IMAGING PERFORMED BY

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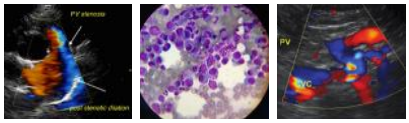

SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™
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DATE

2/20/23

PATIENT

Reed Stetson

SPECIES

Canine

BREED

Chesapeake Bay Retriever

SEX

Intact Male

AGE

12/6/12

WEIGHT

78 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Essex Middle River VC

REFERRING VET

Dr. Hicks

INVOICE

21219

PRESENTING CLINICAL SIGNS

History: CC- Weight loss; GI issues; some black stool 2 weeks ago followed by +mucous, since then seems cleared but intermittent straining, liquid diarrhea; good appetite; O feeding homemade food last 2 weeks PE- P lost 15 lb since 1/16/2023; BCS- 4/9; mm pink/moist. Abdomen palp- possible some intestinal thickening rear caudal abdomen; enlarged prostate; right testicle firm but sl smaller than left; incr. HR (140) Hx- 102022- poss seizure, bldwk at this time only showed mild anemia (37, normal 38); then 12/6/22 in for +V due to eating stuffed animal, P eventually vomited this up and P seemed fine but since this visit (12/8/2022) P has lost total of 22#

Current Medications: None.
Radiographs: 12/8/22: Distended loops of bowel; ingesta in stomach
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed By: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with a large amount of echogenic non-shadowing debris, both suspended, as well as gravity dependent, most consistent with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can also present with echogenic debris. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Prostate is symmetrically enlarged with smooth margins that are well differentiated from surrounding tissue. Normal bilobed shape is maintained. Parenchyma is diffusely hyperechoic. Several small anechoic cysts are noted. No mineral is noted.

Left kidney is normal is size (7.14 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed. A subtle hyperechoic band parallel to the corticomedullary border is present.

Right kidney is normal is size (7.28 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed. A subtle hyperechoic band parallel to the corticomedullary border is present.

Adrenal Glands

Left adrenal gland is normal in size (3.18 cm long x 0.68 cm at cranial pole and 0.65 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (3.08 cm long x 0.65 cm at cranial pole and 0.69 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen
Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver
Liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal
The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness and layering. Contents are consistent with normal formed feces and gas.

Pancreas
The observed pancreas appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen
There is no evidence of peritoneal effusion. The mesenteric and medial iliac lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

Other
Both testicles are visualized without significant evident testicular pathology noted.

No evidence of heart base or pericardial pathology is noted in these images at this time. If cardiac function is desired, a full echocardiogram is recommended.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Subtle bilateral medullary rim sign - This finding is of unknown clinical significance and can be a normal variant, often idiopathic. Medullary rim sign can be present with renal disease including FIP, lymphoma, hypercalcemic nephropathy, Leptospirosis, tubular disease, other and should be interpreted in combination with other more specific indications of kidney disease such as isosthenuria, proteinuria, azotemia, etc. This is a common incidental finding in patients with diabetes mellitus.

- Reactive mesenteric and medial iliac lymph nodes- infiltrative neoplastic disease cannot be ruled out but is considered less likely.

Secondary Findings

- A large amount of urinary bladder debris
- Benign Prostatic Hyperplasia with cysts – Prostatic findings are most consistent with Benign Prostatic Hyperplasia (BPH) and concurrent benign prostatic cysts. Active prostatitis cannot be ruled out. Infiltrative neoplasia cannot be ruled out but is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

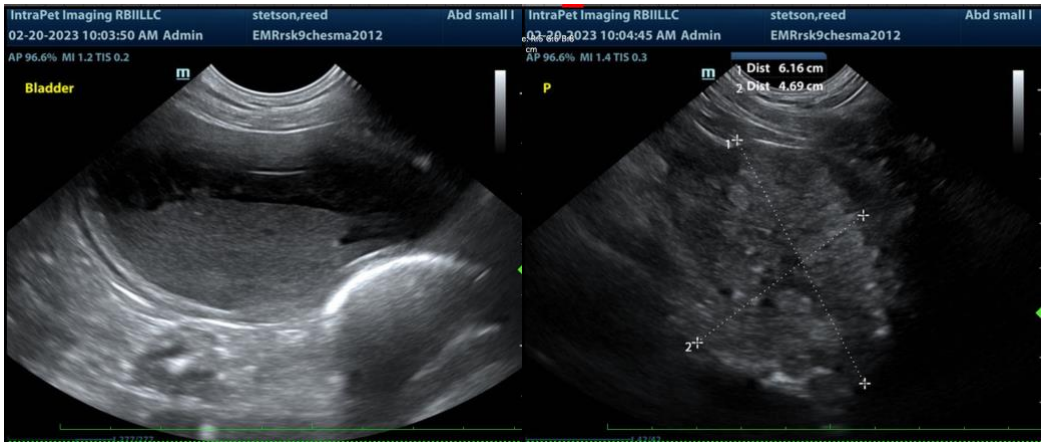
If not recently evaluated, a urine culture is recommended to rule out an occult urinary tract infection. If the culture is negative and proteinuria is persistent, a urine protein to creatinine ratio is recommended for further quantification of the proteinuria.

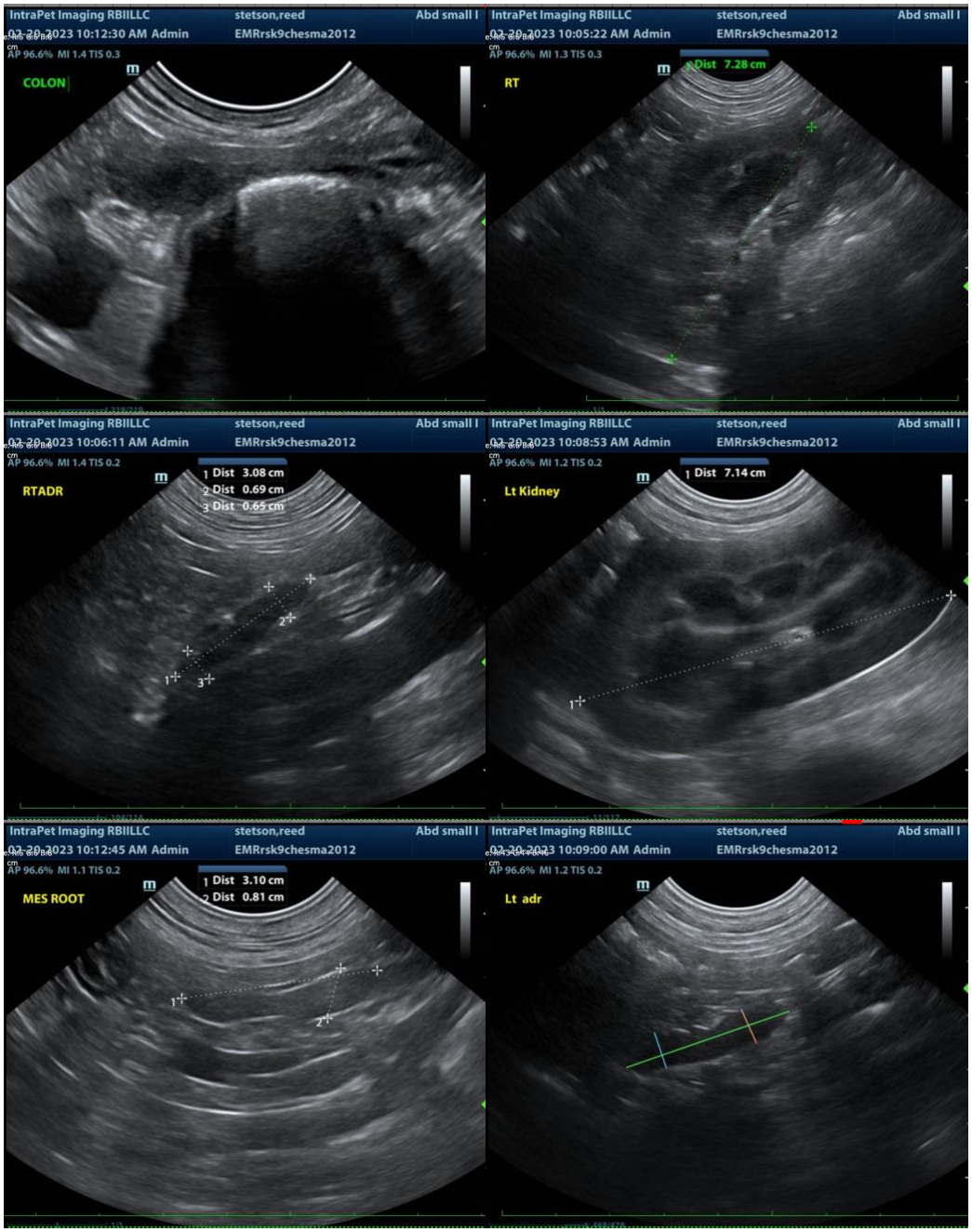
There is no ultrasonographically visible explanation for this patients reported gastrointestinal signs or hematochezia, therefore, next diagnostic recommendations include a fecal exam, if not recently evaluated, as well as a fecal enteropathogen PCR panel to Texas A&M GI Laboratory, for further evaluation of possible infectious disease, and a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory, for further evaluation of GI and pancreatic function.

Additionally, a baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

In the meantime, empirical deworming with a 5-day course of Panacur is recommended, as is a probiotic, such as Visbiome or Proviable and potentially a transition in diet based on trial-and-error response, with options being a hydrolyzed protein diet (some patients respond to one brand but not a different brand), a bland easy to digest or low-fat diet, or potentially a fiber response colitis diet, etc.

Ultimately, if clinical signs persist, further evaluation of the gastrointestinal tract via upper and lower endoscopy/colonoscopy may be necessary for further evaluation visually, as well as biopsies.

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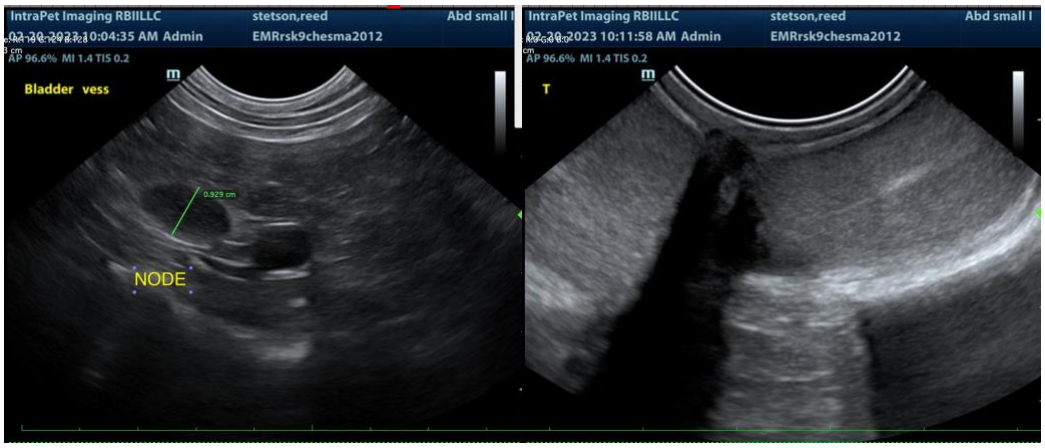

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM DACVIM
Beth.Johnson@SonoPath.com