

## PATIENT

Miley White

## SPECIES

Canine

## BREED

Whippet

## SEX

Spayed Female

## AGE

10 years

## WEIGHT

29.4 lbs

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Loetitia Saint-Jacques,  
RVT LVT

## HOSPITAL NAME

Brighton Greens VH

## REFERRING VET

Dr Robin Janeway

## INVOICE

11868

## DATE

12.16.22

## PRESENTING CLINICAL SIGNS

History: Annual exam noted new heart murmur grade 4/6 as well as weight loss of 1 lb. (8/2021 wt 30.4lbs, pt usually between 30.4 up to 32 lbs), otherwise pt seems like her normal self. Lab results 11/22/2022 TP 4.8 (L), Albumin 2.5 (L), Chol 534 (H), Amylase 1288 (H), PSL 158 (H), CBC WNL, T4 1.6, UA USG 1.016, 2+ proteinuria, trace blood, fecal negative and accuplex negative. UPC 0.9 (ref <0.5) Pt on ursodiol ¼ x 250mg tab PO SID U/S 2018- Mildly reactive mesenteric lymphadenopathy, mild gastritis, flattened right adrenal gland, right renal agenesis.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended with anechoic urine. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 1-2 cm, are normal.

The left kidney is normal size (7.07 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. A hyperechoic medullary band is observed at the corticomedullary junction. Trace pyelectasia is present. There is no evidence of nephroliths, infarcts or hydroureter.

The region of the right kidney is evaluated. The right kidney is not visualized.

### Adrenal Glands

The left adrenal gland is normal size (0.64 cm at cranial pole) (0.62 cm at caudal pole); 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 normal size (0.43 cm at cranial pole) (0.56 cm at caudal pole); 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.

### Spleen

The spleen is normal in size (1.62 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A few ill-defined myelolipomas are observed in the region of the hilus. Splenic vasculature is normal.

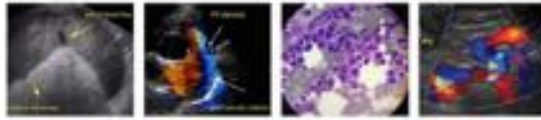
### Liver

The liver is normal to slightly prominent in size with normal curvilinear peripheral contours. The parenchyma isoechoic relative to the spleen. A few hypoechoic nodules/areas are visualized (the largest measuring 1.15 cm in length). 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 small amount of mostly gravity dependent, echogenic debris/sludge 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 not distended. The gastric wall and pylorus are normal in thickness with a normal layering



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pattern. 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. There is no evidence of an obstructive pattern.

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### **Pancreas**

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

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### **Free Abdomen**

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

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## ULTRASONOGRAPHIC FINDINGS

### Primary Findings

- Bilateral nonspecific chronic renal changes. Given the presence of proteinuria, an early protein-losing nephropathy may be present.
- The trace ascites may be secondary to increased vascular permeability (i.e., due to vasculitis), low oncotic pressure, or increased hydrostatic pressure.

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### Secondary Findings

- The hypoechoic hepatic nodules trend toward the benign (i.e., regenerative nodules) with a lower possibility of emerging neoplasia. The diffuse hepatic parenchymal changes are nonspecific and are likely secondary to a benign process (i.e., vacuolar hepatopathy), which may be endocrine or idiopathic in nature. In light of the normal liver values, inflammatory disease or other insidious hepatopathies are considered less likely.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Suspected right renal agenesis

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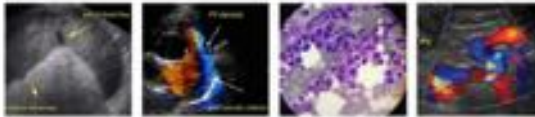
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## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the elevated UPC, consider initiation of an angiotensin receptor blocker (i.e., telmisartan), omega 3 fatty acids and a prescription renal diet. A baseline blood pressure measurement should also be obtained. Serial monitoring of the patient's renal values, UPC and blood pressure measurements is recommended to assess for progression.
- To evaluate for concurrent causes of hypoalbuminemia, consider the following:
  1. Fecal evaluation for ova and Giardia
  2. Resting cortisol level to screen for atypical hypoadrenocorticism
  3. Pre-and postprandial serum bile acids to assess hepatic function
  4. GI panel including serum cobalamin, folate, TLI and PLI
  5. +/- GI biopsies



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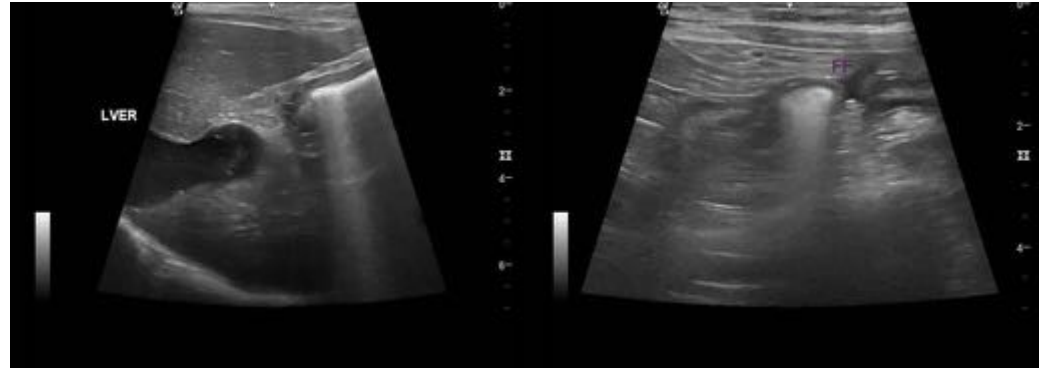
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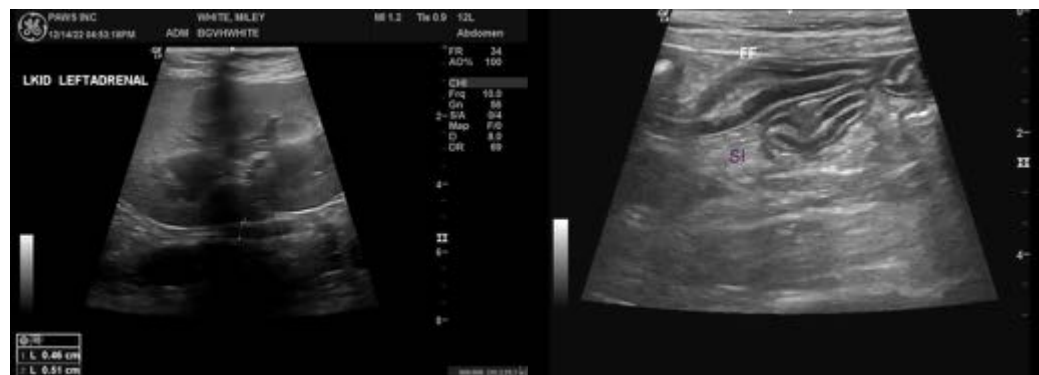
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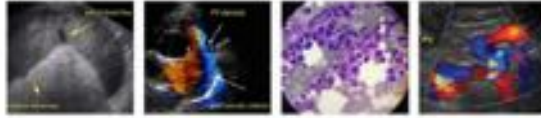
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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