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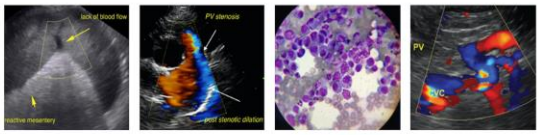

SonoPath
Clinical Sonography & Telecytology
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PATIENT

Molly Iatalese

SPECIES

Canine

BREED

Rottweiler

SEX

FS

AGE

2012

WEIGHT

110

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY

Rebekah Jakum, CVT ARDMS/RVT

HOSPITAL NAME

Blue Ridge VC

REFERRING VET

Dr. Filchner

INVOICE

16750

DATE

5/3/23

PRESENTING CLINICAL SIGNS

Weight loss, bad breath, drooling, occasional vomiting and loose stool.

Albumin 2.0, Globulin 7.8, WBC 3.7, Platelets 123

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 4.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

The area of the aortic trifurcation was free of pathology.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 7.3 cm in length. The right kidney measured 7.1 cm in length.

Adrenal Glands

The bilateral adrenal glands were overtly normal in size, position, and shape. The left adrenal gland measured 0.54 cm width at the caudal pole and 0.53 cm width at the cranial pole. The right adrenal gland subjectively measured 0.48 cm width at the caudal pole.

Spleen

The spleen was normal in size and contour with mild generalized parenchyma heterogeneity. No visualized splenic masses or nodules were noted.

Liver/ Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact mildly prominent wall layering. The lumen of the stomach was empty with mild luminal gas and no evidence of retained ingesta, fluid, or foreign material.

The visualized segments of the small intestine exhibited overall subjective intact wall layering with segmental to possible generalized propensity for mildly prominent intestinal muscularis layer, as well as segmental to generalized mildly prominent to thickened hyperechoic submucosa layer.

Normal visible colon wall layers were present with apparent formed feces in lumen.

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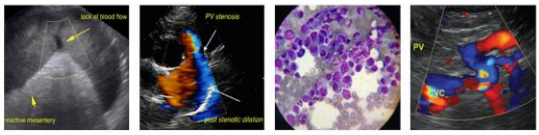

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Pancreas

The parenchyma of the left limb, body, and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease were evident.

Free Abdomen

No omental masses, lymphadenopathy, or evidence of peritoneal effusion were noted.

ULTRASONOGRAPHIC FINDINGS

- Mild heterogeneous spleen - nonspecific, incidental hyperplasia, hematopoiesis, potential for infiltrative neoplasia thought less likely
- Empty stomach exhibiting intact mildly prominent / thickened wall layering
- Enteropathy
- Age-related kidneys

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A GI panel to include PLI/TLI/Cobalamin/Folate as well as three-view chest radiographs to rule out occult thoracic pathology as a contributing factor to the patient's weight loss is recommended.

The gastrointestinal presentation may indicate inflammatory criteria, i.e., nonspecific gastroenteritis, inflammatory bowel disease, or similar. Infectious disease, dysbiosis, occult parasitism, dietary intolerance, and infiltrative neoplasia are all possible.

Protein electrophoresis, given the hyperglobulinemia, to assess polyclonal vs. monoclonal is suggested. If monoclonal, screening splenic FNA cytology using a 25-gauge needle and assuming normal clotting status would be recommended. Likewise, intestinal biopsies would be required for a definitive diagnosis.

Empirically, a limited antigen or hydrolyzed diet trial with potential long-term dietary therapy, prophylactic deworming (Panacur 50 mg/kg SID x 5 consecutive days with repeat protocol in 3 weeks even if fecal testing is negative), high colony count probiotic (Proviable or Visbiome), antibiotic trial and as needed gastrointestinal support with an assessment of clinical response may prove beneficial.

Although considered less likely, a resting cortisol level to rule out occult Addison's Disease could be considered.

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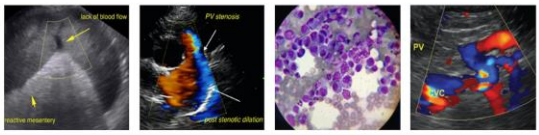

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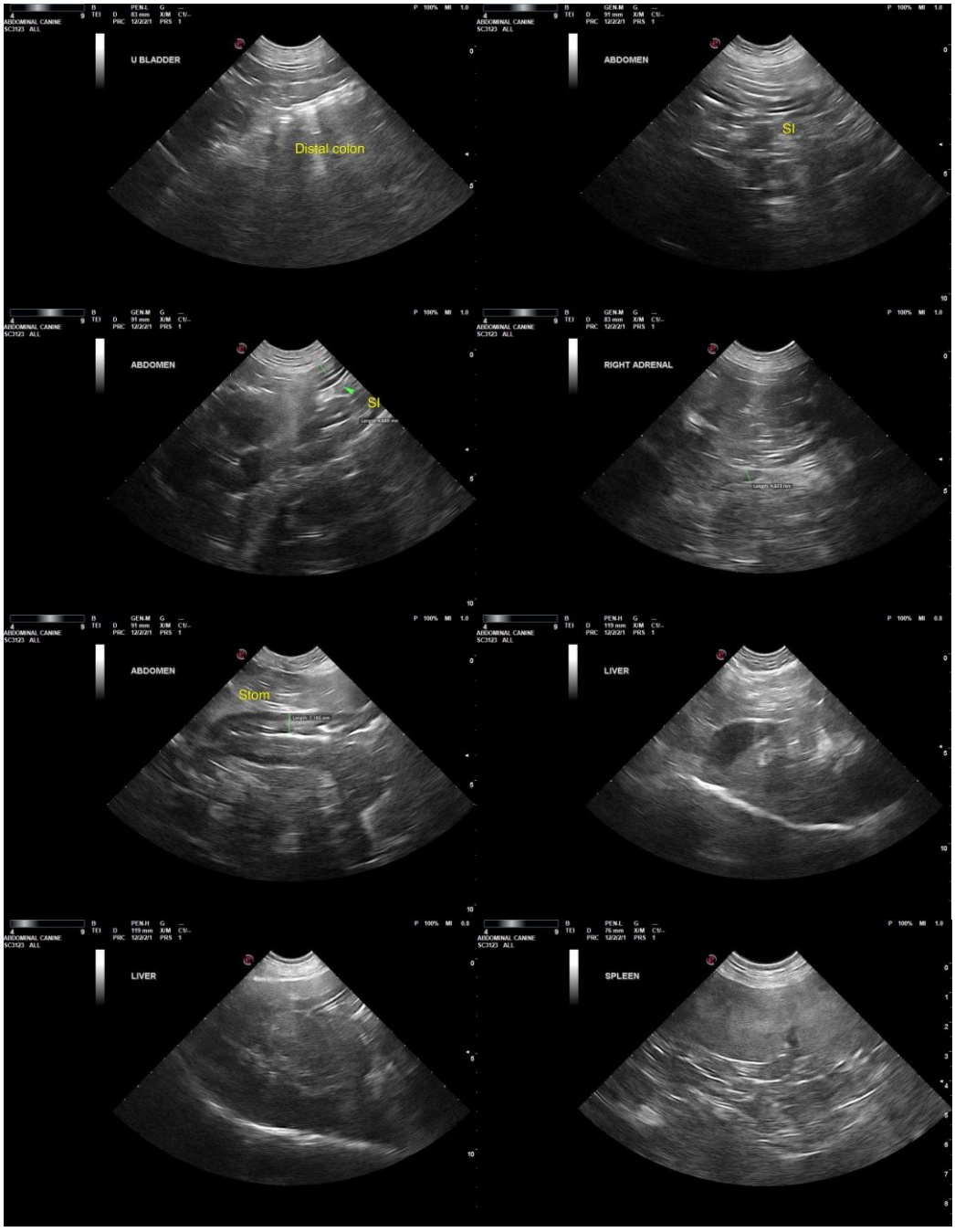

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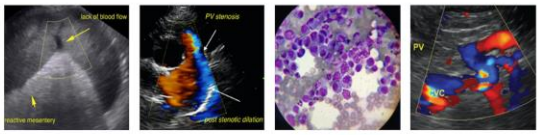

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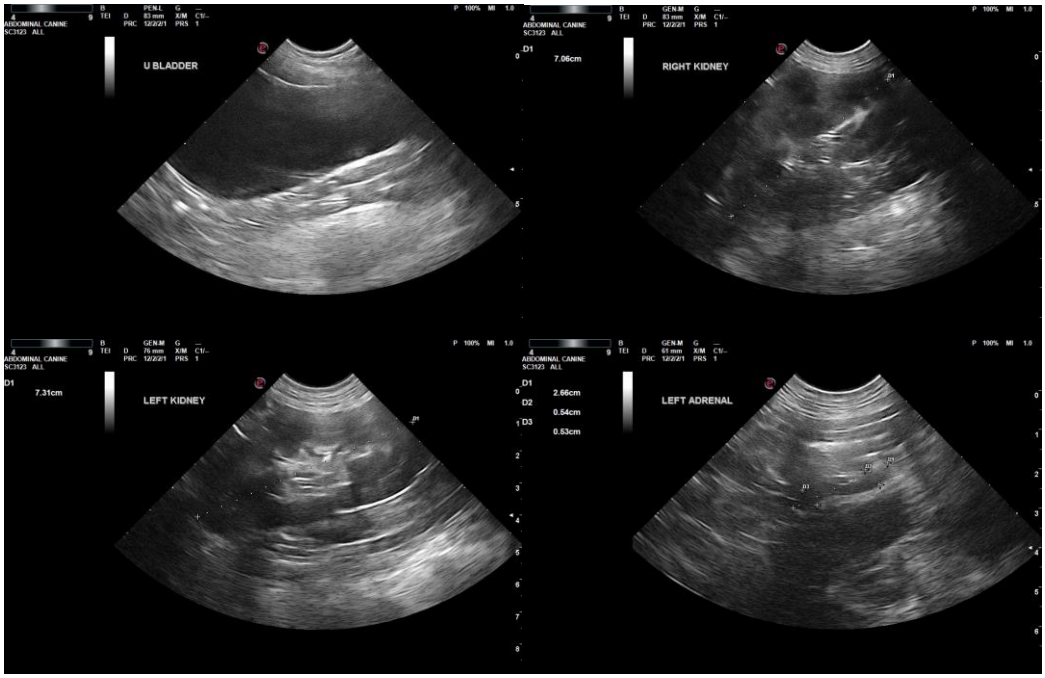

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine/Feline Practice)
mac.daniel@sonopath.com