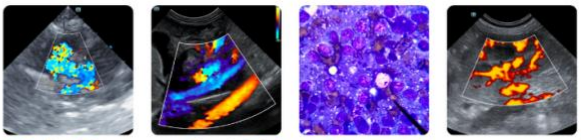

PATIENT

Walter Hess

SPECIES

Canine

BREED

Maltese

SEX

Neutered Male

AGE

16

WEIGHT

17.8 lbs

INTERPRETED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

IMAGING PERFORMED BY

Meghan Morse LVT CVT

HOSPITAL NAME

Narrowsburg Veterinary

REFERRING VET

Dr. Hess

INVOICE

22431

DATE

1-22-26

PRESENTING CLINICAL SIGNS

- Intermittent v+
- Current meds: Librela, Carprofen, and Gabapentin

Abnormal PE/Chem/CBC/UA Results: Recent rads- hepatomegaly, metal wire like FB cranial abdomen- significance?

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (0.73 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal in size (4.19 cm in length)) with a normal shape, smooth peripheral margins, and normal internal architecture. There is moderate loss of corticomedullary distinction. Several, small, cortical cysts are seen. 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 in size (4.48 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. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.65 cm at cranial pole) (0.72 cm at caudal pole) with a normal shape and 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 (0.89 cm at cranial pole) (0.57 cm at caudal pole) with a normal shape and 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 (1.19 cm in width at the level of the hilus) with a normal capsular contour. The parenchyma is mottled in appearance. A few myelolipomas are observed in the region of the hilus. Splenic vasculature is normal.

Liver

The liver is subjectively prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits mild heterogeneity. On the right side, a 1.6 x 1.1 cm ill-defined hypoechoic nodule is observed. Hepatic vasculature and biliary tracts are of normal volume with no evidence of congestion.

The gallbladder lumen is moderately distended. The wall is thin and smooth. Several, small, polypoid-like lesions are arising from the mucosal surface. A small amount of gravity-dependent, echogenic debris is

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observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is not distended. The gastric wall is diffusely thickened (up to 0.73 cm). There is questionable loss of normal layering in some regions. The mesentery effacing the serosal surface of the stomach is hyperechoic. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. The colonic wall is normal. The colonic lumen contains some shadowing fecal material. There is no obvious evidence of an obstructive pattern.

Pancreas

The base and right limb are prominent-in-size, with slightly swollen peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat, and subtly mottled in appearance. The pancreatic duct is not overtly dilated. Surrounding mesentery is hyperechoic.

Lymph Nodes

A 0.54 cm hypoechoic lymph node is observed in the cranial abdomen, just caudal to the stomach.

Free Abdomen

There is no obvious evidence of free fluid.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The gastric wall changes could be consistent with gastritis or emerging neoplasia (i.e., lymphoma, adenocarcinoma).
- The pancreatic changes are consistent with chronic active pancreatitis with parenchymal remodeling.
- Cranial peritonitis, likely secondary to gastric and/or pancreatic pathology

Secondary Findings

- The diffuse hepatic changes are nonspecific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory disease, infiltrative neoplasia and other hepatopathies are considered less likely. However, correlation with the patient's clinical history is recommended. The hypoechoic hepatic nodule trends toward the benign (i.e., regenerative nodule) with a lower possibility of an emerging tumor.
- Bilateral nonspecific age-related renal changes with subtle dystrophic mineralization
- Mild bilateral adrenomegaly
- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or antigenic stimulation with a lower possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).
- The prominent cranial abdominal lymph node could be consistent with reactive change or emerging neoplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Further evaluation could include the following:

1. GI panel including serum cobalamin and folate, TLI and PLI
2. Endoscopic or surgical GI biopsies, with particular attention to the stomach. Three-view thoracic radiographs should be performed prior to any anesthetic event.

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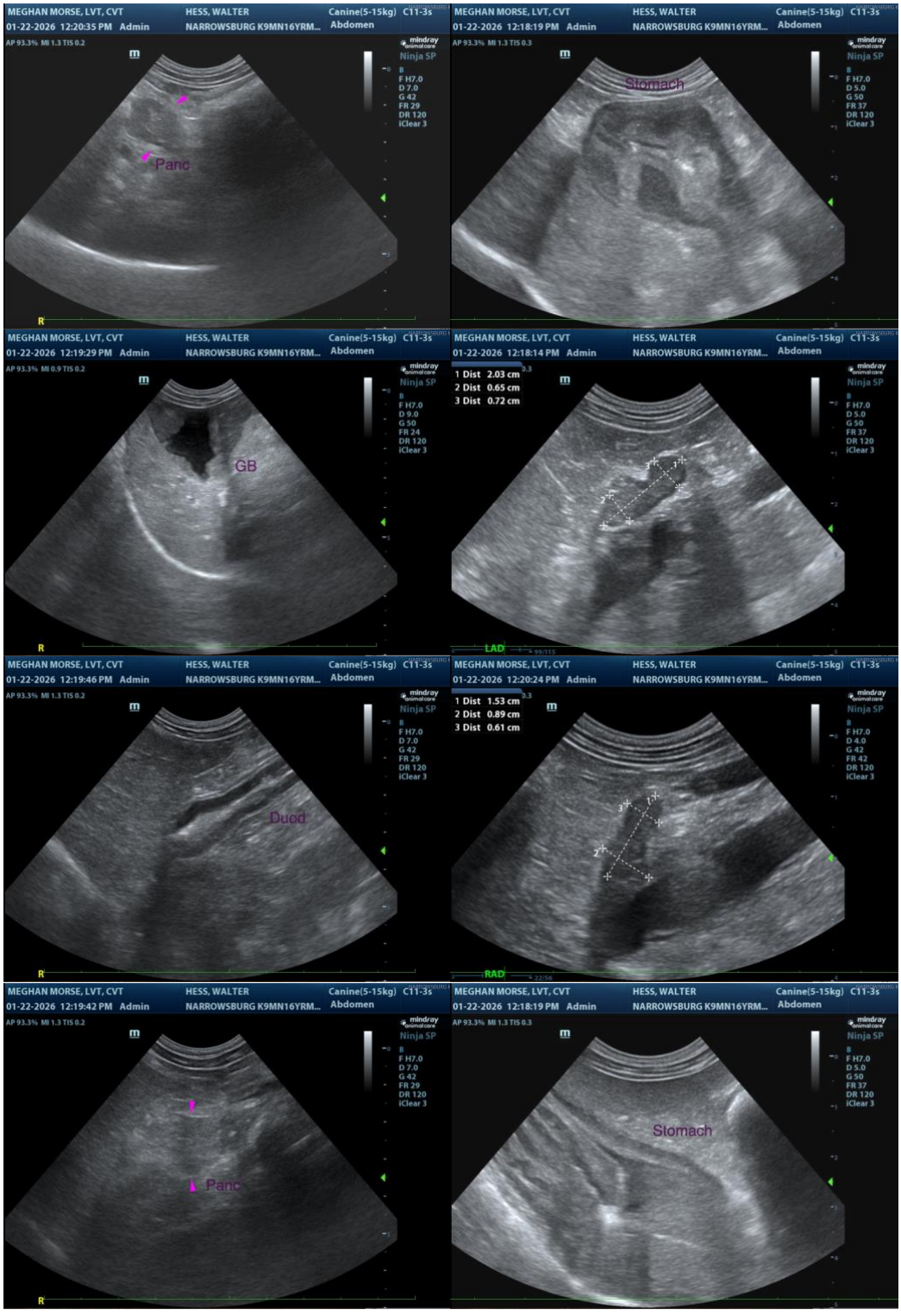
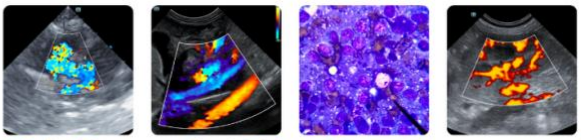
3. In the meantime, symptomatic care for gastritis/pancreatitis is recommended.
4. Consider discontinuation of the NSAIDs until the cause for the patient's clinical signs is identified.



New Jersey Mobile
FUELED BY SONOPATH VETERINARY ULTRASOUND



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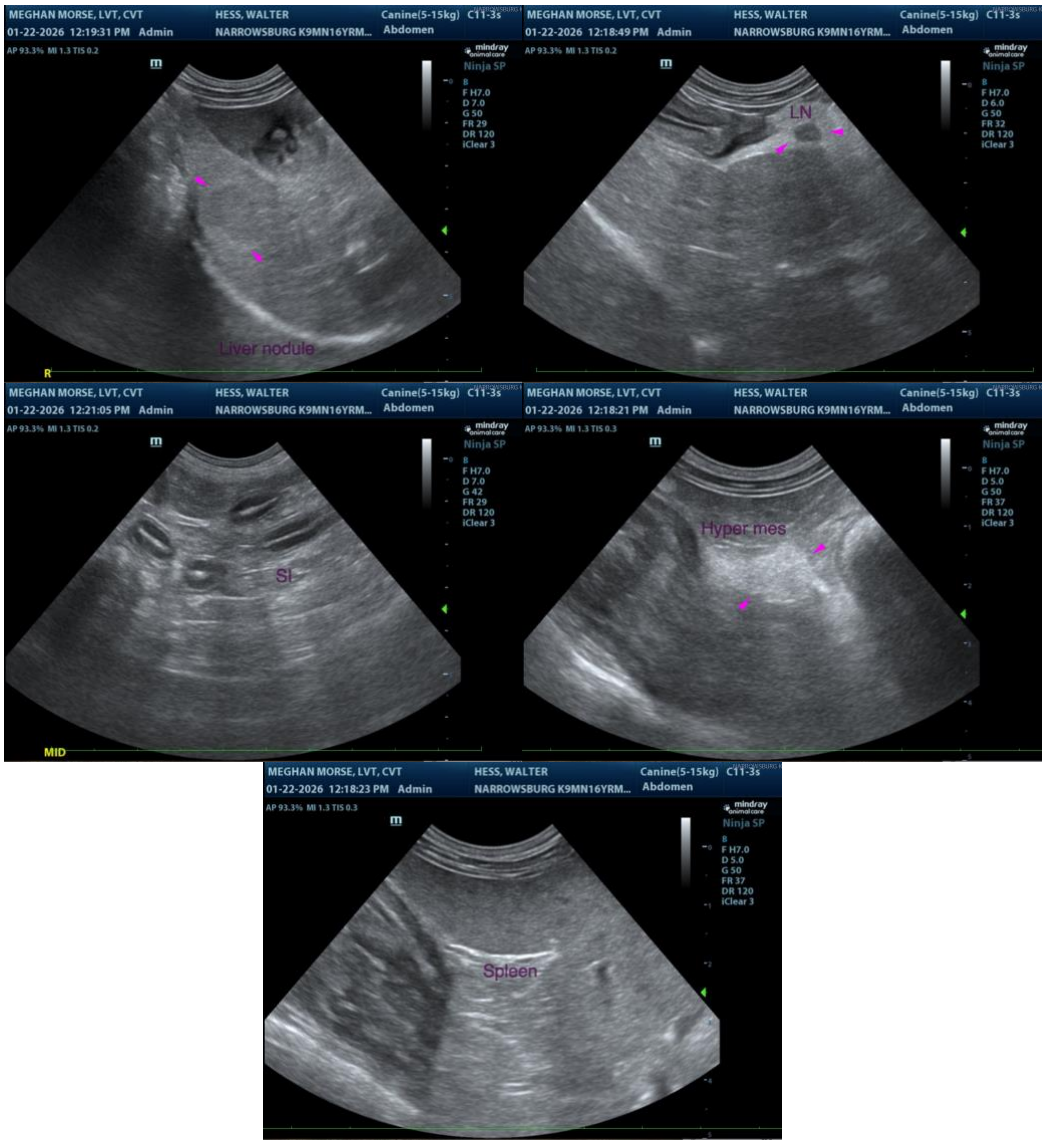

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com