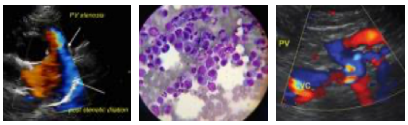
IMAGING PERFORMED BY

IntraPet.com



SonoPath
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DATE

5/23/22

PATIENT

Buddy Carter

SPECIES

Canine

BREED

Bichon Frise

SEX

Male, neutered

AGE

7/3/2015.

WEIGHT

10 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Banfield White Marsh

REFERRING VET

Dr. Racz

INVOICE

13400

PRESENTING CLINICAL SIGNS

Diarrhea for the past month. Gradual weight loss since September. Weight 14.5 lbs in September. Today he is tense on palpation of his abdomen, holds his breath when palpating, pain score 2/5. Had presented 1 month prior for same symptoms and treated with same meds as today. Did well on meds but then once meds were done, symptoms resumed.

Current Medications: Dispensed on 5/21/22: Metronidazole 250mg Tablet Instructions: Give 0.25 tablets every 12 hours for 8 days
Cerenia 16mg (4-pack) Instructions: Give 1 tablet every 24 hours for 4 days, Cerenia Injection
Lab Results: 4/26/22 - IOF unremarkable. 2/27/22 - CBC/IOF unremarkable, Fecal neg.
White blood cell count 20,000 with a neutrophilia, mild anemia, albumin 1.3, globulins 1.7.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are 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 (0.95 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal size (3.99 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.

The right kidney is normal size (4.29 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.

Adrenal Glands

The left adrenal gland is normal size (0.43 cm at cranial pole) (0.52 cm at caudal pole) (1.67 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.

One still image of the right adrenal gland is available for interpretation. The right adrenal gland is normal size (0.68 cm at cranial pole) (0.54 cm at caudal pole) (1.80 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 in size (0.72 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal contours and structure. The liver is isoechoic relative to the spleen. No overt structural evidence of inflammatory, infiltrative or 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 thin and smooth. A small polypoid lesion is arising from the luminal surface. Luminal contents are mostly anechoic. 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 diffusely thickened (up to 0.57 cm) with retention of the normal layering pattern and appropriate mural detail. There is evidence of mucosal fogging in most segments. Discreet masses are not identified. The colonic wall is normal. No obstructive disease is noted.

Pancreas

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic 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

A small amount of anechoic free fluid is present. The mesentery throughout the abdomen is hyperechoic. A 0.81 cm gastric lymph node is visualized.

Other

A brief echocardiogram reveals no obvious evidence of pericardial effusion or obvious chamber enlargement. Pleural effusion is present.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The clinical history and small intestinal wall changes are most consistent with a protein-losing enteropathy. Top differentials include inflammatory bowel disease, lymphangiectasia, lymphoma, and infectious/parasitic disease.
- Diffuse peritonitis, likely secondary to bowel pathology.
- The ascites and pleural effusion are most likely secondary to low oncotic pressure.

Secondary Findings:

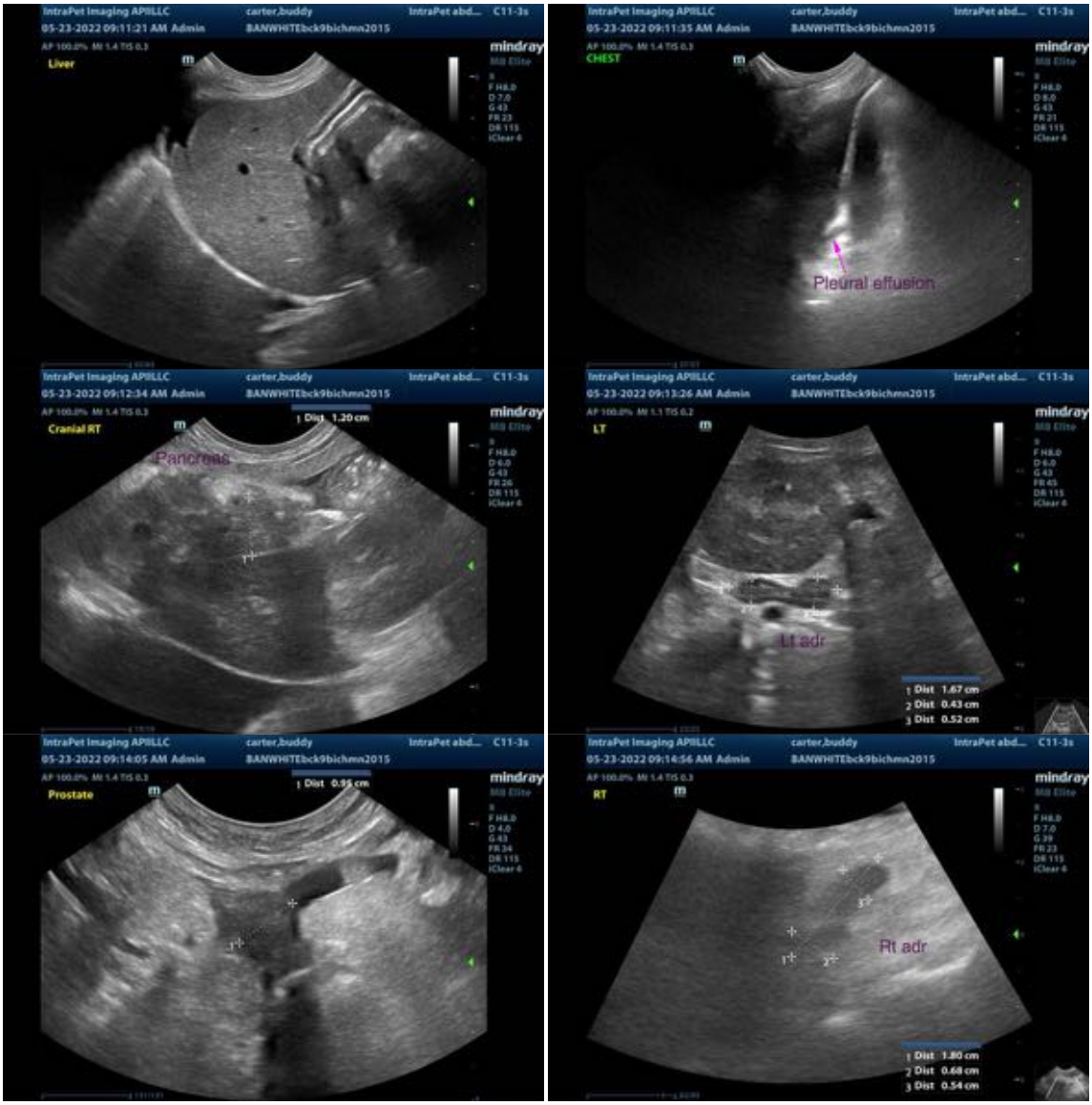
- Minor age-related pancreatic remodeling.
- The prominent gastric lymph node is likely reactive.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Fecal evaluation for ova/Giardia, if not already performed
- Prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.

- GI panel (send to Texas A&M).
- GI biopsies (i.e., endoscopic or surgical) would be necessary to get a definitive diagnosis. Surgical biopsies are preferred in that all areas of bowel can be accessed. However, there is more risk of healing complications with surgical biopsies in this patient due tohypoalbuminemia. Thoracic radiographs should be performed prior to any anesthetic event.
- To further evaluate for concurrent causes of hypoproteinemia, consider the following:

    1. Pre- and post-prandial serum bile acids.
    2. UPC (if proteinuria is present).
    3. A resting cortisol level to screen for atypical hypoadrenocorticism.



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.

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