole) (0.67 cm at caudal pole) (2.82 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 (0.66 cm at cranial pole) (0.68 cm at caudal pole) (4.12 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.

Spleen

The spleen is prominent in size (2.84 cm in width at the level of the hilus) with normal curvilinear peripheral margins and a folded contour. The parenchyma is subtly mottled in appearance. 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. A small amount of aggregated, echogenic partially dependent 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 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 right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely hyperechoic 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 0.87 cm lymph node is observed in the cranial abdomen.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis. This is a new finding.
- The prominent cranial abdominal lymph node is likely reactive.

Secondary Findings:

- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or antigenic stimulation with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia). Changes are similar to the previous sonogram.
- Bilateral, degenerative renal changes with a questionable right cortical infarct. The renal changes have progressed since the previous sonogram.

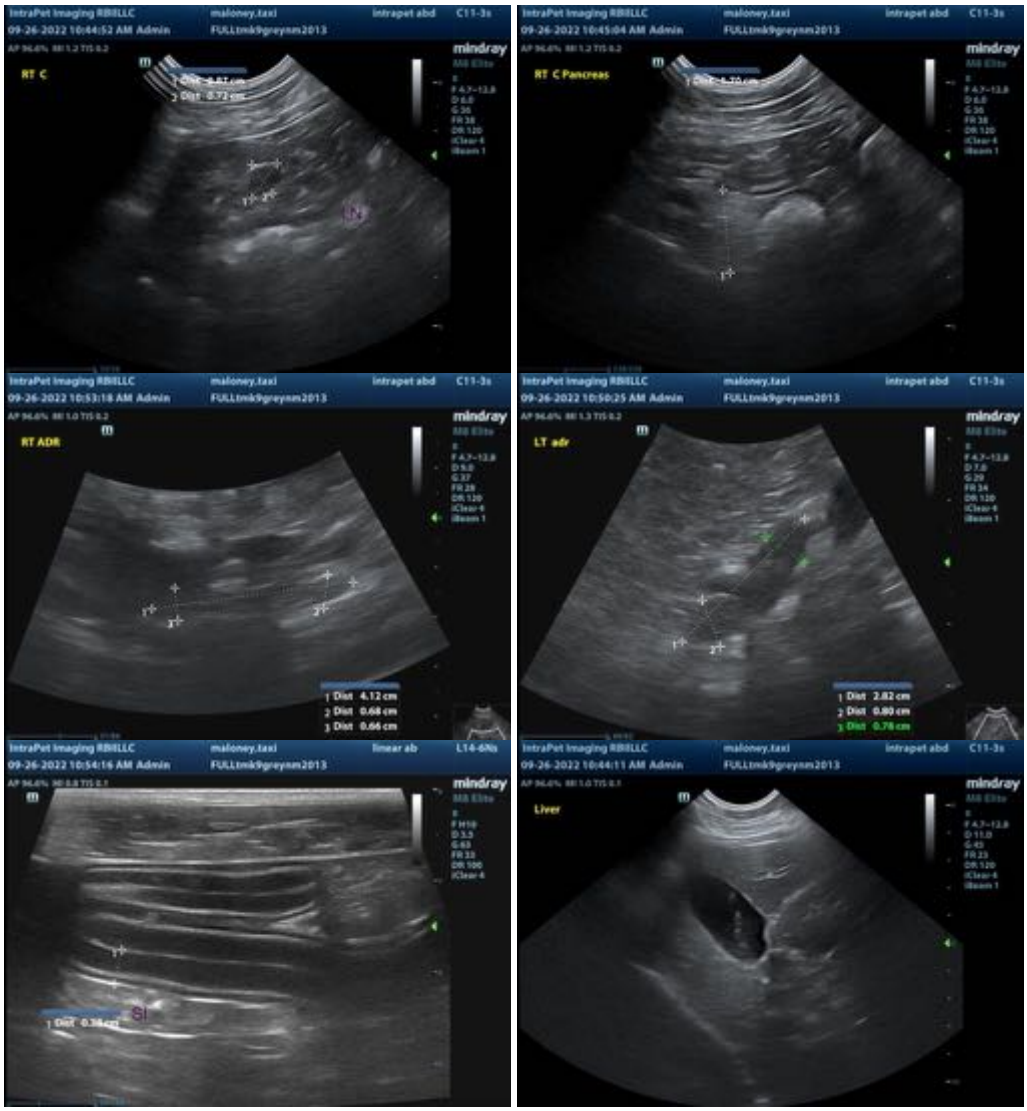
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Despite the negative fecal evaluation, consider prophylactic deworming with Fenbendazole.
- A GI panel including serum cobalamin, folate, TLI and PLI is also recommended.
- Consider a 6-week hydrolyzed protein or limited antigen diet trial to assess for food allergies.
- Also consider repeating a 4-week course of Tylosin (in lieu of Metronidazole) as empirical treatment for small intestinal bacterial overgrowth.

- If the above diagnostics are inconclusive and the diarrhea persists, gastrointestinal biopsies (i.e., endoscopic or surgical) may be necessary to get a definitive diagnosis.

- Regarding the history of proteinuria and the renal changes, consider the following:

    - Recheck baseline blood work, UPC and blood pressure. Depending on results, additional therapy may be warranted.



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, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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