



**PATIENT**

Nela Negron Mendez

**SPECIES**

Canine

**BREED**

Maltese

**SEX**

Female, spayed

**AGE**

10 Yrs.

**WEIGHT**

12 lbs.

**INTERPRETED BY**

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

**IMAGING  
PERFORMED BY**

Dr. Ferrer

**HOSPITAL NAME**

Paseos VC

**REFERRING VET**

Dr. Davila

**INVOICE**

12863

**DATE**

1/18/22

**PRESENTING CLINICAL SIGNS**

**History:** Presented as a referral for an abdominal ultrasound. Patient has a history of gaining weight. Also has pendulous abdomen. Patient not currently on any medication. No vomiting and diarrhea.  
**Abnormal PE/Chem/CBC/UA Results:** PE: Pendulous abdomen Rads: hepatomegaly CBC: Neu 12 (2.95-11.64) Mono 1.48 (0.16-1.12) PLT: 730 (148-484) Chem: ALB: 4 (2-3.9) ALT: 202 (10-125) ALP: 313 (110-212) CHOL: 330 (110-320) T4: 1.2 (1-4)

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder and visible portion of the pelvic urethra are normal for the degree of luminal distension. The urine is anechoic with no evidence of debris. Cystic calculi and discrete masses are not observed. The region of the trigone is normal.

The prostate is not definitively visualized due to its pelvic location.

The left kidney is normal in size (4.47 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. Mild pyelectasia is present (0.22 cm in the transverse plane). There is no evidence of infarcts or hydroureter.

The right kidney is normal size (4.93 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is mild to moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. Mild pyelectasia is present (0.19 cm in the transverse plane). There is no evidence of infarcts or hydroureter.

**Adrenal Glands**

The left adrenal gland is mildly enlarged (0.63 cm at cranial pole) (0.71 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.

The right adrenal gland is mildly enlarged (0.64 cm at cranial pole) (0.67 cm at caudal pole) (2.00 cm in length) with a slightly irregular shape. 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 (0.96 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 prominent to enlarged with swollen peripheral contours. The parenchyma is isoechoic relative to the spleen and mildly heterogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is distended. The wall is normal in thickness. An excessive amount of aggregated echogenic suspended in a partially stellate pattern is observed within the lumen. The cystic and common bile ducts are normal/not seen.



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***Gastrointestinal***

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is mildly distended with ingesta. 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 thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. No obstructive disease is noted.

***Pancreas***

The base and limbs of the pancreas are 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***

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

**ULTRASONOGRAPHIC FINDINGS**

**Primary Findings:**

- 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.
- Mild bilateral adrenomegaly. This finding could be consistent with pituitary dependent hyperadrenocorticism if the clinical history and further testing supports this diagnosis.
- The gallbladder changes are most consistent with a developing mucocele.

**Secondary Findings:**

- Bilateral age-related renal changes with dystrophic mineralization.
- Age-related pancreatic remodeling +/- fibrosis. Concurrent low-grade pancreatitis is also possible, particularly if the patient exhibits discomfort on cranial abdominal palpation.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

- Further testing for Cushing's disease (i.e., low dose Dexamethasone suppression test or ACTH stimulation test) is warranted.
- A UPC is also recommended, if proteinuria is present as well as a baseline blood pressure measurement.
- Given the patient's age, three-view thoracic radiographs are recommended to assess cardiopulmonary status.



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- Regarding the gallbladder changes, consider initiation of Ursodiol therapy with serial sonographic monitoring (i.e., every 4-6 weeks) of the patient's gallbladder to assess for progression to a fully formed mucocele. It should be noted that mucoceles have the potential to rupture at any point, resulting in bile/septic peritonitis. Therefore, a prophylactic cholecystectomy can also be considered. If surgery is pursued, referral to a board certified surgeon is recommended due to the potential for perioperative complications.

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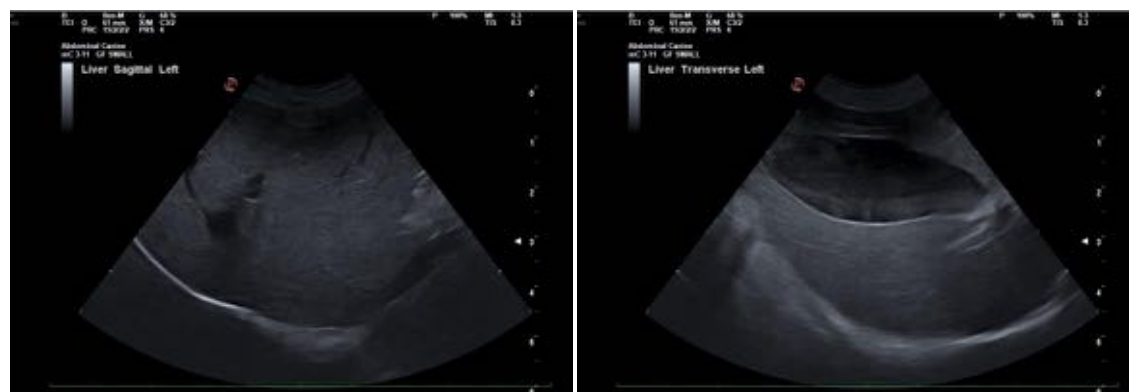
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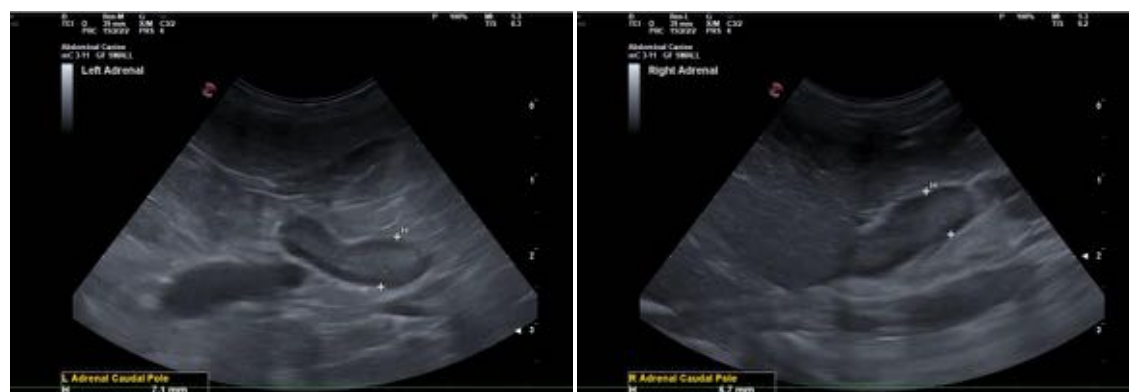
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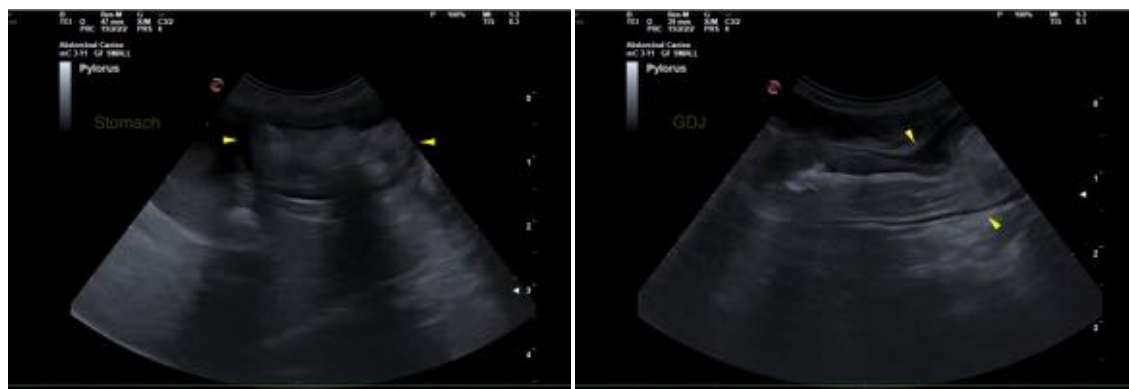
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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*)

Andrea.nicastro@sonopath.com