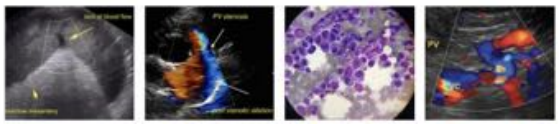

PATIENT

Max Alexander

SPECIES

Canine

BREED

Miniature Schnauzer

SEX

Male, neutered

AGE

14 Yrs.

WEIGHT

N/A

INTERPRETED BY

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

IMAGING PERFORMED BY

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HOSPITAL NAME

Flowertown AH

REFERRING VET

Dr. Guffey

INVOICE

14172

DATE

11/1/22

PRESENTING CLINICAL SIGNS

The patient presented with neurologic signs (i.e., circling, random barking) and chronic diarrhea.

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 prostate is normal in size (1.27 cm in width) normal curvilinear peripheral contours. Parenchyma is subtly mottled in appearance. No distinct focal lesions are observed. The prostatic urethra is not overtly dilated.

The left kidney is normal in size (4.31 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. A few small, non-obstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (4.15 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with 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 normal size (0.53 cm at cranial pole) (0.47 cm at caudal pole) (1.53 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.

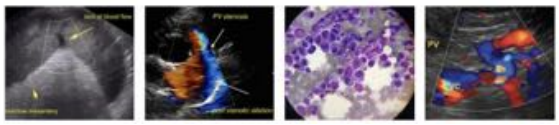
The right adrenal gland is normal size (0.75 cm at cranial pole) (0.46 cm at caudal pole) (1.93 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal to slightly prominent in size (1.18 cm in width at the level of the hilus) with slightly irregular peripheral contours. A 1.91 cm isoechoic to slightly heterogeneous swelling is observed at the cranial medial aspect. The remaining parenchyma is subtly mottled in appearance. Splenic vasculature appears normal with no evidence of thrombosis.

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



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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 normal in thickness and a small amount of aggregated to mineralized debris/sludge +/- cholelith is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

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 is normal to mildly thickened (up to 0.31 cm). There is retention of the normal layering pattern with disruption in the normal1:3 muscularis: mucosal ratio in most segments. A focal area of descending colonic wall is thickened (up to 0.62 cm) with questionable retention of the normal layering pattern. There is suspected mild luminal narrowing in this region. The mesentery effacing the serosal surface in this area is hyperechoic. The remaining colonic wall is normal to slightly thickened.. Shadowing fecal material is observed within the colonic lumen.

Pancreas

The left limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely hypoechoic 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

Trace free fluid is observed. A few prominent mesenteric lymph nodes are visualized, the largest measuring 0.75 cm. In addition, a 1.14 cm rounded hypoechoic lymph node is observed in the mid to caudal abdomen, adjacent to the descending colon. Surrounding mesentery is hyperechoic.

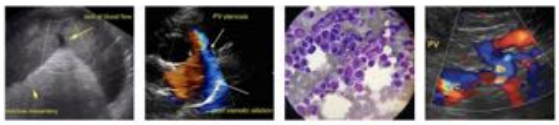
Other

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The focal colonic wall thickening could be consistent with emerging neoplasia, a severe inflammatory process, hypertrophy, other. Adjacent peritonitis is present.
- The abdominal lymphadenopathy could be consistent with infiltrate neoplasia or reactive change.
- The diffuse small intestinal wall changes are most consistent with inflammatory bowel disease with potential for emerging lymphoma.
- The splenic swelling could be consistent with a benign process (i.e., lymphoid hyperplasia, extramedullary hematopoiesis). However, emerging neoplasia cannot be excluded.



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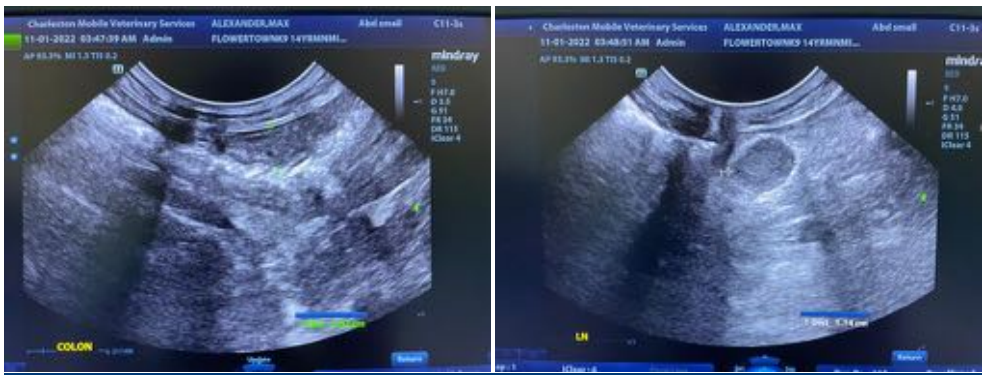
- Trace ascites.

Secondary Findings:

- Mineralized gallbladder sludge- incidental.
- Bilateral, age-related renal changes.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The prostate changes are most consistent with age-related remodeling.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess cardiopulmonary status if not already performed.
- Other diagnostic/therapeutic considerations include the following:
    - Prophylactic deworming with Fenbendazole despite the negative fecal evaluation
    - Malabsorption panel including serum cobalamin, folate, TLI and PLI
    - Hypoallergenic or limited antigen diet trial
    - GI biopsies (i.e., endoscopic or surgical). Endoscopic biopsies would be the safer procedure for obtaining biopsies of the colon.



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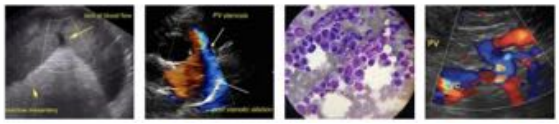

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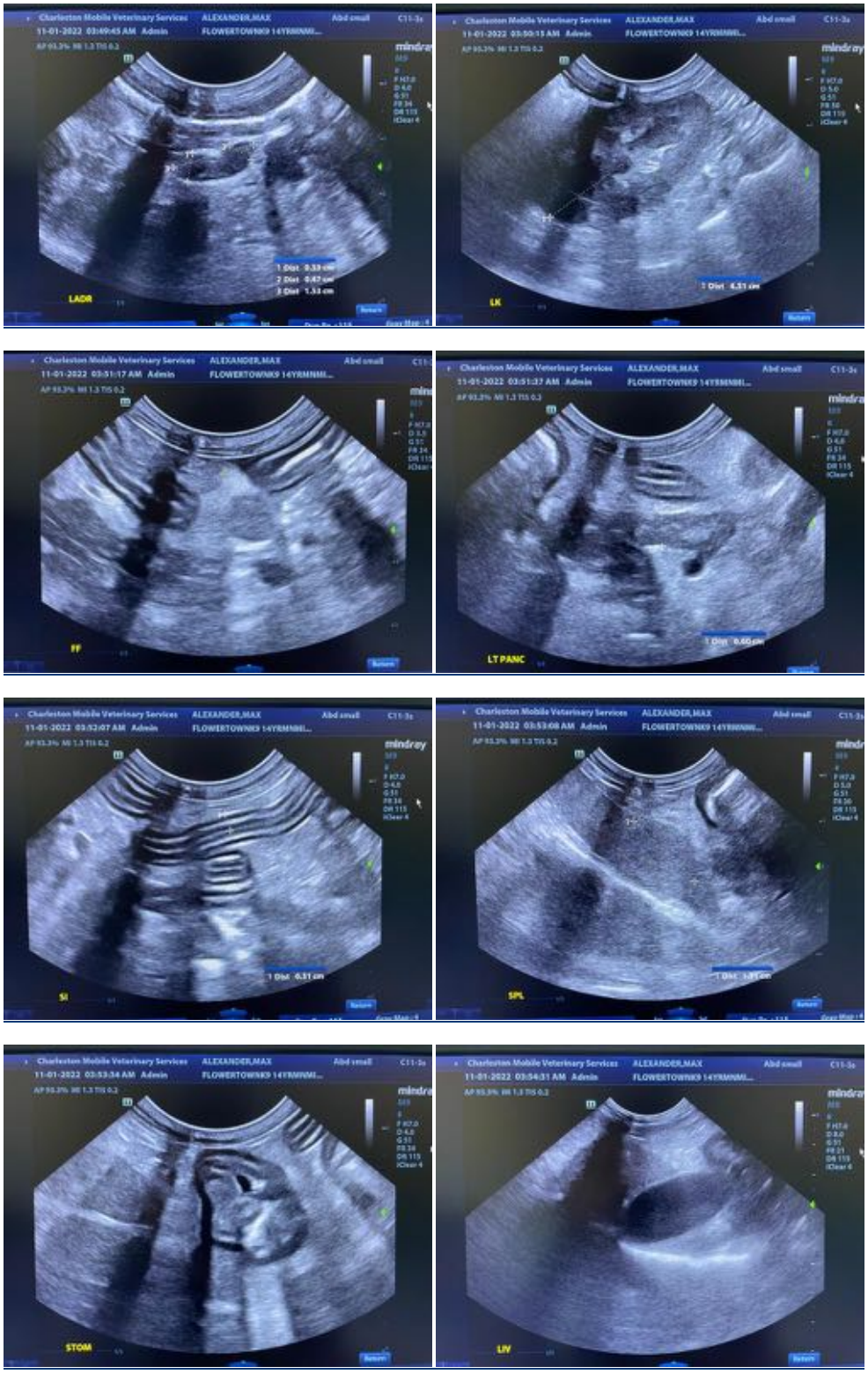

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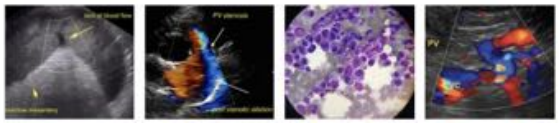

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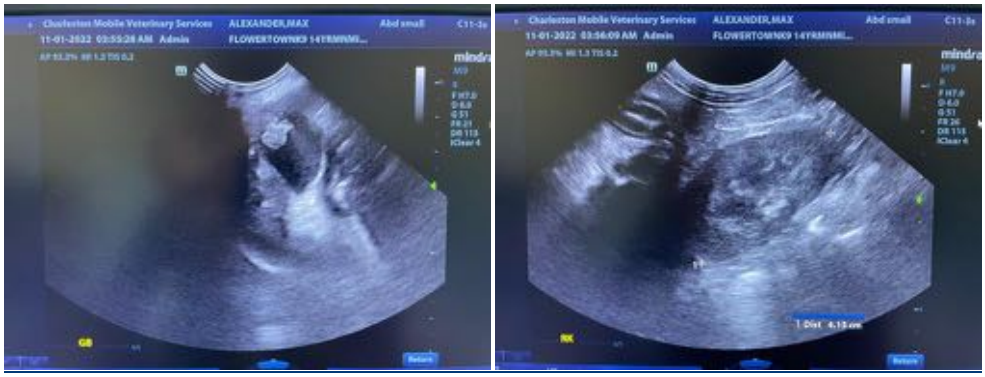

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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