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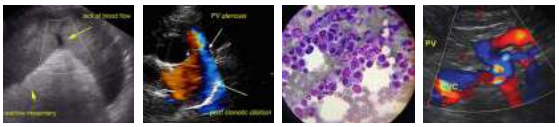


ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

PATIENT
Akira Davis

SPECIES
Canine

BREED
Akita Mix

SEX
Female Spayed

AGE
11 years

WEIGHT
83.2 lbs.

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

IMAGING PERFORMED BY
Jenna Walsh

HOSPITAL NAME
VCA McKenzie Animal Hospital

REFERRING VET
Dr. Fricke

DATE
9/24/21

INVOICE
11892kk

PRESENTING CLINICAL SIGNS

History: Persistent hypersalivation, regurgitation of mucoid saliva during and following extended anesthesia dental procedure August 18, 2021. Poor appetite. Initial radiographs were suspicious for bronchopneumonia, patient improved on oral antibiotics and Cerenia, then relapsed off antibiotics. Restarting antibiotics did not improve appetite or reduce salivation. Recheck radiographs showed normal thoracic structures. Akira has improved temporarily with manual therapy of the head and neck, but signs recur after a few days. Anesthesia to remove the final fractured tooth done on 9/22/2021. Signs worsened again after anesthesia: hypersalivation, vomiting, inappetence. The patient is also having an echocardiogram performed today.

Current Medications: Hydromorphone, Meloxicam injections given 9/23/21. Oral medications are not tolerated- regurgitated.

Abnormal PE/Chem/CBC/UA Results: September 14 labs: Normal CBC, Superchem panel normal with 3.7 globulin (1.6-3.6 range)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder and visible portion of the pelvic urethra are normal for the degree of luminal distension. The urine is anechoic with no evidence of debris. Cystic calculi and discrete masses are not observed. The region of the trigone is normal.

The left kidney is normal size (7.00 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. A 0.54 cm cortical cyst is visualized. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (6.31 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. Renal vasculature is normal.

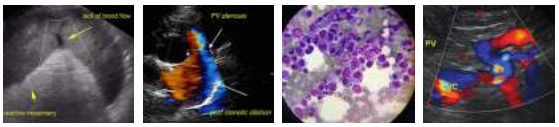
Adrenal Glands

The left adrenal gland is enlarged at the cranial pole and normal in size at the caudal pole (1.32 cm at cranial pole) (0.54 cm at caudal pole) (2.75 cm in length). A 2.00 x 1.29 cm hyperechoic nodule is observed at the cranial aspect. Within this nodule, a 0.66 x 0.42 cm hyperechoic to mineralized focus is present. Glandular echogenicity and detail at the caudal pole are normal. The phrenicoabdominal vein and surrounding vasculature appear normal.

The right adrenal gland is normal size (0.68 cm at cranial pole) (0.48 cm at caudal pole) (2.29 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 normal in size (1.44 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



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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 is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. 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 segmentally dilated with gas. 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 pancreas is normal in size with normal peripheral contours. The pancreatic duct is normal. The base and limbs of the pancreas are isoechoic to surrounding omental fat. No focal lesions are observed. There is no evidence of peripancreatic 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.

Other

A brief echocardiogram reveals no evidence of pericardial effusion.

ULTRASONOGRAPHIC FINDINGS

- The left adrenal changes could be consistent with a hyperplastic nodule with a focus of mineralization. Alternatively, an early neoplastic process may be present.

**An obvious cause for the patient's clinical signs is not identified in this study. The left lateral thoracic radiograph included with the history reveals a gas-distended esophagus, which may be indicative of esophageal dysfunction (i.e., secondary to reflux esophagitis), primary megaesophagus or aerophagia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Supportive care for reflux esophagitis is recommended. An upper GI endoscopy would be ideal to assess for esophageal and gastric mucosal lesions. If an endoscopy is pursued, gastrointestinal biopsies should also be obtained, particularly if there is no evidence of esophagitis. If the patient's nutritional intake is sub-par, a gastrostomy tube, which can be placed at the time of endoscopy, may be warranted. Esophagitis medications can also be administered through a gastrostomy tube.

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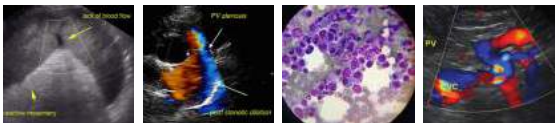

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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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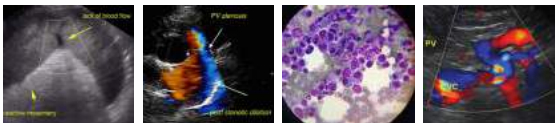

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Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance, please contact me.

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Andrea.nicastro@sonopath.com