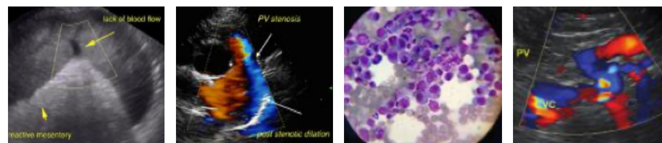
SonoPath
Clinical Sonography & Telecytology

EDUCATIONAL TELECONSULTATION SERVICES™



SonoPath.com™
1-800-838-4268 info@sonopath.com

PATIENT

Snoopy Caballero

SPECIES

Canine

BREED

Bichon Frise

SEX

Male, neutered

AGE

7 Yrs.

WEIGHT

13.1 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Ferrer

HOSPITAL NAME

Paseos VC

REFERRING VET

Dr. Cruz

INVOICE

14649

DATE

2/28/23

PRESENTING CLINICAL SIGNS

History: The patient presented as a referral for an abdominal ultrasound for evaluation of possible pancreatitis. Pt started with inappetence and dehydration on February 25th and was hospitalized at an Emergency Clinic. Prior to the EC visit on Feb 17th pt had a FB and regular veterinarian treated as outpatient and passed the FB.

Abnormal PE/Chem/CBC/UA Results: PE: No provided BW and Radiographs were taken, but no available. 4DX - Heartworm Positive FNA of the spleen and mesenteric LNs were done during abd u/s and it pending

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. A small amount of suspended echogenic debris is observed within the lumen. 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 prostate is normal in size (0.62 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 (4.52 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.

The right kidney is normal size (4.23 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.

Adrenal Glands

The left adrenal gland is normal in length with a flattened contour (0.22 cm at cranial pole) (0.21 cm at caudal pole) (1.60 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 small in size (0.60 cm at cranial pole) (0.23 cm at caudal pole) with slight flattening at the caudal pole. 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 (1.17 cm in width at the level of the hilus) with mild scalloping of the peripheral margins. The parenchyma is diffusely and severely mottled, bordering on a “moth-eaten” appearance. Splenic vasculature appears normal with no evidence of thrombosis.

Liver

The liver is subjectively prominent to enlarged with slightly swollen peripheral contours. The parenchyma is isoechoic relative to the spleen and subtly heterogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of

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congestion. The gall bladder lumen is mildly to moderately distended. The wall is thickened (up to 0.26 cm) with a “double-walled” effect. Luminal contents are mostly anechoic. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is minimally fluid distended. The gastric wall is normal in thickness with a normal layering pattern. 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 ileocecocolic junction is normal. The wall of the descending colon is borderline thickened (up to 0.22 cm) with retention of the normal layering pattern. The colonic lumen contains granular appearing fecal material. There is no evidence of an obstructive pattern.

Pancreas

The pancreas is diffusely visible/prominent in size with minimal deviation from the normal peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat. No focal lesions are observed. The pancreatic duct is not overtly dilated.

Free Abdomen

The mesentery in the cranial to mid-abdomen is hyperechoic. Trace free fluid is observed. The medial iliac lymph nodes are prominent, the largest measuring 1.14 cm in length. A 0.96 cm rounded lymph node is also observed in the right cranial quadrant. A few enlarged rounded hypoechoic to slightly heterogeneous mesenteric lymph nodes are also seen, the largest measuring 2.32 cm in length.

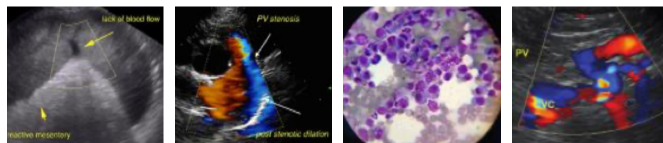
ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The splenic and abdominal lymph node changes are concerning for infiltrative neoplasia. Lymphoma is the top differential. Inflammatory disease or reactive change are possible but considered less likely.
- The hepatic parenchymal changes could be consistent with infiltrative neoplasia, inflammatory disease, regenerative nodular hyperplasia, vacuolar hepatopathy or other hepatopathy.
- The pancreatic changes may be a normal variant for this patient or could be consistent with mild pancreatitis. Correlation with clinical findings is recommended.
- Cranial to mid-abdominal peritonitis, which may be secondary to splenic, lymph node or pancreatic pathology.

Secondary Findings:

- The flattened adrenal glands may be a normal variant or could be consistent with early atrophy (i.e., secondary to hypoadrenocorticism)
- The gallbladder wall changes could be consistent with cholecystitis, low oncotic pressure (if applicable), increased hydrostatic pressure, immune mediated hemolytic anemia, anaphylaxis, other.



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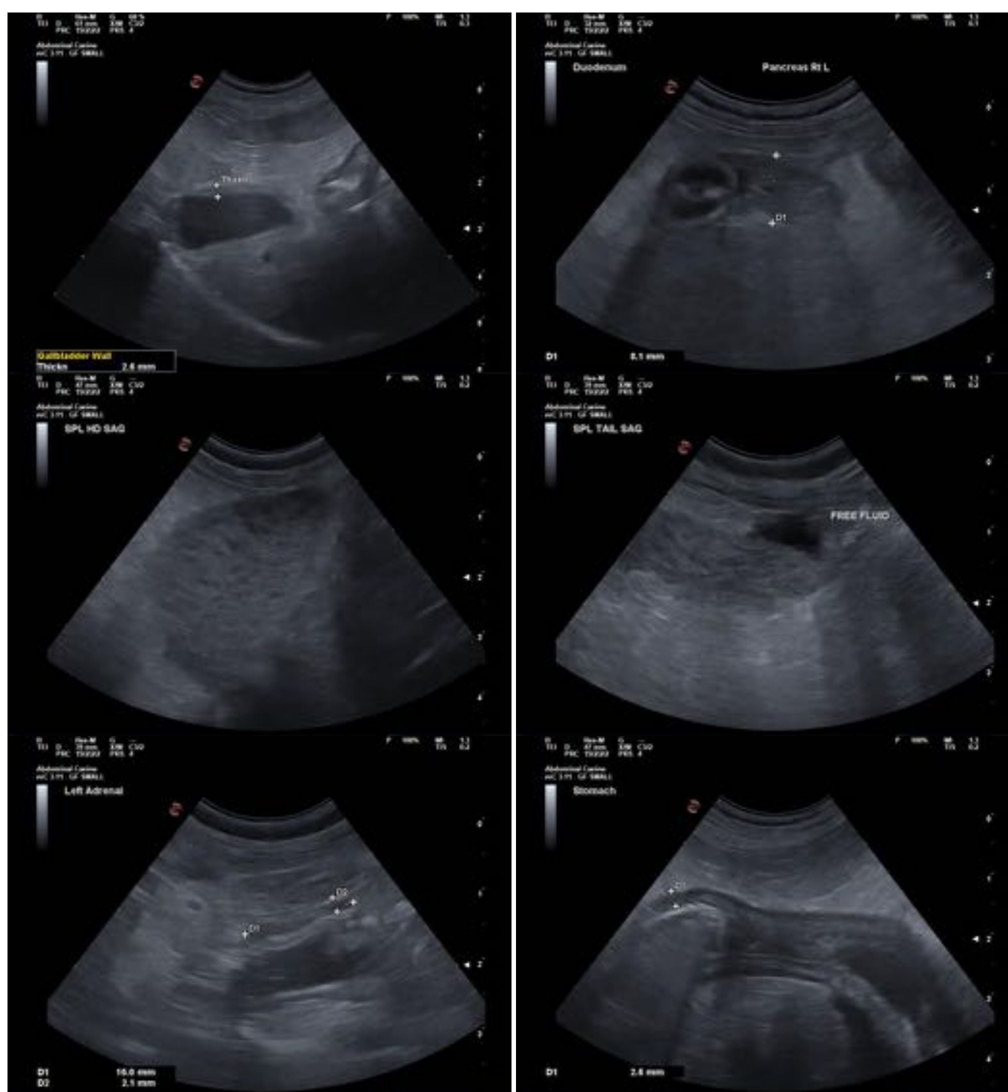
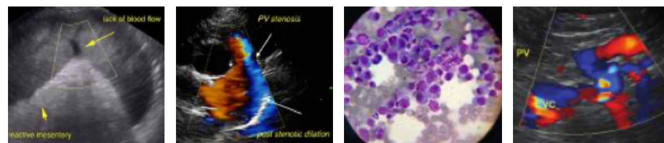
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for lymphadenopathy in the chest.
- If splenic and abdominal lymph node cytology results are inconclusive, further workup (i.e., PARR, flow cytometry or biopsies) may be necessary to get a definitive diagnosis.
- Consider a cPLI to further evaluate for pancreatitis.





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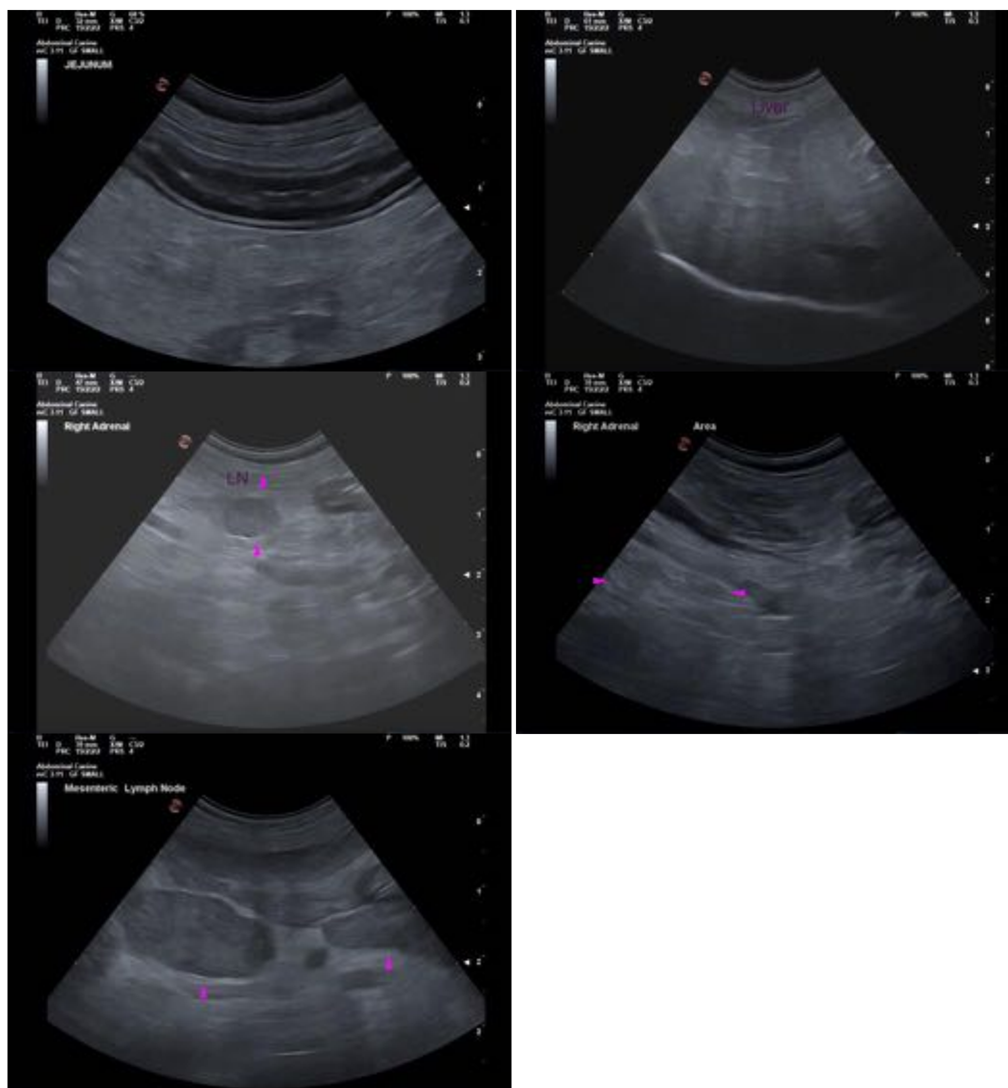

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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