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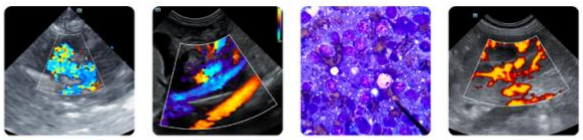

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Red Welkis

SPECIES

Canine

BREED

Mixed Breed

SEX

Female Spayed

AGE

03/29/2009

WEIGHT

29.2 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 Michael Marino

INVOICE

22226

DATE

12-5-25

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Evaluate liver and kidneys; recent neurologic event
Abnormal lab-work values: Bloodwork (NSAID Panel): BUN 62 mg/dL, CREA 1.9 mg/dL, AST 61 U/L, ALT 183 U/L. Kidney values are stable. The liver values have increased slightly.

Urinalysis (cysto): pH 6.0, USG 1.024, proteinuria 30 mg/dL, mild pyuria 9 WBC/hpf, hematuria >50 RBC/hpf. Significant hematuria and a mild increase in white blood cells. No bacteria were observed on sediment examination.
Chest Radiograph Findings: Mild bronchial pattern. Heart size is normal. No evidence of a mass or tracheal collapse. There is a loss of the cranial cardiac waist on both lateral views. There is a slight bulge in this area on the right lateral view.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly distended with mostly anechoic urine. The wall in the region of the apex is rthi (up to 0.79 cm) with a slightly irregular 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 and the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is borderline small in size (4.15 cm in length) with a slightly irregular shape. The cortex is variably thickened with moderate 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 (5.18 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. Trace pyelectasia is present. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.58 cm at cranial pole) (0.57 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 (0.48 cm at cranial pole) (0.56 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 (1.25 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 subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and slightly mottled in appearance. No distinct focal lesions are observed. 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. Luminal contents are mostly anechoic. The cystic and common bile ducts are normal. The common bile duct measures 0.31 cm near the

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distal aspect.

Gastrointestinal
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 normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecocolic junction and colonic wall are 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
(See "Other" category).

Free Abdomen
There is no obvious evidence of free fluid.

Other
A 2.05 x 2.03 cm heterogenous mass is observed in the mid- to caudal abdomen. Surrounding mesentery is slightly 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

- Mid- to caudal abdominal mass, the origin of which is unclear. It may be arising from mesentery, lymph node, other. Neoplasia (i.e., carcinoma, sarcoma, round cell tumor) is suspected with a lower possibility of a feline infectious peritonitis/granuloma. Mild adjacent peritonitis is present.
- Bilateral non-specific chronic renal changes
- The hepatic parenchymal changes are most consistent with age-related parenchymal remodeling. However, given the mild elevation in ALT, other hepatopathies (i.e., reactive hepatopathy, inflammatory disease, hepatotoxicosis (i.e., copper)) should also be considered.

Secondary Findings

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The urinary bladder wall changes could be consistent with cystitis or may be artifactual due to lack of full repletion. Correlation with the patient's clinical history is recommended.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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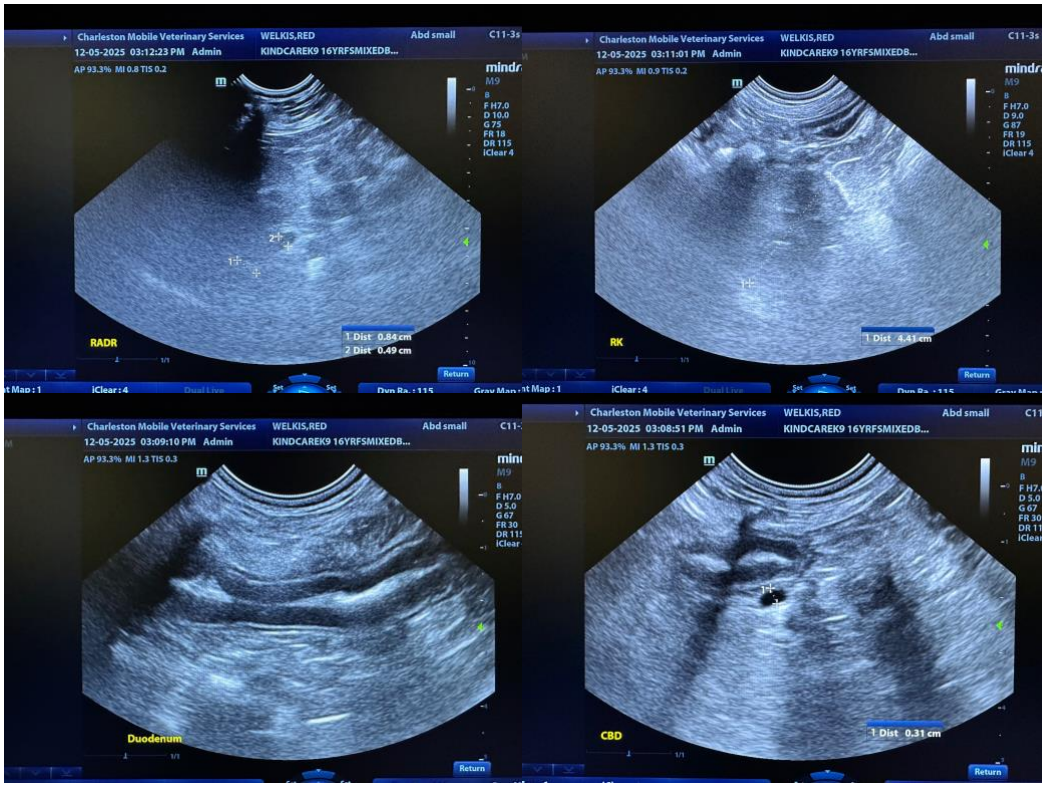
- Regarding the mid- to caudal abdominal mass, consider the following:

  1. Fine-needle aspiration (assuming normal clotting status). A 25-gauge needle should be used. Depending on the cytology results, excisional biopsy with submission for histopathology should be considered. Liver biopsies can also be obtained at the time of surgery to assess for micrometastatic disease.

- Regarding the azotemia, consider the following:

  1. Urine culture and sensitivity
  2. UPC if proteinuria is present in the absence of infection and hematuria
  3. Baseline blood pressure measurement
  4. Transition to a prescription renal diet (if tolerated)
  5. Serial monitoring of the patient's renal values to assess progression of the azotemia



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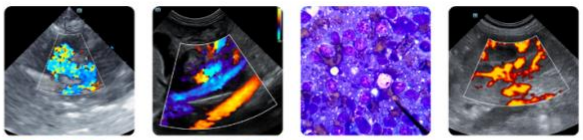

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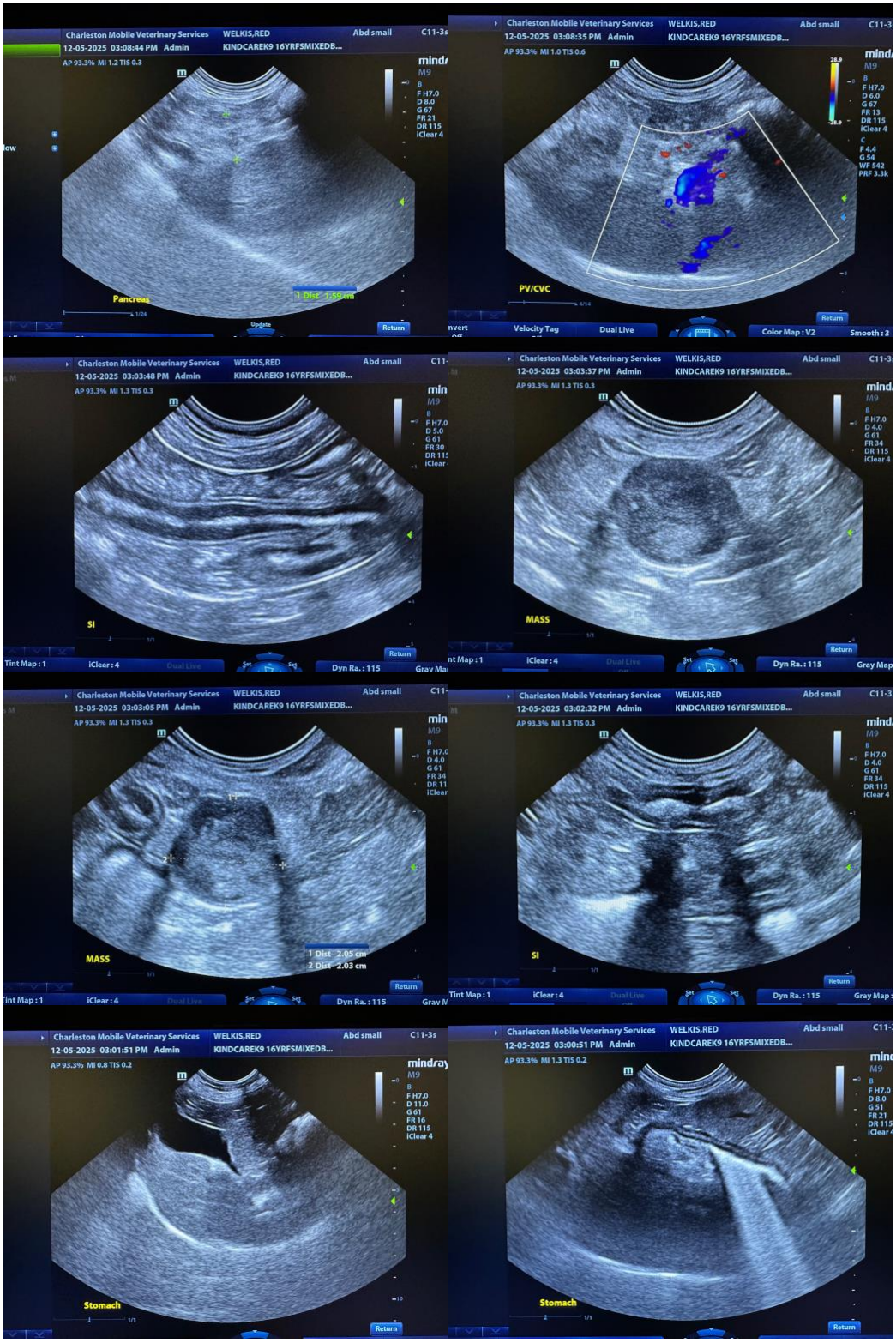

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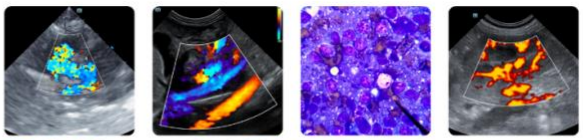

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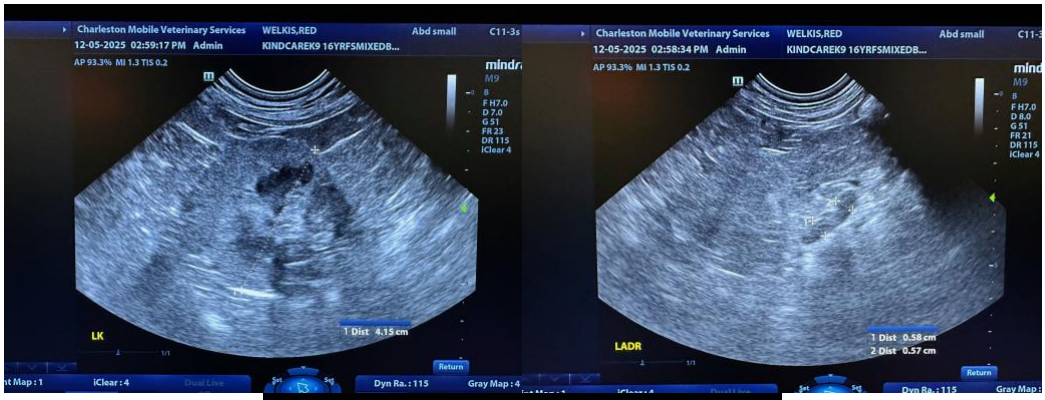

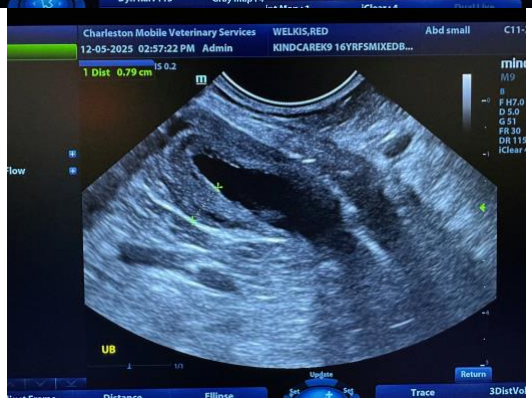

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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