



PATIENT

Shelby Velcro Kraft-Pender

SPECIES

Canine

BREED

Maltese mix

SEX

Female, spayed

AGE

2/8/2015

WEIGHT

8.8 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

Charleston Animal
Society

REFERRING VET

Dr. Pelletier

INVOICE

14231

DATE

11/16/22

PRESENTING CLINICAL SIGNS

Employee pet. Presented 11/15 with 3-day history of distended abdomen, pollakiuria, and stranguria. PE unremarkable w/ exception of moderate abdominal distension. Moderate free fluid on aFAST, none seen on tFAST. Loss of serosal detail on abdominal radiographs, no other obvious abnormalities.

Alb 2.0, Glob 1.6, TP 3.6, ALP 15, Amylase 1261, Ca 7.4. Unable to obtain urine on presentation.

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 left kidney is normal in size (3.68 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. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal size (4.02 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. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.59 cm at cranial pole) (0.50 cm at caudal pole) (1.59 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 (0.46 cm at cranial pole) (0.43 cm at caudal pole) (1.38 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 normal in size with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is normal to slightly prominent in size with normal curvilinear peripheral contours. The parenchyma is hyperechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion. The portal vein: caudal vena cava ratio is approximately 1:1. The gall bladder lumen is moderately distended. The wall is thin and smooth. A scant amount of echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is distended with ingesta, consistent with a post prandial presentation. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is



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patent. The small intestinal lumen is segmentally dilated with chyme. The small intestinal wall is normal to mildly thickened (up to 0.40 cm) with retention of the normal layering pattern. There is evidence of mucosal fogging in most segments. Discreet masses are not identified. The colonic wall is normal. The colonic lumen contains a small amount of liquid fecal material. No obstructive disease is noted.

Pancreas

A portion of the pancreas is obscured by the gastric distention. In the visualized portions, the pancreas is prominent in size with minimal deviation from the normal peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and subtly mottled in appearance. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated.

Free Abdomen

The mesentery throughout the abdomen is mildly hyperechoic. A small to moderate amount of slightly echogenic free fluid is present. A few prominent mesenteric lymph nodes are visualized, the largest measuring 1.55 cm in length.

Other

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The patient's clinical history, in conjunction with the sonographic bowel changes, is most consistent with a protein losing enteropathy. Top differentials include inflammatory bowel disease, lymphangiectasia, infectious/parasitic disease or less likely, emerging neoplasia (i.e., lymphoma).
- The ascites is likely secondary to low oncotic pressure.

Secondary Findings:

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- 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.
- Minor, age-related renal changes with subtle dystrophic mineralization.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A fecal evaluation for ova/Giardia.
- Consider prophylactic deworming with Fenbendazole.
- Malabsorption panel including serum cobalamin, folate, TLI and PLI.



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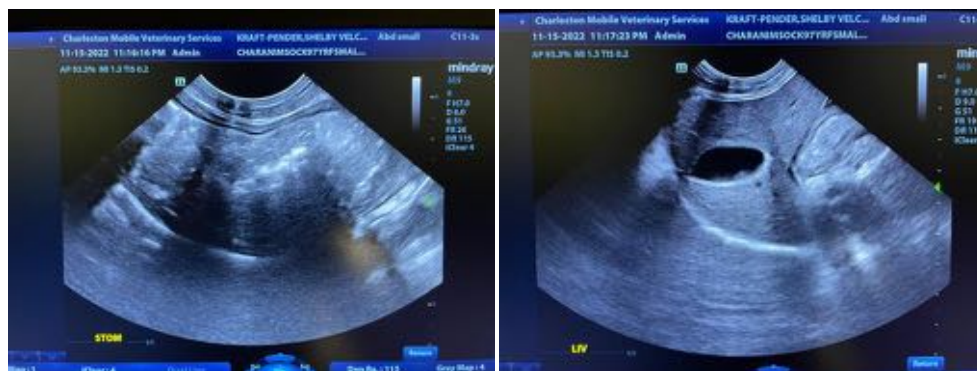
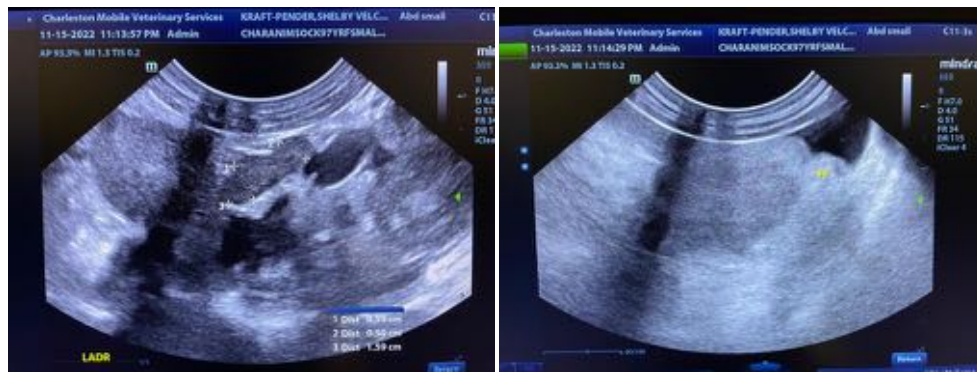
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- Consider transitioning to a low fat, limited antigen or hydrolyzed protein diet, if not already performed.
- Also consider initiation of a probiotic and fiber supplement (i.e., Metamucil or Konsyl).
- Ultimately, gastrointestinal biopsies (i.e., endoscopic or surgical) would be necessary to get a definitive diagnosis.
- To further investigate for concurrent causes of hypoalbuminemia, consider the following:
 1. UPC (if proteinuria is present)
 2. Resting cortisol level to screen for atypical hypoadrenocorticism
 3. Pre and post prandial serum bile acids to assess for occult hepatic dysfunction





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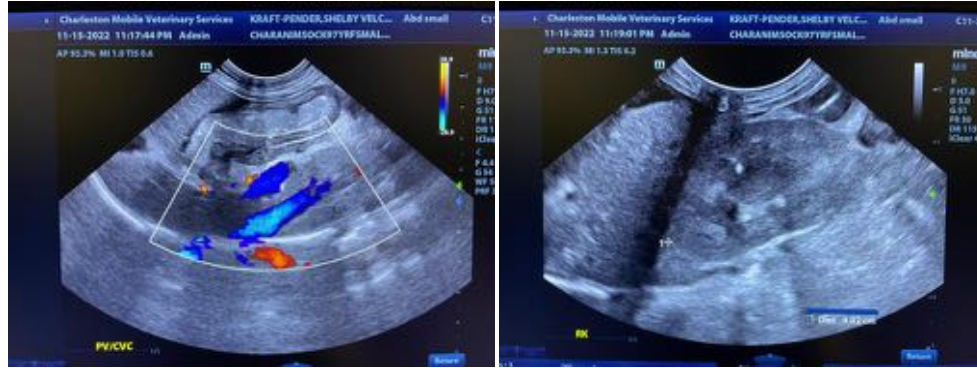
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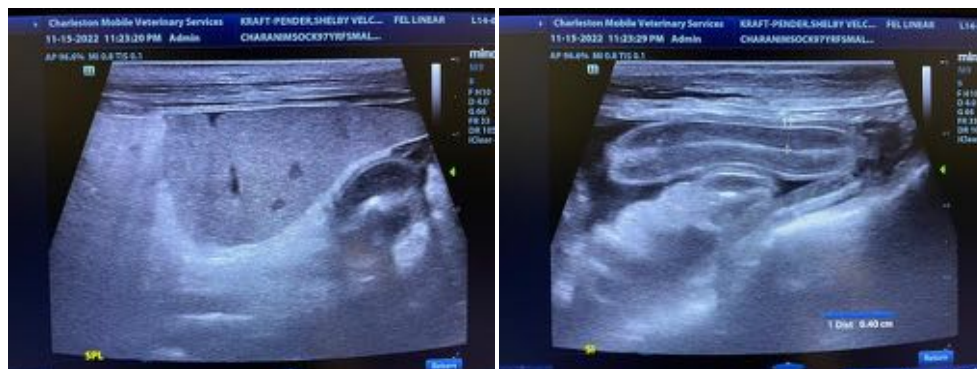
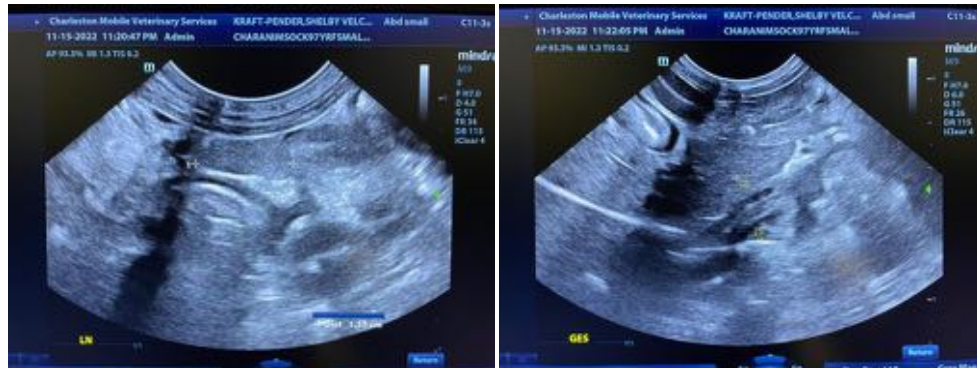
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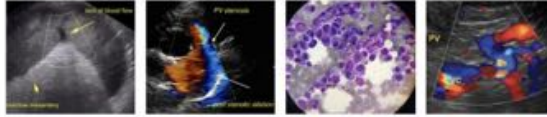
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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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info@SonoPath.com

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