



**PATIENT**

Maggie Sue Smith

**SPECIES**

Canine

**BREED**

Pitbull mix

**SEX**

Female Spayed

**AGE**

67

**WEIGHT**

11/12/2016

**INTERPRETED BY**

Andrea Nicastrò DVM  
Diplomate ACVIM  
(Sm Animal Internal Med)

**IMAGING  
PERFORMED BY**

Andrea Nicastrò DVM  
Diplomate ACVIM  
(Sm Animal Internal Med)

**HOSPITAL NAME**

Ashley Pines AH

**REFERRING VET**

Dr Savannah Lavallee

**INVOICE**

22457

**DATE**

1-26-26

**PRESENTING CLINICAL SIGNS**

Hx of:  
bladder stones  
anorexia  
splenomegaly  
dehydration  
elevated ALT, ALP and bilirubin

Assessment: Patient presented last week- QAR on presentation and more dull than previously. O reports difficulty in administering medications to pt. Pt not interested in eating anything they offer her. On examination today, patient has an elevated skin tent and is 5-8% dehydrated.

01/26/2026:

O called in the morning at 8:02am reporting that patient doing worse - was unable to administer oral medications over the weekend. Patient more lethargic and hiding in places she does not normally go. O reports that she is vomiting up bile. O said they called bluepearl this morning and was suggested to them to follow up with us to see if patient could get a feeding tube with us for cheaper. O asked for update on ultrasound schedule. Informed O that we have not been in contact as they also just opened but the plan was to call them. Discussed with O that if ultrasound can be done today, still may be recommending transfer for referral level of care or hospitalization with us depending on results.

Abnormal lab-work values:

MCHC 39.3  
Hemoglobin 21.2  
Lymphocytes 0.88  
Monocytes 2.78  
eosinophils 0.01  
platelets 143  
mpv 14.0  
chloride 105  
ALT 360  
ALP 330  
Tbili 1.0  
Amylase 440

Current Medications: None in the last 24 hrs as O reports they have not given what we prescribed

**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 and the proximal urethra (visible to a depth of 2.0 cm) are normal.

The left kidney is normal in size (6.75 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 loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (6.83 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 loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal



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vasculature is normal.

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**Adrenal Glands**

The left adrenal gland is normal in size (0.60 cm at cranial pole) (0.66 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.

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The right adrenal gland is normal in size (1.03 cm at cranial pole) (0.62 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.

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**Spleen**

The spleen is mildly enlarged (2.56 cm in width at the level of the hilus) with a curled contour. There is appropriate echogenicity and echotexture. A 1.74 cm hyperechoic nodule is observed at the lateral aspect. Splenic vasculature is normal.

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**Liver**

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. 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.

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The gallbladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are mostly anechoic. The cystic and common bile ducts are normal/not seen.

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**Gastrointestinal**

The gastric lumen is minimally fluid-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 segmentally fluid-distended (mild-to-moderate). The duodenal wall is thickened (up to 0.72 cm). The jejunal wall is normal-to moderately thickened (up to 0.68 cm). There is a slight disruption in the normal 1:3 muscularis: mucosal ratio in several segments. Discreet masses are not identified. The ileocecolic junction is normal. Ty wall of the descending colon is mildly-thickened (up to 0.48 cm) with retention of the normal layering pattern. The colonic lumen contains liquid-appearing fecal material. There is no obvious evidence of an obstructive pattern.

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**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.

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**Lymph Nodes**

A cluster of enlarged, rounded hypoechoic mesenteric lymph nodes are visualized (one measuring 4.3 x 2.5 cm). In addition, two hypoechoic, rounded, periportal lymph nodes are seen (one measuring 2.5 x 1.4 cm). Surrounding mesentery is hyperechoic.

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**Free Abdomen**

The mesentery throughout the abdomen is hyperechoic. Trace free fluid is observed.

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**Other**

A brief echocardiogram reveals no obvious evidence of pericardial or pleural effusion in the visible window.



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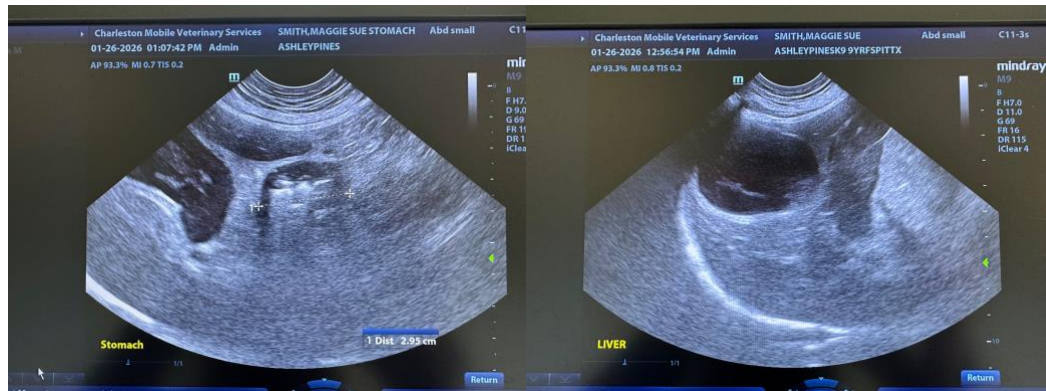
**ULTRASONOGRAPHIC FINDINGS**

- The abdominal lymphadenopathy is concerning for infiltrative neoplasia (i.e., lymphoma) with a lower possibility of lymphadenitis or lymphoid hyperplasia.
- The diffuse bowel changes could be consistent with an inflammatory process (i.e., inflammatory bowel disease) or emerging neoplasia (i.e., lymphoma).
- Diffuse peritonitis, likely secondary to lymph node and bowel pathology
- 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 hyperechoic nodule is most consistent with a myelolipoma, with a lower possibility of an emerging tumor.

\*Ultrasound-guided fine-needle aspiration of a mesenteric lymph node was performed at the end of this study without incident.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Stat cytology on the mesenteric lymph node is recommended. Depending on the results, consultation with a board-certified oncologist may be warranted. In the meantime, symptomatic care is recommended.





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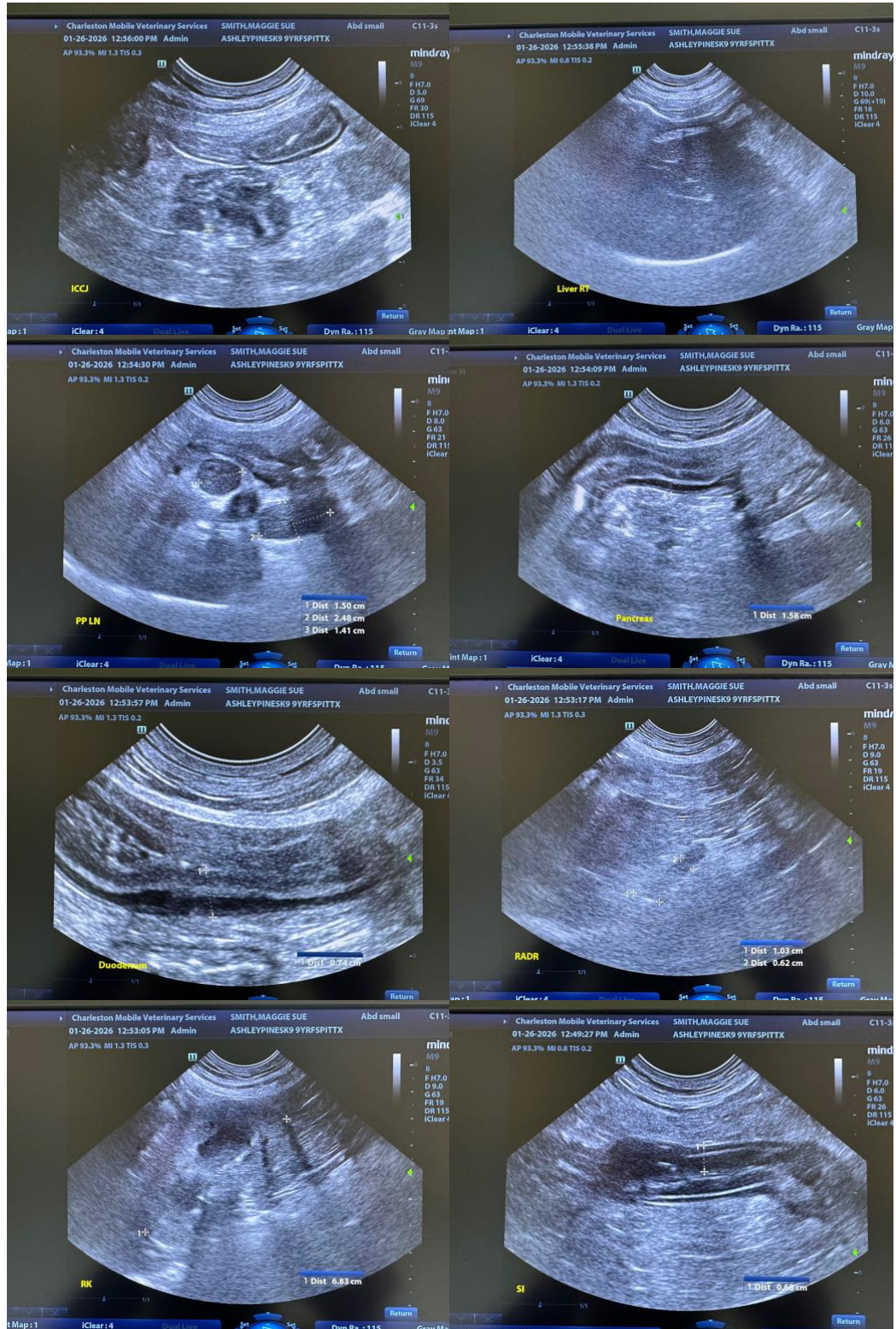
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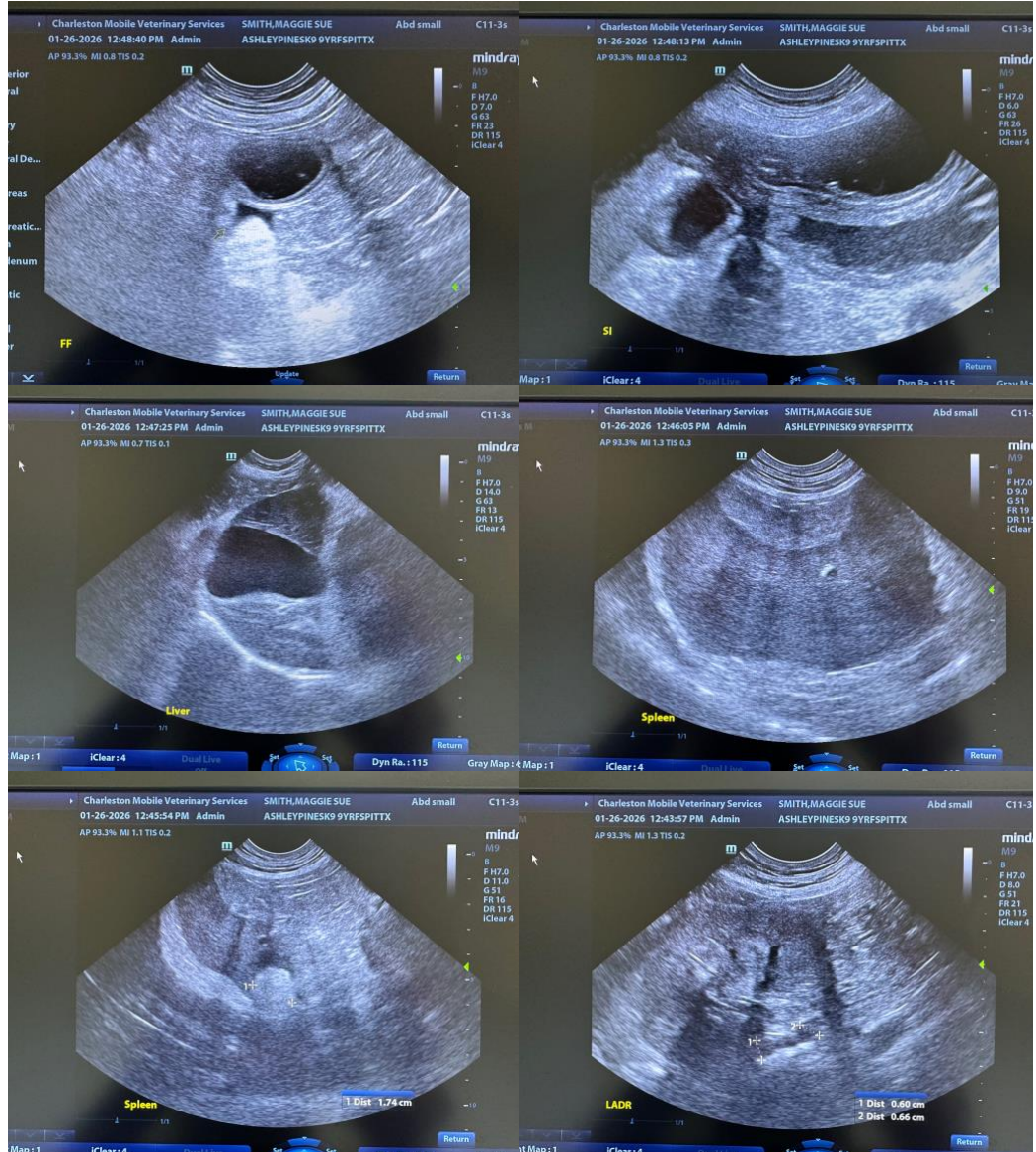
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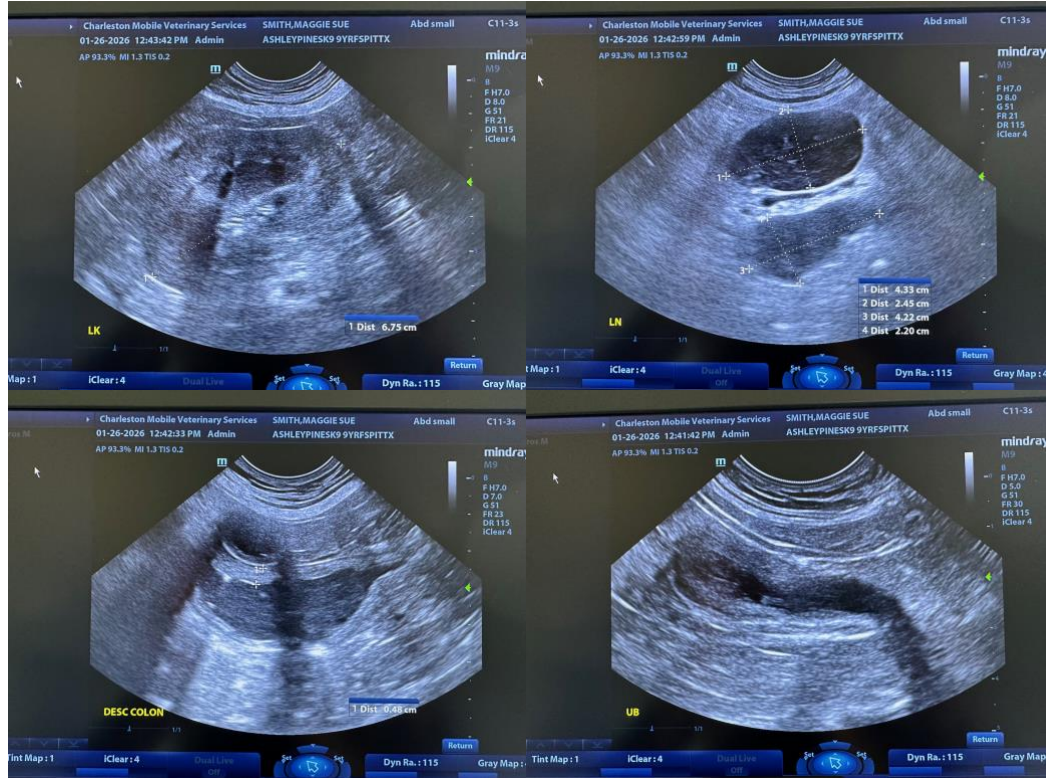
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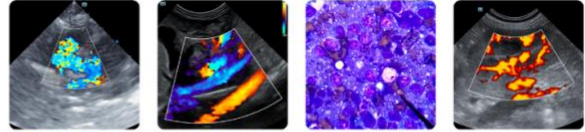
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)**  
[info@SonoPath.com](mailto:info@SonoPath.com)



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