



PATIENT

Mia Eggleston

SPECIES

Canine

BREED

Maltese

SEX

Spayed Female

AGE

10 years

WEIGHT

7.05 lbs

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Bethany Coe, DVM

HOSPITAL NAME

Riverside Animal Clinic

REFERRING VET

Bethany Coe, DVM

INVOICE

10412

DATE

2/18/22

PRESENTING CLINICAL SIGNS

History: Chronic, intermittent inappetence and occasional diarrhea for past year. Always a "picky eater" per owner - they often have to hand feed her. Licks carpet/fabrics occasionally (on Prilosec 10mg SID). No vomiting, but occasional hack/gag. On a home-cooked diet for over a year, and intermittently won't eat that. Tried balanceit.com diet and supplement - patient won't eat supplement. Owner hesitant to feed commercial diet despite discussions to that effect. Complete labwork, urinalysis, abdominal radiographs, echocardiogram, and Texas GI panel performed over the past year.

Abnormal PE/Chem/CBC/UA Results: 8/2021: CBC/Chemistry = unremarkable. Fecal flotation = Negative Giardia SNAP = Negative Urinalysis =USG 1.022, pH 5.0, sediment quiet Abdominal radiographs = Hepatomegaly. Urolithiasis. Prominent ruggae stomach. 9/2021: Echocardiogram (Michigan State Univ) - Mild tricuspid regurgitation, Mild mitral regurgitation, Moderate asymptomatic systolic pulmonary hypertension - No treatment needed. 1/2022: Texas GI Panel = All results WRI PE Abnormalities: Grade III/VI systolic murmur. BCS 6/9. Mucoïd discharge OU (STT low OU - Tx with Tacrolimus 0.02%)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly distended. The wall is of appropriate thickness for the level of repletion. A 0.46 cm cystic calculus is observed within the lumen. The region of the trigone and the visible portion of the proximal urethra are normal.

The left kidney is normal size (3.73 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal size (4.49 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal size (0.65 cm at cranial pole) (0.43 cm at caudal pole) (1.62 cm in length); normal shape and smooth peripheral contours. A 0.61 x 0.46 cm hypoechoic nodule is observed at the cranial pole. Glandular echogenicity and detail at the caudal pole are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.95 cm at cranial pole) (0.54 cm at caudal pole) (1.81 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.

Spleen

The spleen is normal in size (0.77 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



PATIENT vasculature is normal.

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Liver

The liver is subjectively prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits mild heterogeneity. A 0.58 cm anechoic cyst is observed at on the left side. Hepatic vasculature and biliary tracts are of normal volume with no evidence of congestion.

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The gall bladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal/not seen.

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Gastrointestinal

The gastric lumen is not distended. The gastric wall is suspected to be thickened, but wall thickness is difficult to evaluate due to excessive rugal folds. The wall in the region of the pyloric antrum is thickened (up to 0.82 cm). 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. The colonic wall is normal. There is no evidence of an obstructive pattern.

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Pancreas

A 1.62 x 0.98 cm hypoechoic nodule/mass appears to be arising from the left limb. The remaining parenchyma in this region is slightly hypoechoic relative to surrounding omental fat. The pancreatic duct is not overtly dilated. In the region of the base/right limb, a 2.27 x 1.54 cm hypoechoic, slightly irregular mass is also seen. Surrounding mesentery is hyperechoic.

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Free Abdomen

There is no obvious evidence of free fluid.

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Lymph nodes

(See "Pancreas")

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The left pancreatic nodule/mass is most concerning for neoplasia (i.e., adenocarcinoma) with a lower possibility of benign pathology. The nodule/mass in the region of the right limb may represent a second pancreatic lesion, enlarged lymph node, other. Regional peritonitis is present
- Cystic calculus
- The pyloric wall thickening can be considered with inflammation hypertrophy, or emerging neoplasia.

Secondary Findings

- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory and infiltrative disease are considered less likely.
- Bilateral age-relate renal changes

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- The hypoechoic left adrenal nodule can be considered with a regenerative nodule or an emerging tumor.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- If accessible, fine-needle aspirates of the pancreatic regions can be considered (if clotting status is appropriate). Otherwise consider referral to a board-certified surgeon to discuss mass removal or biopsy. An abdominal CT scan would be useful in presurgical planning

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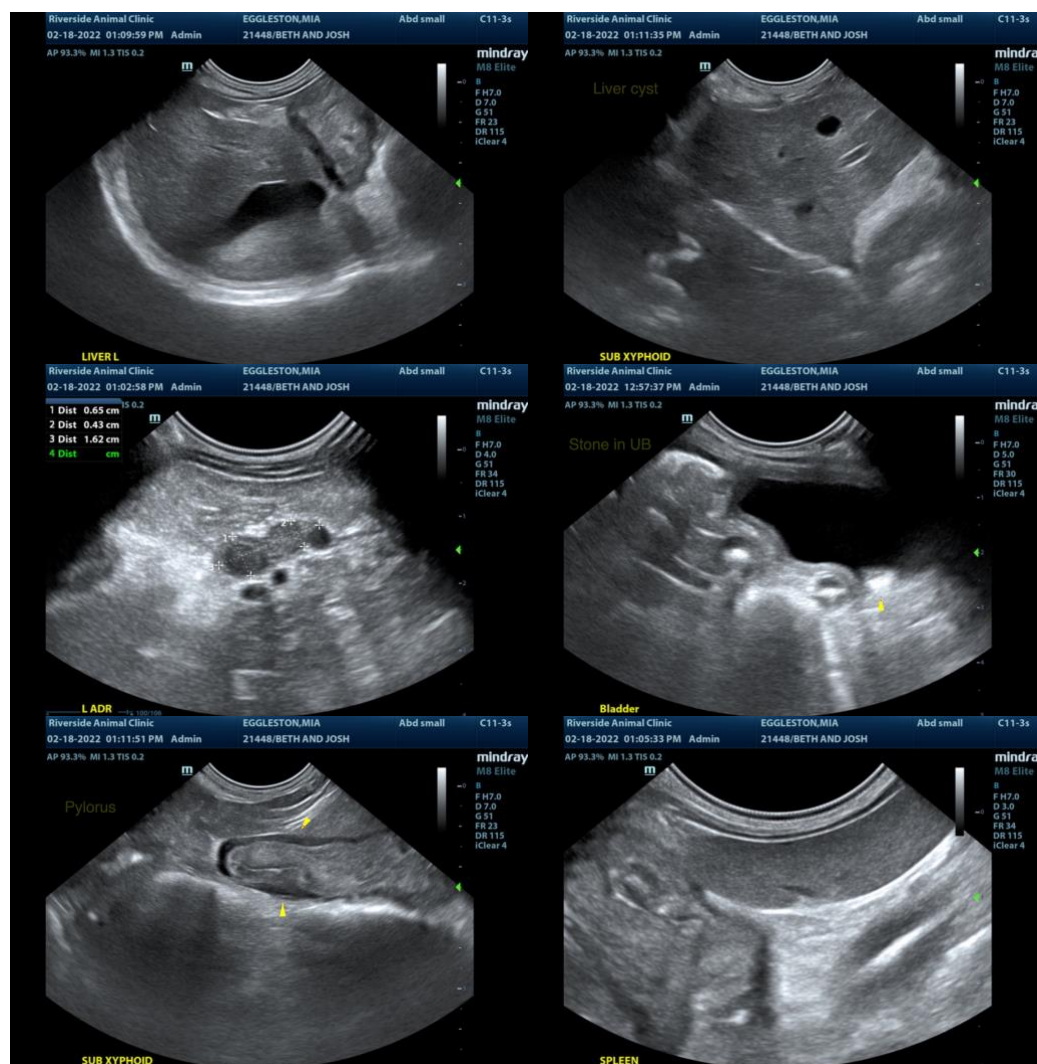
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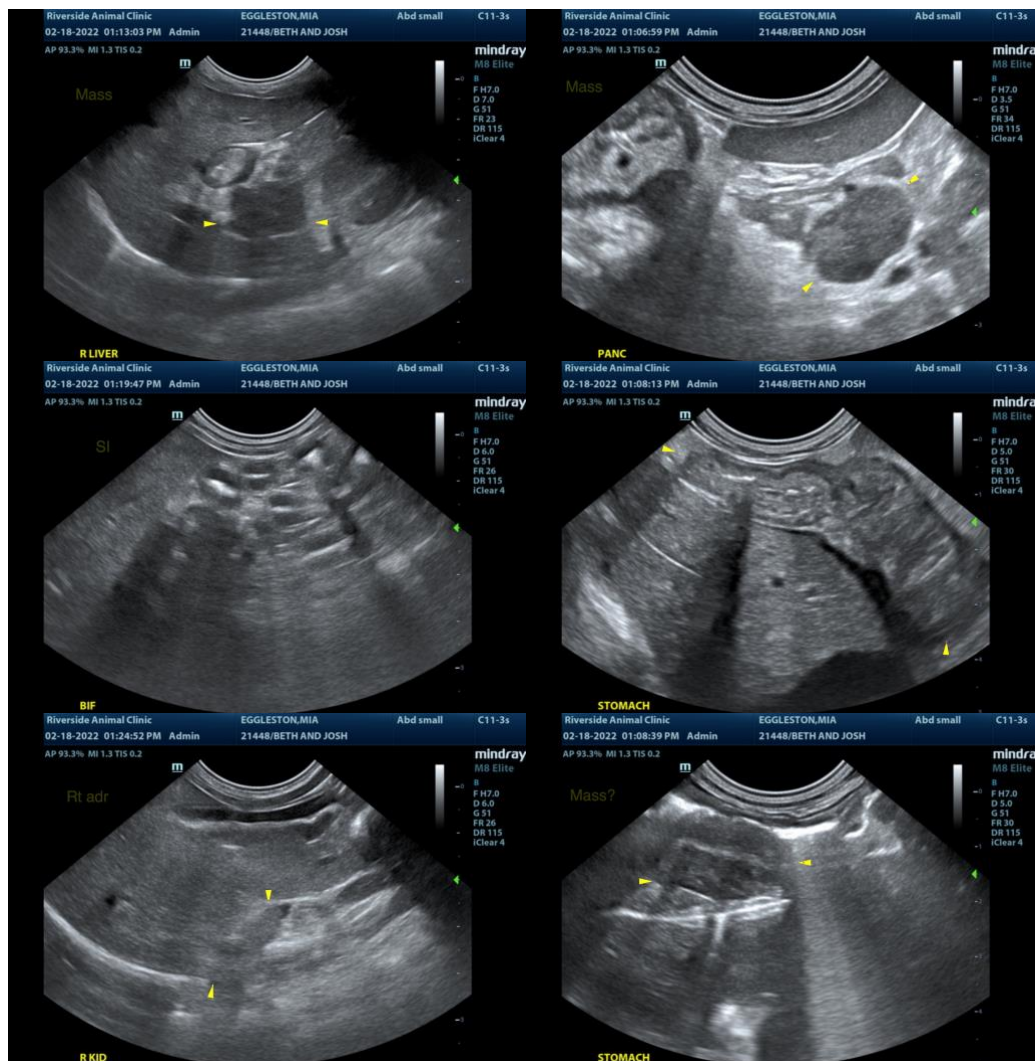
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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info@SonoPath.com