

DATE

1-23-26

PATIENT

Bettis Lang

SPECIES

Canine

BREED

Silver Labrador

SEX

Neutered Male

AGE

1/23/2017

WEIGHT

34.6kg

INTERPRETED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME

Mason Dixon AEH

REFERRING VET

Dr. Yolles

INVOICE

22445

PRESENTING CLINICAL SIGNS

Patient History: Lethargy, anorexia for one week. Significant weight loss, with 5 pounds loss offer last 4 days. Was seen at rDVM 1/19 and admitted for IVF, Maropitant, Entyce. Did very well after for one day. Then became very lethargic again and was admitted to rDVM 1/22 for IVF, Maropitant, Entyce, no improvement. 2-year history of PLN, managed with Enalapril. Last UPC was 3.6 (H). PE: severely dehydrated, HR 70, BO 90 mm Hg, lethargic, BCS 3/9. Crackles right ventral lung field.

Current Medications: Enalapril. Recent IVF, Maropitant and Entyce

Labwork Results: Labwork not attached, reported as: 1/19/26 rDVM: ALT 148, ALP 731, BUN 31, CREA 1.7, CPL 198 suspicious for pancreatitis.

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: STAT requested.

Imaging Performed by: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The wall in the region of the apex is moderately thickened (up to 0.48 cm) with a smooth mucosal surface. The wall tapers to a normal thickness as it extends towards the cystourethral junction. No cystic calculi are observed. The region of the trigone is normal.

The region of the prostate is not visualized due to its pelvic location.

The left kidney is small in size (5.09 cm in length) and misshapen. The cortex is variably thickened with poor corticomedullary distinction. Moderate-to-severe pyelectasia is present (0.72 cm in the longitudinal plane). There are suspected cortical infarcts. Several hyperechoic foci are observed within the cortex. There is no evidence of hydroureter. Renal vasculature is normal.

The right kidney is normal in size (5.45 cm in length) and misshapen. The cortex is variably thickened with poor corticomedullary distinction. Mild pyelectasia is present (0.31 cm in the longitudinal plane). There are suspected cortical infarcts. Several hyperechoic foci are observed within the cortex. There is no evidence of hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is enlarged (1.10 cm at cranial pole) (0.92 cm at caudal pole) with swollen peripheral contours. 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 normal in size (1.06 cm at cranial pole) (0.75 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 (1.77 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.



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Liver

The liver is subjectively normal-in-size with normal peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits mild heterogeneity. No distinct focal lesions are 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. A moderate amount of aggregated, echogenic-to-mineralized, partially dependent debris/sludge is 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 subjectively diffusely thickened. The small intestinal is not dilated. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

Pancreas

The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

Lymph Nodes

The abdominal lymph nodes are normal/not visible.

Free Abdomen

There is no obvious evidence of free fluid.

Other

A brief echocardiogram reveals no obvious evidence of right atrial or auricular mass. There is no obvious evidence of pericardial effusion. Several B-lines are observed in the visualized portion of the thorax.

ULTRASONOGRAPHIC FINDINGS

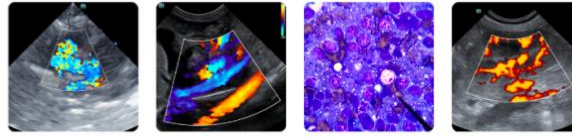
Primary Findings

- The gastric wall thickening is suggestive of gastritis, with a lower possibility of emerging neoplasia.
- 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.
- The gallbladder changes are suggestive of a developing mucocele.
- Bilateral chronic nephropathy with pyelectasia (more pronounced in the left kidney) and nonobstructive nephrolithiasis. Cortical infarcts are also suspected bilaterally.
- Suspected B-lines. This finding could be consistent with pulmonary parenchymal disease.

Secondary Findings

- The urinary bladder wall changes are suggestive of cystitis. Correlation with the patient's clinical history and urinalysis findings is recommended.
- Mild left adrenomegaly

Imaging performed by



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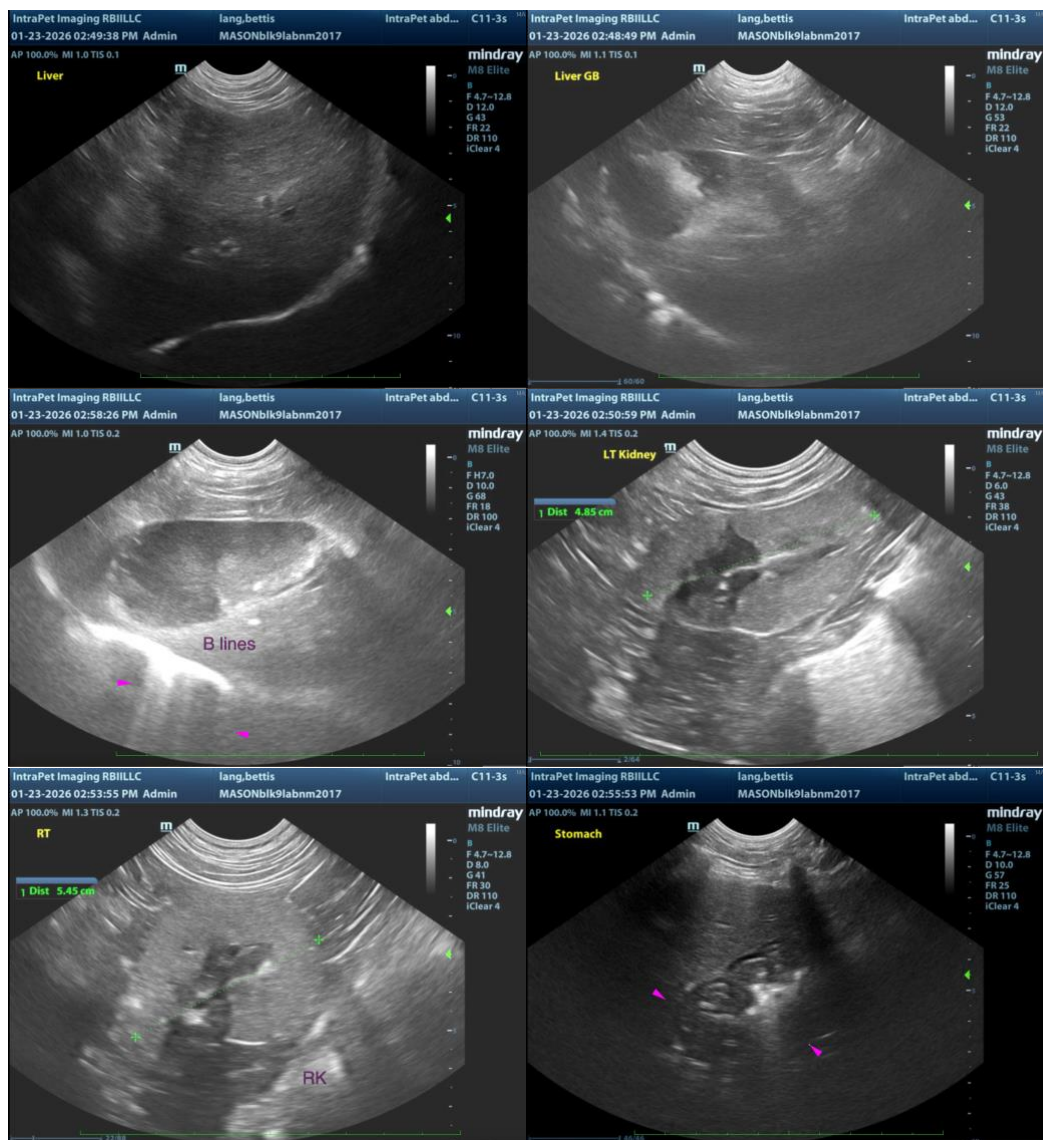
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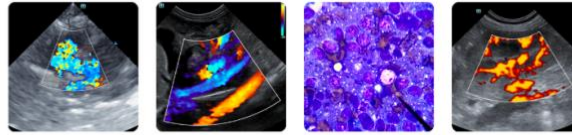
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the clinical history, three-view thoracic radiographs are recommended to assess cardiopulmonary status. Depending on the results, further work-up may be indicated.
- Given the gall bladder changes, Ursodeoxycholic acid (Ursodiol) is recommended. Serial sonographic monitoring (e.g., every 6-8 weeks) of the gall bladder is recommended to assess for progression to a fully formed mucocele. If progression occurs, a cholecystectomy may be warranted.



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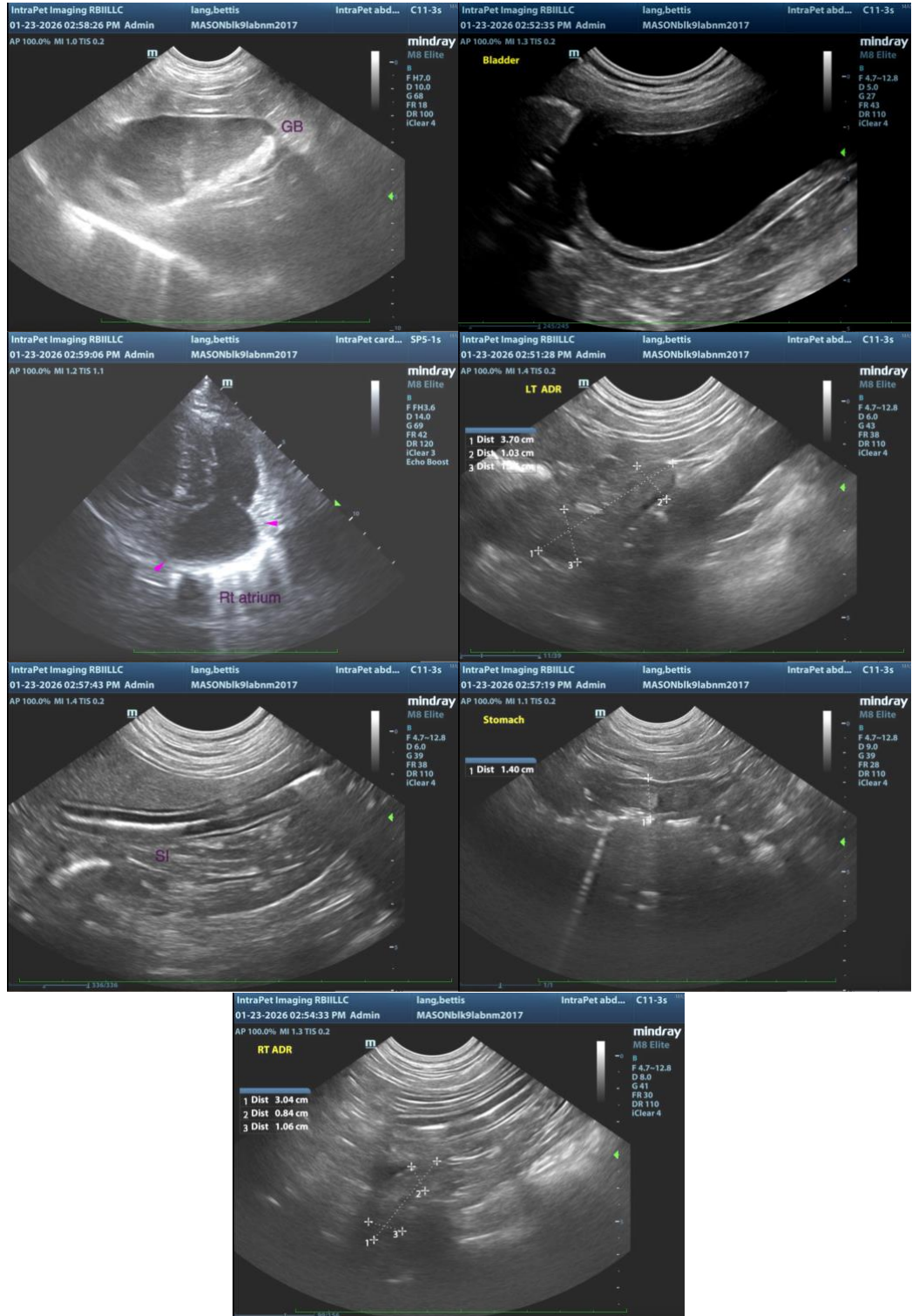
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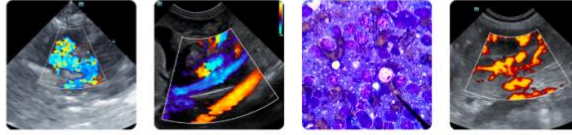
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in

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the image/video clips provided.

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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.

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