Charleston Mobile Veterinary Services
IN PARTNERSHIP WITH SONOPATH VETERINARY ULTRASOUND

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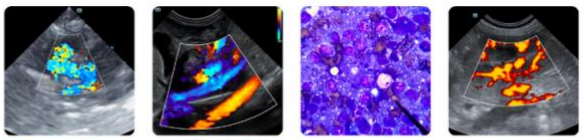

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Lexie Reed

SPECIES

Canine

BREED

Weimaraner

SEX

Female Spayed

AGE

05/11/2012

WEIGHT

56.8 lb

INTERPRETED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

IMAGING PERFORMED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME

Kind Care AH

REFERRING VET

Dr Adri Casagrande

INVOICE

22438

DATE

1-23-26

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: U/S from another DVM April 2025

Abdominal Ultrasound Conclusion:
1. Segmental muscularis layer thickening of the small intestine. Differentials are inflammatory bowel disease, enteritis, or small cell lymphoma.
2. Heterogenous liver with hypoechoic and hyperechoic nodules. Primary differentials are vacuolar hepatopathy, hepatitis with nodular regeneration or round cell neoplasia.
3. Partially mineralized cholecystic sediment

P continues to be symptomatic with intermittent GI signs (vomiting, diarrhea) Prior to April 205 was consider chronic pancreatitis and IBD dog. Change to Hill/s ID dry food stopped most symptoms until Jan 2026.

Abnormal lab-work values: Jun 2025 ALT 200 ALP 1398. Jan 2026 ALT 238 ALP >2000.
Current Medications: Denamarin, Sucralfate, Metronidazole, Hills i/d low fat
Radiographic Findings: none

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 mostly anechoic. No cystic calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The left kidney is normal in size (6.58 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal-to-mild corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (7.15 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal-to-mild corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.85 cm at cranial pole) (0.85 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 normal in size (0.64 cm at cranial pole) (0.45 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 (1.35 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 normal-to-prominent-in-size, with normal peripheral contours. The parenchyma is isoechoic

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relative to the spleen, and diffusely heterogenous, bordering on nodular in appearance. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1: 1.

The gallbladder lumen is moderately distended. The wall is thin and smooth. A small amount of aggregated, echogenic-to mineralized, gravity-dependent debris/sand is observed within the lumen. The cystic and common bile ducts are normal/not seen.

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 is diffusely thickened (up to 0.50 cm). There is disruption in the normal 1:3 muscularis: mucosal ratio, with a 1:1 ratio in some segments. Discreet masses are not identified. The ileocecal colic junction and colonic wall are normal. The colonic lumen contains shadowing fecal material. There is no obvious evidence of an obstructive pattern.

Pancreas
(See ***"Other"*** category).

Lymph Nodes
(See ***"Other"*** category).

Free Abdomen
There is no obvious evidence of free fluid.

Other
In the left cranial abdomen, a 3.7 x .36 cm walled structure with a central fluid pocket is visualized. Surrounding mesentery is mildly hyperechoic.

A brief echocardiogram reveals no obvious evidence of right atrial or auricular mass. There is no obvious evidence of pericardial effusion.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The origin of the mass/lesion in the left cranial quadrant is unclear. It may be arising from pancreas, lymph node, mesentery, other. Considerations include abscess, abscessed tumor, other. Mild adjacent peritonitis is present.
- The hepatic changes are nonspecific and could be secondary to inflammatory disease (i.e., cholangiohepatitis, chronic hepatitis), hepatotoxicosis, infiltrative neoplasia (i.e., lymphoma), vacuolar hepatopathy, regenerative nodular hyperplasia, other hepatopathy, or some combination thereof.
- Gallbladder debris/sand, non-mucocele
- The small intestinal wall changes could be consistent with inflammatory bowel disease or emerging lymphoma.

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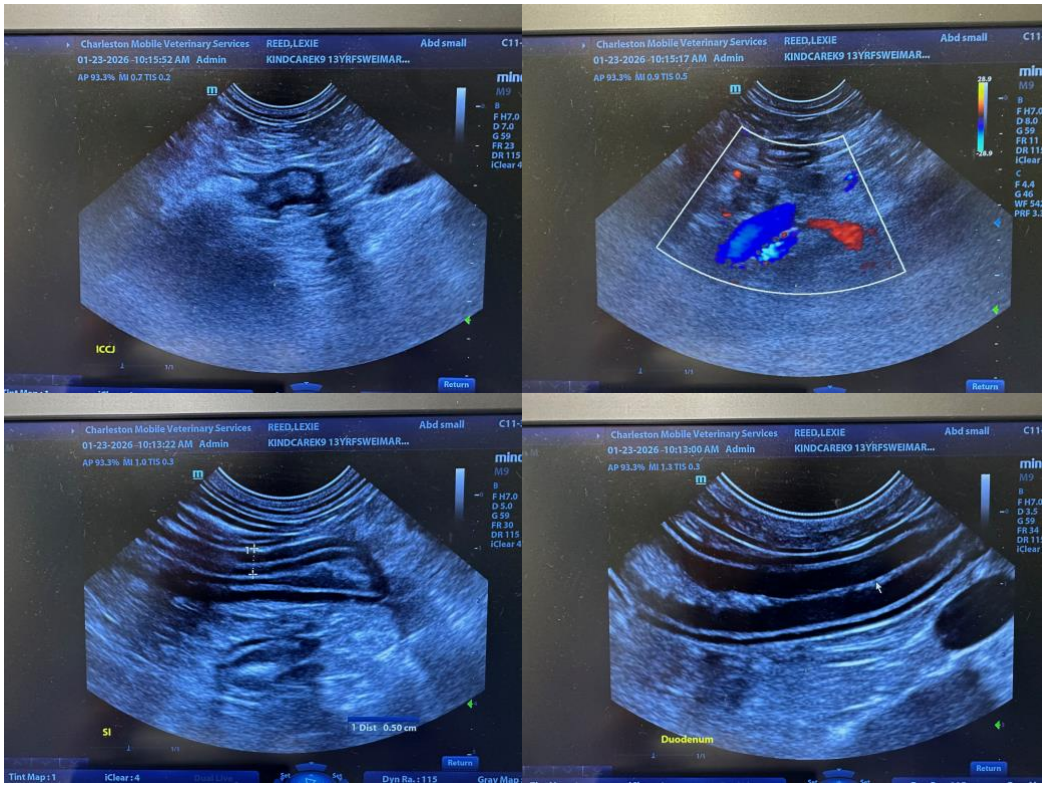
Secondary Findings

- Minor bilateral age-related renal changes
- Mild left adrenomegaly
- Minor retained gastric ingesta

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases
- Consider fine-needle aspiration of the mass in the left cranial quadrant, with submission for cytology, as well as aerobic and anaerobic bile cultures. Hepatic tissue sampling (i.e., aspirates or biopsies) can also be considered. If biopsies are pursued, aerobic and anaerobic bile cultures and hepatic copper quantitation should also be performed. GI biopsies should also be obtained.
- Given the patient's clinical signs, other considerations include the following:

1. Fecal evaluation for ova and Giardia
2. GI panel including serum cobalamin and folate, TLI, PLI and resting cortisol level
3. Limited antigen or hydrolyzed protein diet trial



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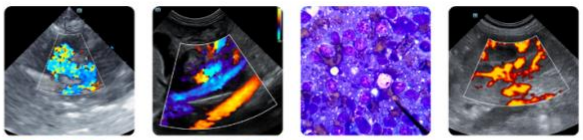

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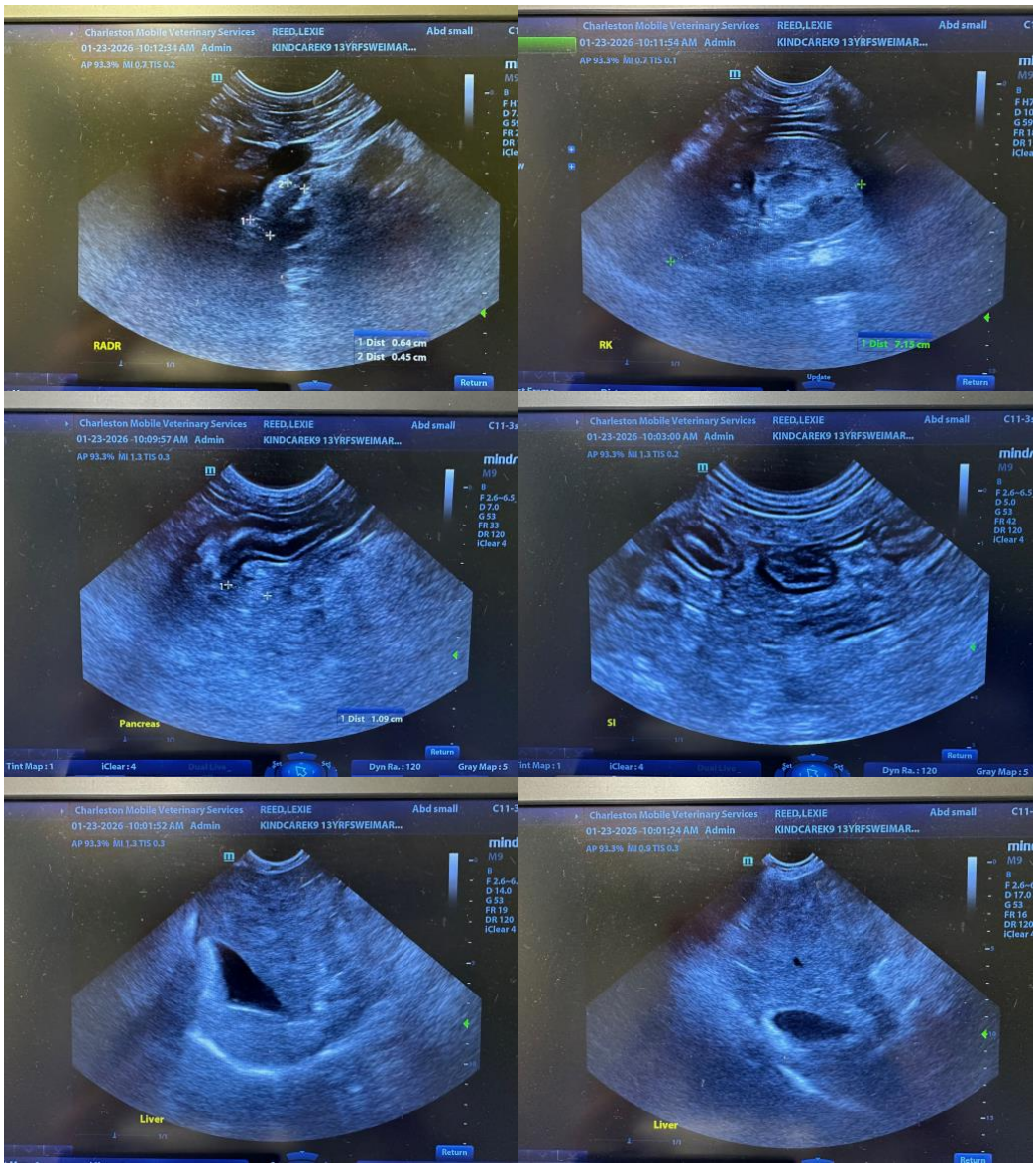

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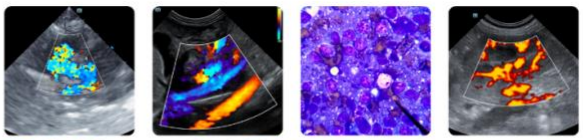

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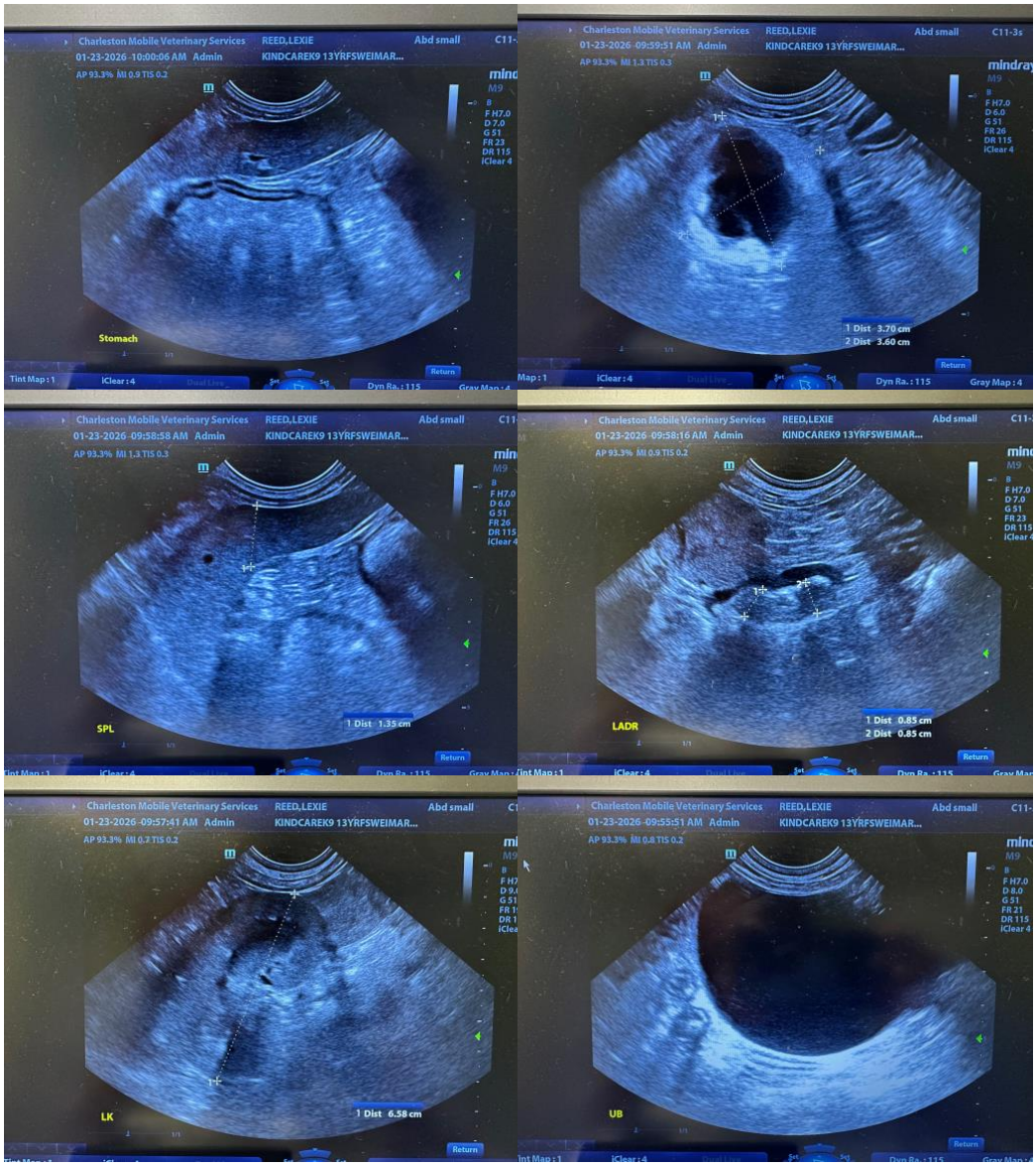

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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