



PATIENT

Boots Otey

SPECIES

Canine

BREED

Golden Retriever

SEX

Male Neutered

AGE

12 Years

WEIGHT

55 lbs.

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Potomac Mobile
Veterinary Ultrasound

HOSPITAL NAME

Village Vet Clinic of
Warrenton

REFERRING VET

Dr. Jarrett

INVOICE

11943kk

DATE

10/1/21

PRESENTING CLINICAL SIGNS

History: Losing weight; lost 18lbs. No vomiting but doesn't eat well. Coughing, dyspnea. Chest films (taken 5 days ago) looked normal. Collapsing in the rear (maybe from hip/arthritis issues). Elevated liver values. Rads of abdomen showed a very opaque object in the vicinity of the stomach/pylorus.

Abnormal PE/Chem/CBC/UA Results: ALT 171, ALP 287, GGT 25, ALB 2.5, pSL 732

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended. The wall in the region of the apex is variably thickened (up to 0.64 cm) and irregular with foci of mineralization within the wall. The wall tapers to a normal thickness as it extends towards the urinary bladder neck. Mineralized sand/tiny calculi are observed within the lumen along with a small to moderate amount of suspended, echogenic debris. The region of the trigone and the visible portion of the proximal urethra are normal.

The prostate is normal in size (2.83 x 0.77 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal size (7.14 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (6.60 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is minimal 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 normal size (0.61 cm at cranial pole) (0.66 cm at caudal pole) (3.06 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 not definitively visualized due to patient discomfort when evaluating this region.

Spleen

The spleen is subjectively normal in size (2.31 cm in width at the level of the hilus). A 3x3 cm heterogeneous mass is observed at the caudal aspect. The mass causes mild capsular expansion. The remaining peripheral contours are curvilinear. A light micronodular pattern is observed in the remaining parenchyma. Splenic vasculature appears normal with no evidence of thrombosis.

Liver

The liver is subjectively prominent in size with slightly irregular peripheral contours. The parenchyma is diffusely heterogeneous and nodular in appearance. There is no visibly normal hepatic parenchyma. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is moderately distended. The wall is thin and smooth. A moderate amount of echogenic to mineralized gravity-dependent debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.



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Gastrointestinal

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The gastric wall and pylorus are normal in thickness with a normal layering pattern. The gastric lumen contains a 2.53 cm hyperechoic, shadowing foreign body that is non-obstructive and a small amount of ingesta. 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 colonic wall is normal. No obstructive disease is noted.

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Pancreas

The body/right limb of the pancreas is prominent in size with slightly irregular peripheral contours. The parenchyma is isoechoic relative to surrounding omental fat with a nodular appearance, particularly in the region of the body. The pancreatic duct is not overtly dilated. There is no evidence of peripancreatic effusion.

Free Abdomen

Trace free fluid is observed. The abdominal lymph nodes are normal/not visible.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

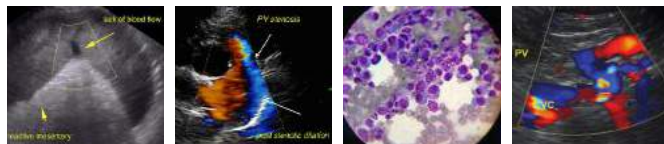
- The hepatic parenchymal changes could be consistent with infiltrative neoplasia (i.e., carcinoma, round cell tumor), diffuse inflammatory disease, fibrosis, or other hepatopathy.
- Splenic mass. Both benign and malignant causes are possible. Given the capsular expansion, malignancy is favored.
- The pancreatic changes could be consistent with benign, age-related remodeling/fibrosis +/- concurrent inflammation. However, infiltrative neoplasia cannot be completely excluded.
- Non-obstructive gastric foreign body.
- The trace ascites is likely secondary to hepatic pathology.
- Urinary bladder sand/tiny cystic calculi with bladder wall changes consistent with cystitis.

Secondary Findings:

- Bilateral, age-related renal changes with right dystrophic mineralization.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. If an aggressive approach is desired, consider an abdominal exploratory with liver and pancreatic biopsies and a splenectomy with submission of all tissues for histopathology. A thoracic CT scan can be considered prior to surgery to assess for small pulmonary lesions that may not be visible on thoracic radiographs.
2. If a more conservative approach is desired, fine needle aspirates of the splenic mass and liver can be considered (if clotting status is appropriate). 25-gauge needles should be used. However, it should be noted that cytologic evaluations may be inconclusive.



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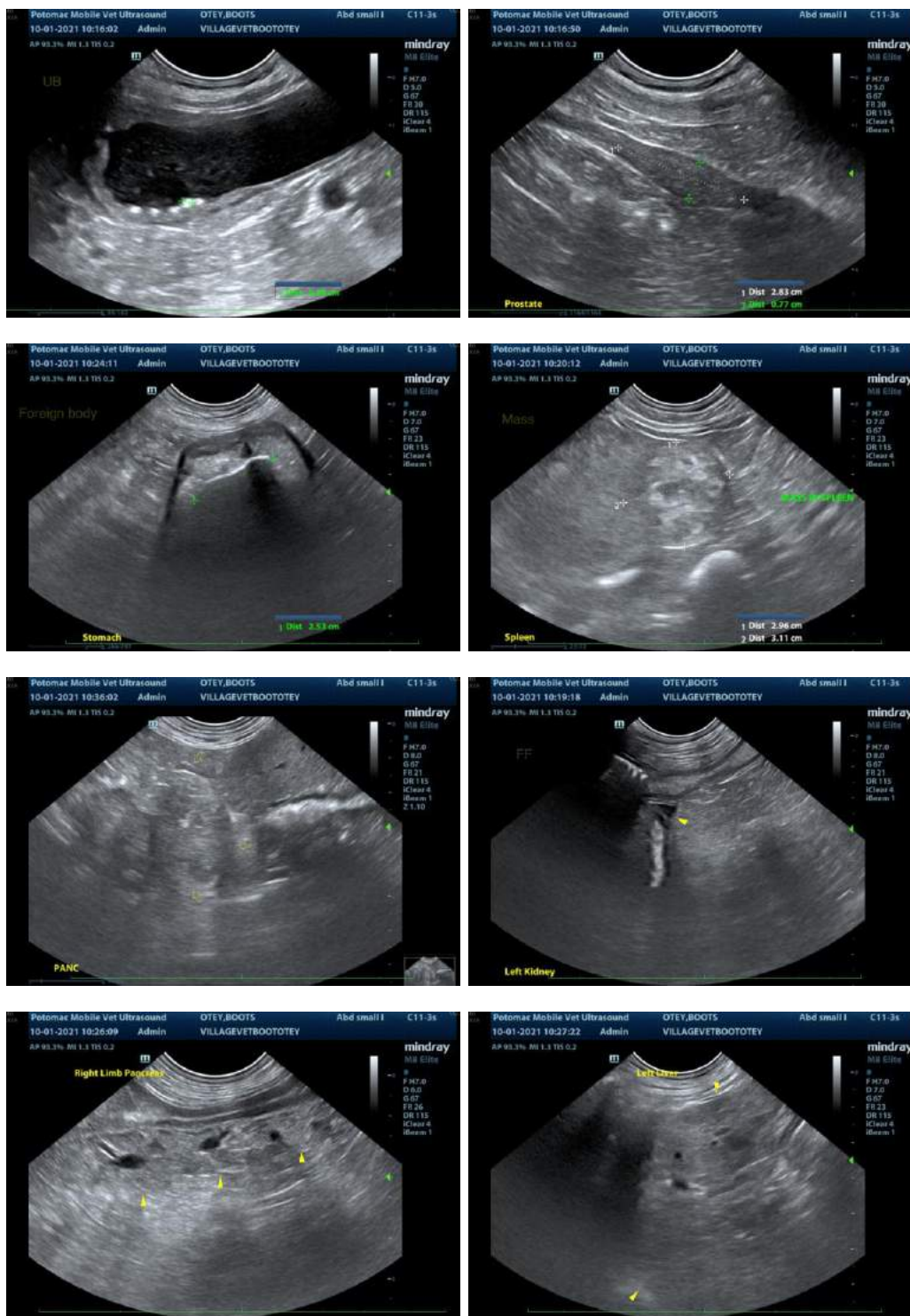
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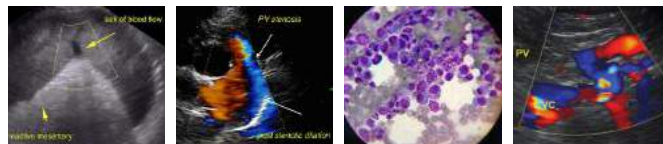
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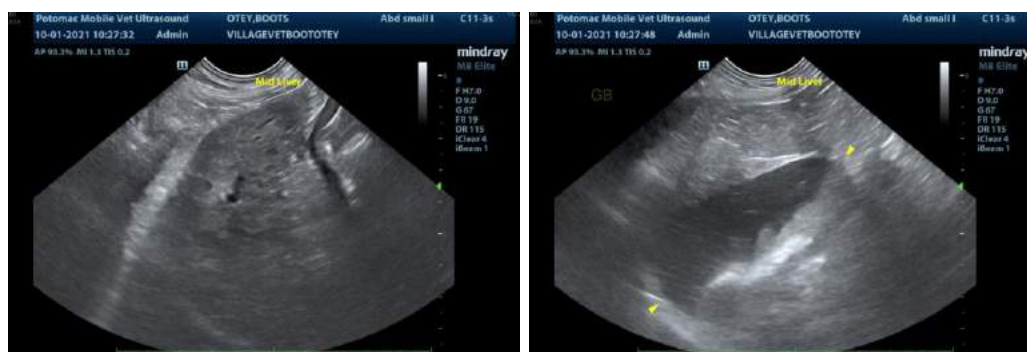
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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