



PATIENT

Mikko Mathews

SPECIES

Canine

BREED

Mixed

SEX

Female Spayed

AGE

02/12/2024

WEIGHT

29.4kg

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

PawMed VUC
W Ashley

REFERRING VET

Dr Erinn Watts

INVOICE

22554

DATE

2-14-26

PRESENTING CLINICAL SIGNS

Patient presents with a history of anorexia, vomiting, lethargy. Last two weeks p has stopped eating her regular food and then she was also leaving kibble all over the floor. P did not defecate for 2 days and then 4 days ago they switched to a bland diet and is more willing to eat again, bowel movements have started again but are looser than normal but not diarrhea. Last p vomited up dinner, in the vomit they noticed what looked like a blood clot. P did not want to eat much after that. This morning p vomited again at 6:30am. P has been lethargic over the last 2 weeks and vomiting on/off as well. Will vomit about 2-3 hours after eating. Patient is clinically icteric.

ALP, ALT – too high to read, GGT – 54, Tbili – 4.8, HCT -35%, platelets – 71,000

In-house Leptospirosis test negative.

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 anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (0.59 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal in size (8.60 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal in size (8.84 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.49 cm at cranial pole) (0.41 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 (0.92 cm at cranial pole) (0.43 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 (1.34 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 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 distended. The wall is normal in thickness. A moderate amount of gravity-dependent debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

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Gastrointestinal

The gastric lumen is mildly 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 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 ileocecolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

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Pancreas

The right limb is visible with minimal deviation from the normal peripheral contours. The parenchyma is slightly hyperechoic relative to surrounding omental fat, and homogenous in appearance. The pancreatic duct is not overtly dilated. There is no evidence of peripancreatic effusion.

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Lymph Nodes

A few prominent mesenteric lymph nodes are visualized (one measuring 1.22 x 0.75 cm). In addition, at least two prominent periportal lymph nodes are seen (one measuring 2.08 x 1.19 cm).

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Free Abdomen

The mesentery adjacent to the caudal aspect of the liver is hyperechoic. There is no obvious evidence of free fluid.

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Other

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The liver is sonographically normal. However, given the patient's clinical history, and acute hepatopathy (i.e., infection, toxin) is suspected, with a lower possibility of a chronic hepatopathy (i.e., chronic hepatitis, copper hepatotoxicosis, other).
- Mild cranial peritonitis, likely secondary to hepatic inflammation.
- The gallbladder distention is likely secondary to fasting. There is no obvious evidence of a bile duct obstruction.

Secondary Findings

- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

- The pancreatic changes may be a normal variant for this patient or could be consistent with mild, chronic pancreatitis. Correlation with clinical findings is recommended.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider further testing for Leptospirosis testing (i.e., blood and urine PCR, convalescent serology).

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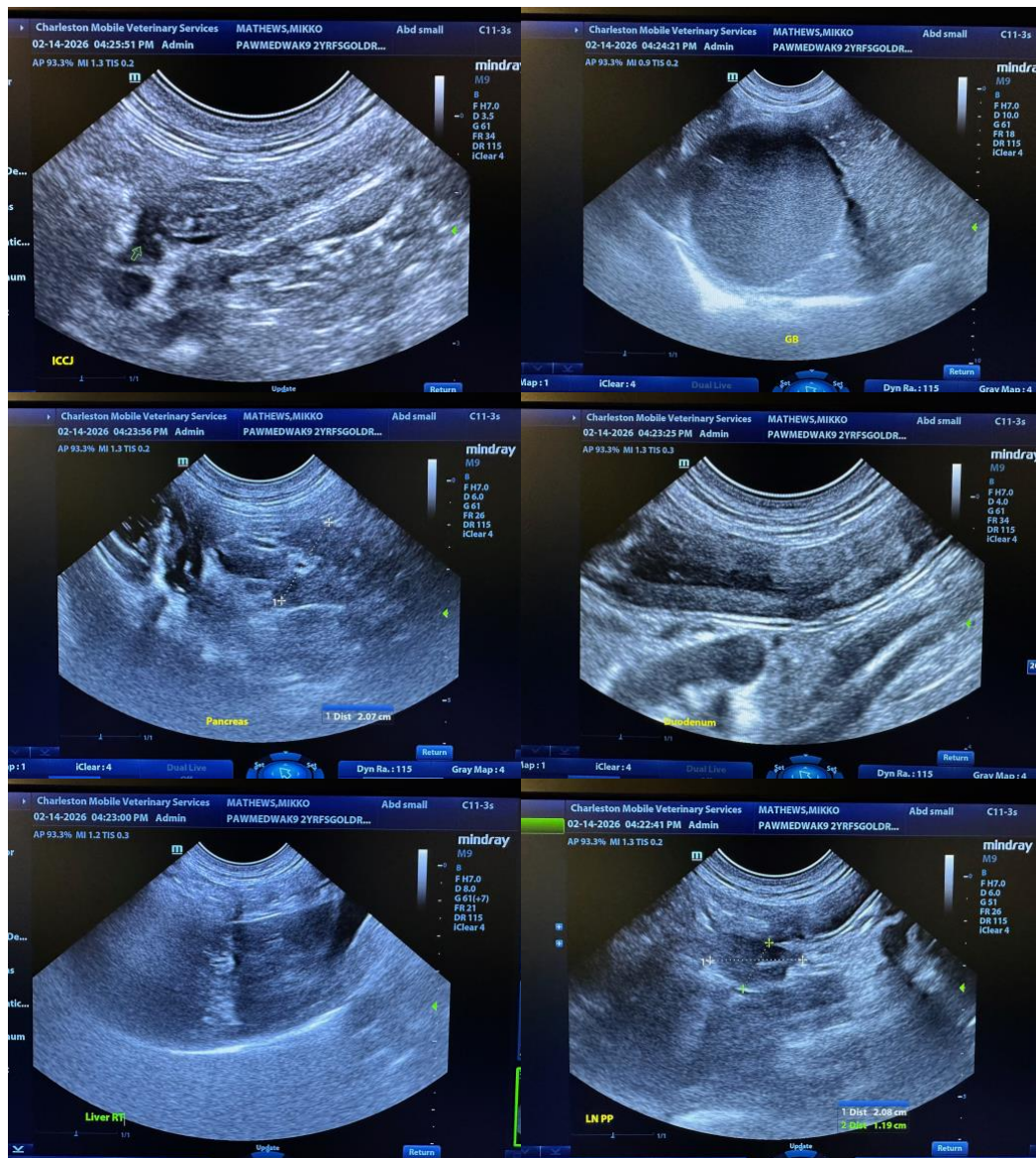
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- If an aggressive approach is desired, consider hepatic tissue sampling (i.e., aspirates or biopsies) assuming normal clotting status. If biopsies are pursued, aerobic and anaerobic bile cultures and hepatic copper quantitation should also be performed.
- If a conservative approach is desired, consider empirical treatment for bacterial cholangiohepatitis/ Leptospirosis/ hepatotoxicity (amoxicillin-clavulanic acid, +/-metronidazole, Denamarin). If no improvement in the liver values is seen within 7-10 days of initiating therapy, antibiotics should be discontinued, and hepatic tissue sampling reconsidered. If liver values improve, continue therapy for at least 4-6 weeks and 1 week beyond normalization of the liver values.





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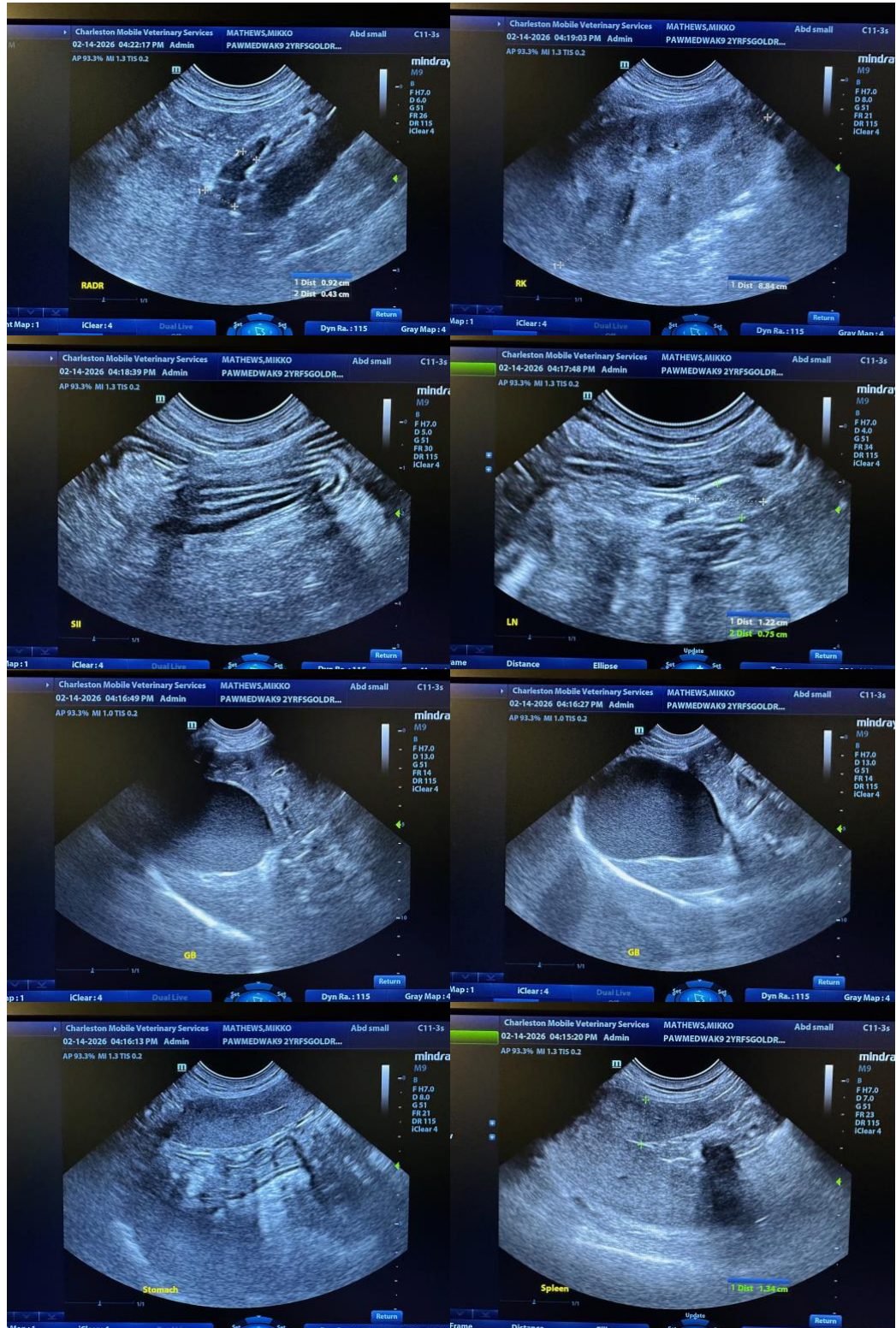
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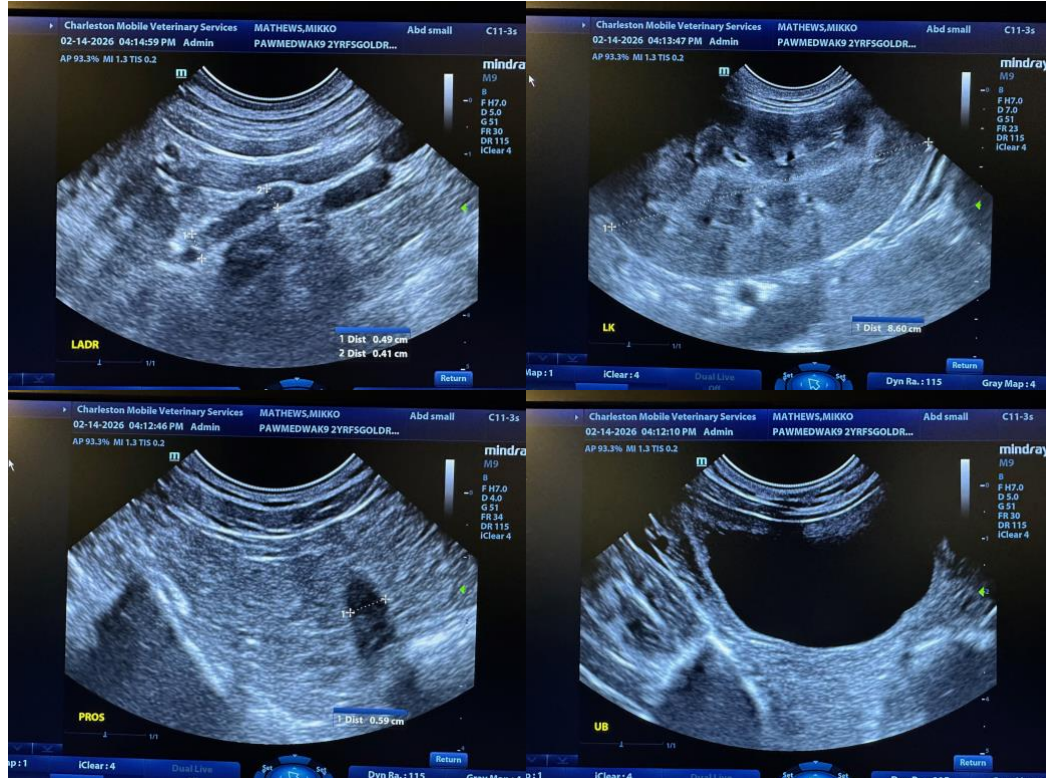
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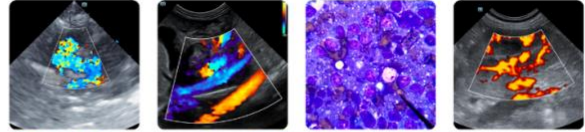
The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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