

**DATE PRESENTING CLINICAL SIGNS**

9/8/21 History: 2 episodes of hematochezia, vomiting, and lethargy within 3–4-week period; weight loss. With the second episode, some pink was noted in vomit.

PATIENT

Finch Rives

Current Medications: Metronidazole, Provable, RC GI low fat, Sucralfate, Zonisamide.

SPECIES

Canine

Lab Results: TP 5.1 (5.2 – 8.2), ALB 2.2 (2.3-4.0), GLOB 2.8 (2.5-4.5). No GI panel at this time. Resting Cortisol 1.7. UA: SP GRAVITY 1.045, BILIRUBIN 1+, PH 6.5, PROTEIN TRACE, WBC UAM 0-2 HPF 0 - 5, RBC UAM 0-2 HPF, RARE RODS <9/HPF, EPI CELL 3+ (6-10)/HPF (this was a free catch sample) unfortunately UPC was not performed due to bacteria. Fecal negative. Snap cPL (performed first episode) negative/normal.

BREED

Labradoodle

Radiographs: Not provided by the veterinarian.

Date of Previous IntraPet Ultrasound: No previous IntraPet scans.

SEX

Male Neutered

Sedation: Sedation not required for scan.

Stat Report: STAT report not requested by the veterinarian.

AGE

5/28/09

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**Urinary System**

The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is smooth.

WEIGHT

59.4 lbs.

The bladder is moderately distended. A small to moderate amount of aggregated, echogenic debris is suspended 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.

INTERPRETED BY

Andrea Nicastro, DVM,
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 (Small Animal Internal
 Medicine)

The prostate is normal in size (1.34 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

HOSPITAL NAME

Frederick Road VH

The left kidney is normal size (6.56 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal size (6.87 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

REFERRING VET

Dr. Beyer

Adrenal Glands

The left adrenal gland is normal size (0.57 cm at cranial pole) (0.51 cm at caudal pole) (2.77 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.

INVOICE

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The right adrenal gland is normal size (0.67 cm at caudal pole) (2.15 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 subjectively prominent in size (2.23 cm in width at the level of the hilus) with slightly swollen peripheral contours. The parenchyma is subtly mottled in appearance. No distinct focal lesions are observed. Splenic vasculature is normal with no evidence of thrombosis.

Liver

The liver is subjectively prominent in size with slightly swollen peripheral contours. The parenchyma is hypoechoic relative to the spleen with several ill-defined, hyperechoic nodules/areas throughout the parenchyma, the largest measuring 1.62 cm in length. The remaining parenchyma is subtly heterogeneous in appearance. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is distended with gas. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The small intestinal lumen is segmentally dilated with gas and chyme. 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

A portion of the pancreas is obscured by the gas-distended stomach. In the visualized portions, no obvious pathology is observed.

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 splenomegaly could be consistent with infiltrative neoplasia (i.e., round cell tumor), lymphoid hyperplasia, extramedullary hematopoiesis or splenitis.

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.
- Urinary bladder debris.

****An obvious cause for the patient's clinical signs is not identified in this study. Considerations include microscopic gastrointestinal disease, low-grade pancreatitis, underlying metabolic issue, and other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. Three-view thoracic radiographs are recommended to assess for occult esophageal disease and neoplasia.
2. Other diagnostic considerations include the following:
 - a. A fecal evaluation for ova/Giardia
 - b. A malabsorption panel including serum cobalamin, folate, PLI and TLI.
 - c. Complete ACTH stimulation test (post-cortisol).

- d. Consider transitioning to a hypoallergenic diet.
 - e. Depending on the results of the above diagnostics, endoscopic or surgical gastrointestinal biopsies may be necessary to get a definitive diagnosis.
3. To assess for other concurrent causes of hypoalbuminemia, consider a UPC and pre- and post-prandial serum bile acids.
 4. Also consider a fine needle aspirate of the spleen to evaluate for round cell neoplasia.





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.

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