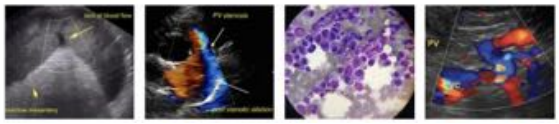


PATIENT

Sunday Showers

SPECIES

Canine

BREED

Golden Retriever

SEX

Female, spayed

AGE

1/17/2011

WEIGHT

74.2 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

West Ashley

REFERRING VET

Dr. Lauren Tierney

INVOICE

14517

DATE

1/31/23

PRESENTING CLINICAL SIGNS

The patient presented for vomiting and black stool. Inappetance. History of elevated PLI. GI issues on and off for last few weeks. Most recent baseline labs (12/22) unremarkable.

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 cm, are normal.

The left kidney is normal size (6.98 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (7.65 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal 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 normal size (0.64 cm at cranial pole) (0.60 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 (1.12 cm at cranial pole) (0.75 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.

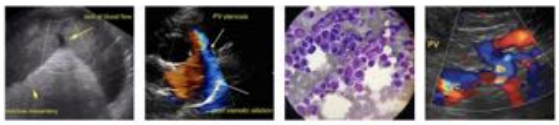
Spleen

The spleen is normal in size (1.60 cm in width at the level of the hilus) with a normal capsular 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 curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen with minor changes consistent with age-related remodeling. No focal lesions are observed. Hepatic vasculature 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 amount of aggregated, echogenic to mineralized debris/sand +/- tiny cholelithsare observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal



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The gastric lumen is mildly to moderately distended with ingesta and soft shadowing irregular hypoechoic bodies. The gastric wall in the region of the fundus is normal in thickness with retention of the normal layering pattern. The pyloric wall is prominent to mildly thickened (up to 1.27 cm) with apparent retention of the normal layering pattern. The pyloric outflow tract appears patent. The proximal duodenal lumen is mildly fluid distended and hypomotile. In the remaining small intestinal segments, the lumen is empty. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. The colonic wall is normal.

Pancreas

The base of the pancreas is visible/prominent with minimal deviation from the normal peripheral contours. The parenchyma is mildly hypoechoic relative to surrounding omental fat. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated.

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 or obvious right atrial/auricular mass.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The pancreatic changes are suggestive of mild pancreatitis (rule out acute vs. chronic).
- The pyloric wall changes could be consistent with an inflammatory process or emerging neoplasia. An inflammatory process is favored.

Secondary Findings:

- Minor age-related hepatic and renal changes.
- Gallbladder sand +/- tiny cholelithsˉ incidental.
- 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).

*It is unclear whether the patient's clinical signs are secondary to primary gastrointestinal disease (i.e., food allergy, inflammatory bowel disease, neoplasia, infectious/parasitic disease), pancreatitis, an underlying metabolic issue (i.e., atypical hypoadrenocorticism) or a combination thereof.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Fecal evaluation for ova/Giardia, if not already performed.
- GI panel including serum cobalamin, folate, TLI and PLI as well as a resting cortisol level (Texas A&M)

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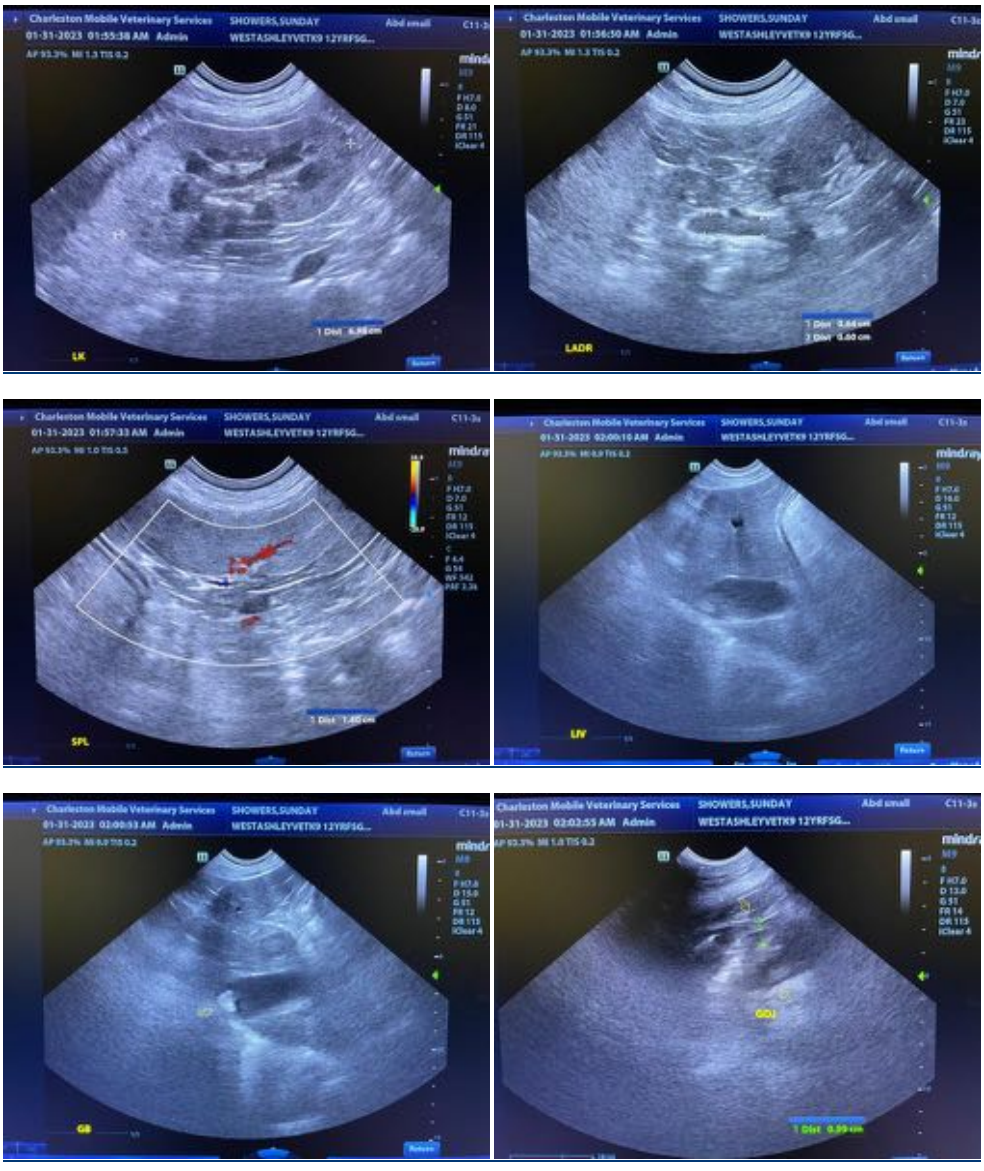
- Thoracic radiographs are recommended to assess for occult esophageal disease.
- Consider initiation of a probiotic, fiber supplement +/- a hydrolyzed protein or limited antigen diet (when the patient is eating again).
- If melena is present, empirical treatment for GI ulceration (i.e., omeprazole, sucralfate x 10-14 days) should be considered.
- Ultimately, GI biopsies (i.e., endoscopic or surgical) may be necessary to get a definitive diagnosis. Endoscopy is a less invasive option and better for evaluating for mucosal lesions.



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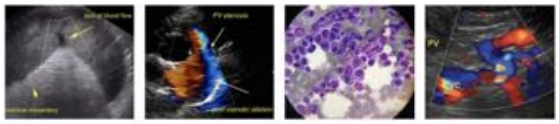

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CharlestonMobile.Net 800.403.5408

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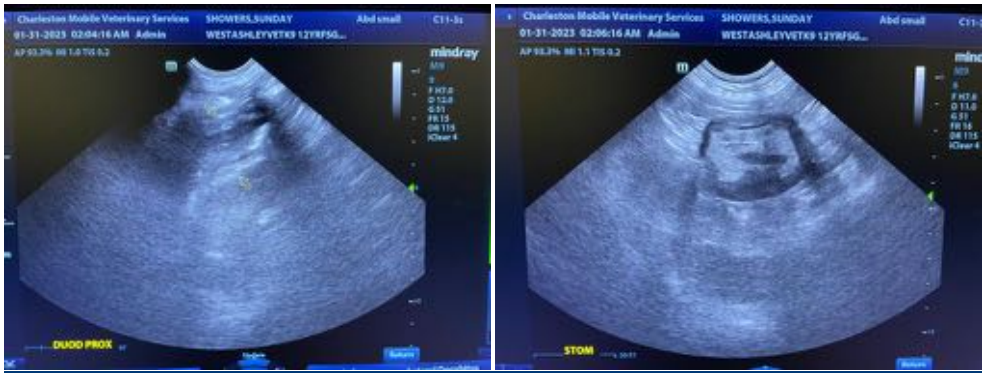

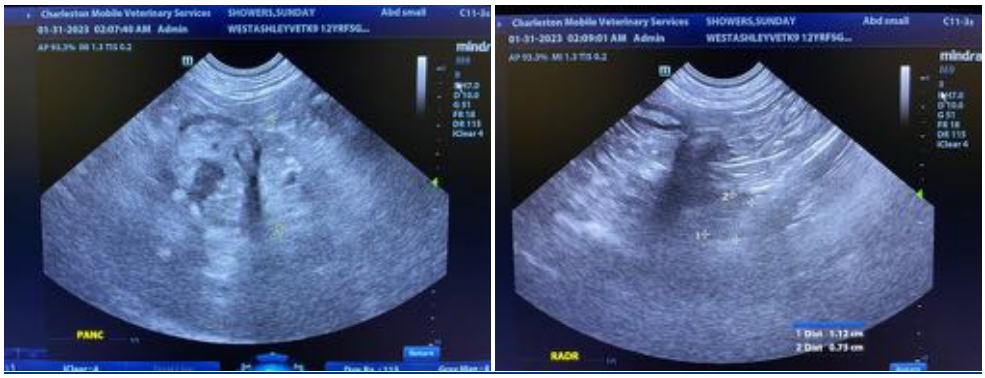

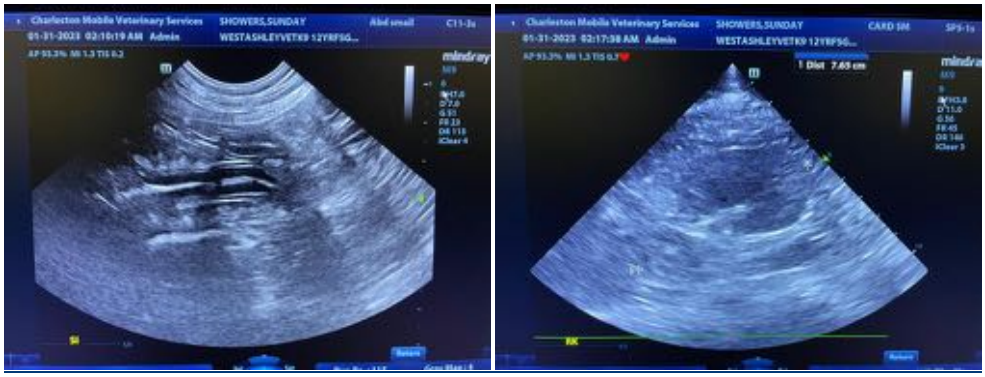

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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