Charleston Mobile Veterinary Services
IN PARTNERSHIP WITH SONOPATH VETERINARY ULTRASOUND

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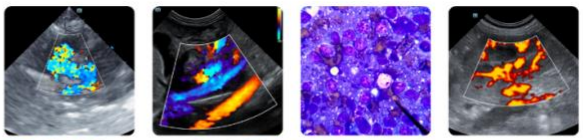

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Doodle Crawford

SPECIES

Canine

BREED

Chihuahua

SEX

Neutered Male

AGE

8

WEIGHT

15.7l

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

VCA Westbury AH

REFERRING VET

Heather Caughey DVM

INVOICE

22673

DATE

3-12-26

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Chronic intermittent pancreatitis with an episode of pain over the weekend. Treated effectively with methadone and Cerenia.
Abnormal lab-work values: Last done in November revealing an ALP of 307. Globulin 3.7.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is 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 (0.67 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 (5.14 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. The cortex is isoechoic relative to the spleen. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (5.14 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. The cortex is isoechoic relative to the spleen. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.51 cm at cranial pole) (0.59 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 mildly enlarged (0.71 cm at cranial pole) (0.55 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 (1.26 cm in width at the level of the hilus) with a normal capsular contour. The parenchyma is subtly mottled in appearance. A 0.68 x 0.62 cm hypoechoic nodule is observed at the craniolateral aspect. Splenic vasculature is normal.

Liver

The liver is subjectively prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic- to hypoechoic relative to the spleen and exhibits mild heterogeneity. No distinct focal lesions are observed. Hepatic vasculature and 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. A small amount of gravity-dependent, echogenic debris is observed within the lumen, some of which is adhered to the mucosal surface. The cystic and common bile ducts are normal/not seen.

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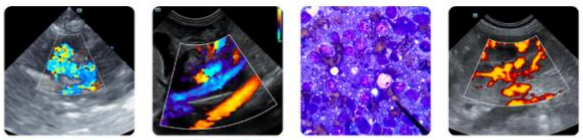

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Gastrointestinal

The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The proximal duodenum is slightly corrugated in appearance. The lumen is empty. The duodenal wall is normal in thickness with normal layering pattern and appropriate mural detail. The remaining small intestinal segments are 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 obvious evidence of an obstructive pattern.

Pancreas

The right limb is enlarged, with irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and mildly heterogenous in appearance. Surrounding mesentery is hyperechoic to saponified. There is suspected trace peripancreatic effusion.

Lymph Nodes

The abdominal lymph nodes are normal/not visible.

Free Abdomen

Trace free fluid is suspected adjacent to the right limb of the pancreas.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The pancreatic changes are suggestive of moderate to severe acute or resolving pancreatitis with parenchymal remodeling. Adjacent peritonitis is present.

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 disease, infiltrative neoplasia and other hepatopathies are considered less likely.
- Gallbladder debris, non-mucocele
- Mild bilateral adrenomegaly
- Bilateral nonspecific age-related renal changes
- The splenic parenchyma changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis or splenitis with a lower possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia). The hypoechoic splenic nodule could be consistent with a benign focus (i.e., lymphoid hyperplasia or similar) or an emerging tumor. Cytologic or histopathologic evaluation would be necessary to get a definitive diagnosis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Supportive care for pancreatitis is recommended.
- A recheck minimum database (i.e., CBC, chemistry panel, urinalysis, and T4) is also recommended in the next few weeks to assess overall metabolic function.

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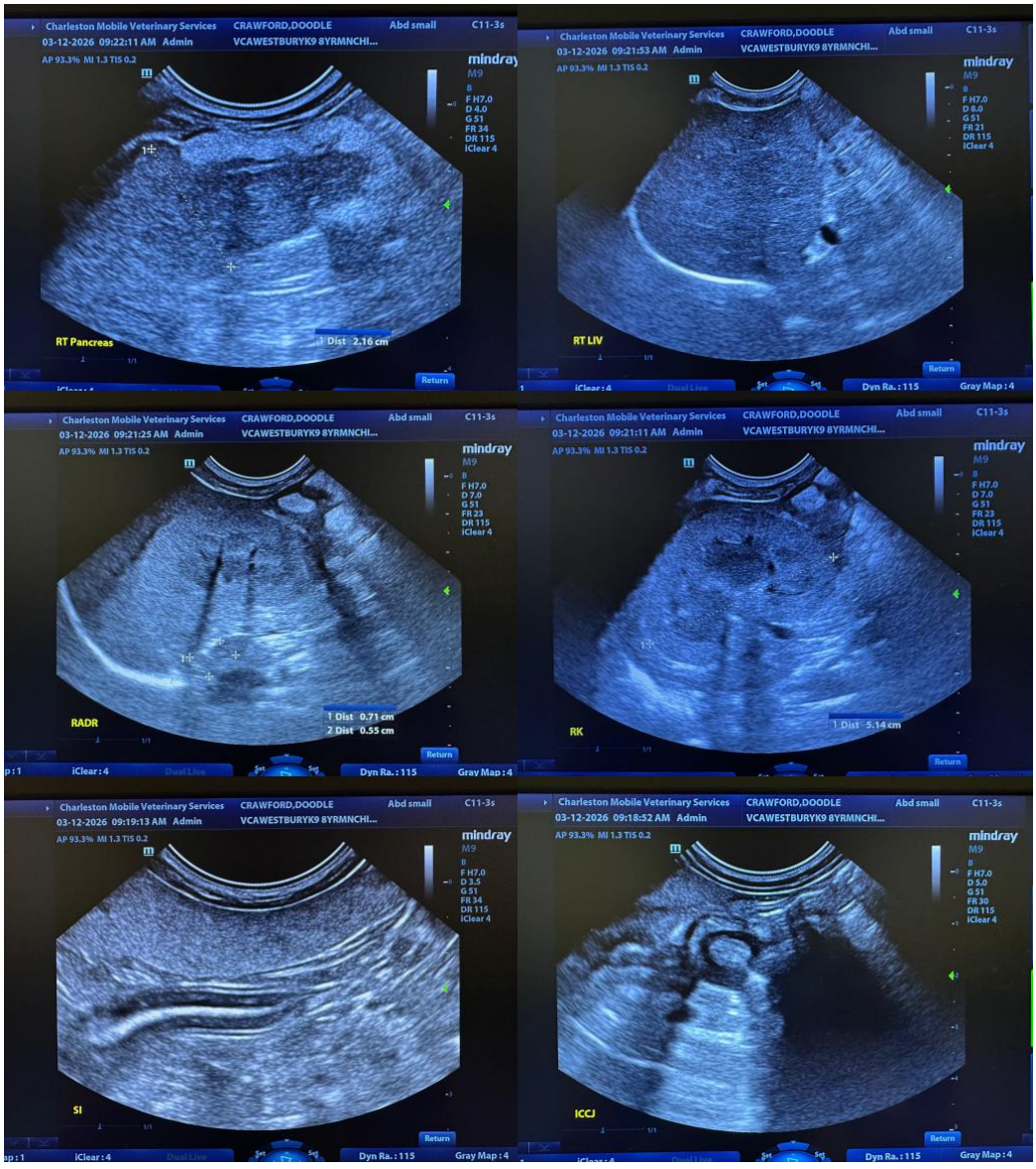
- Consider testing for hyperadrenocorticism with a low-dose dexamethasone suppression test or ACTH stimulation test if clinical signs (i.e., PU/PD) develop in the future.
- Regarding the splenic nodule, consider a recheck ultrasound in 3 months to assess for growth of the lesion. If the lesion continues to grow, fine-needle aspiration can be considered (if accessible and if clotting status is appropriate). A 25-gauge needle should be used.



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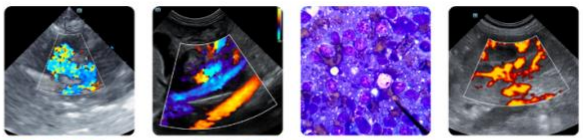

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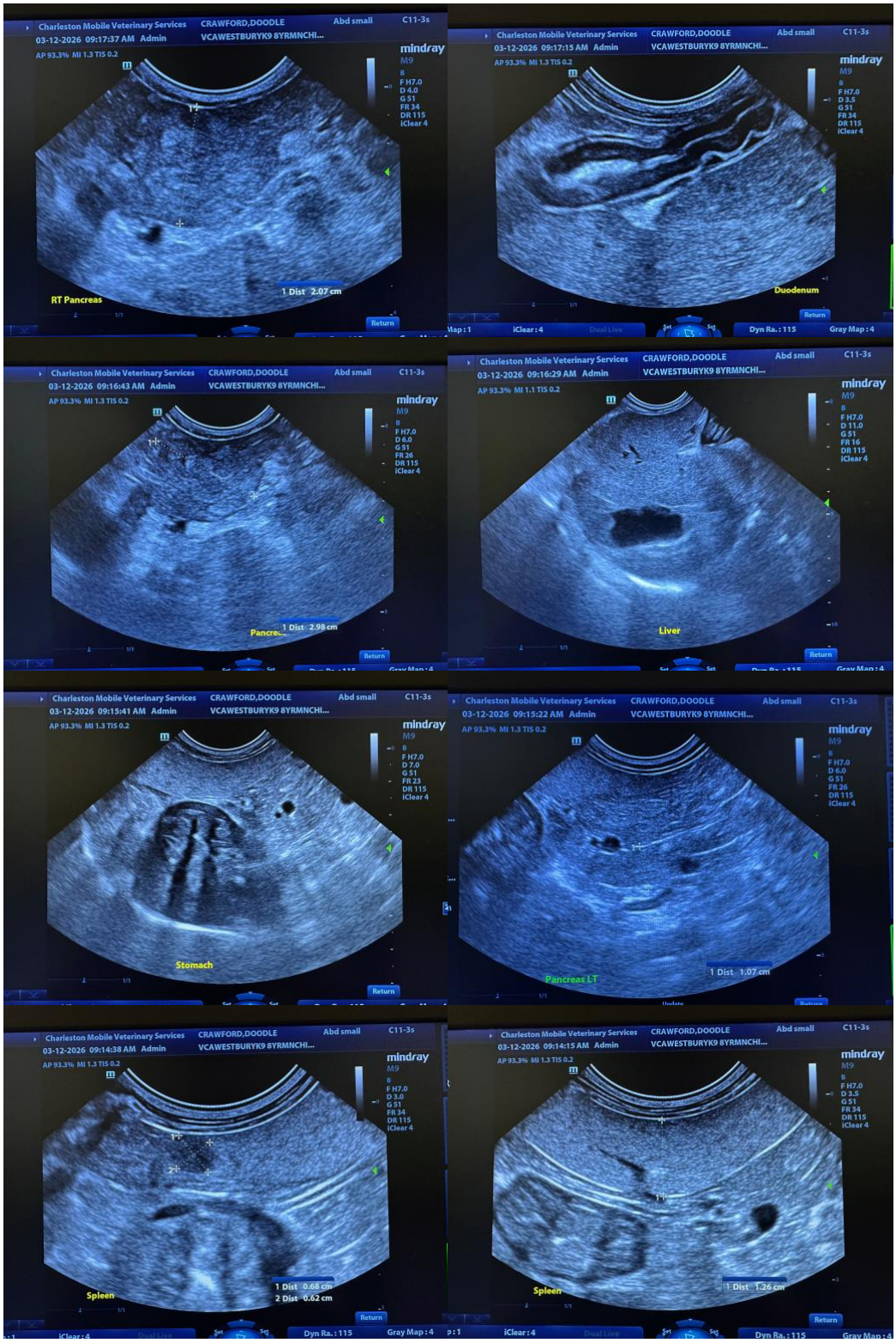

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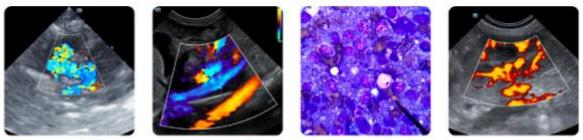

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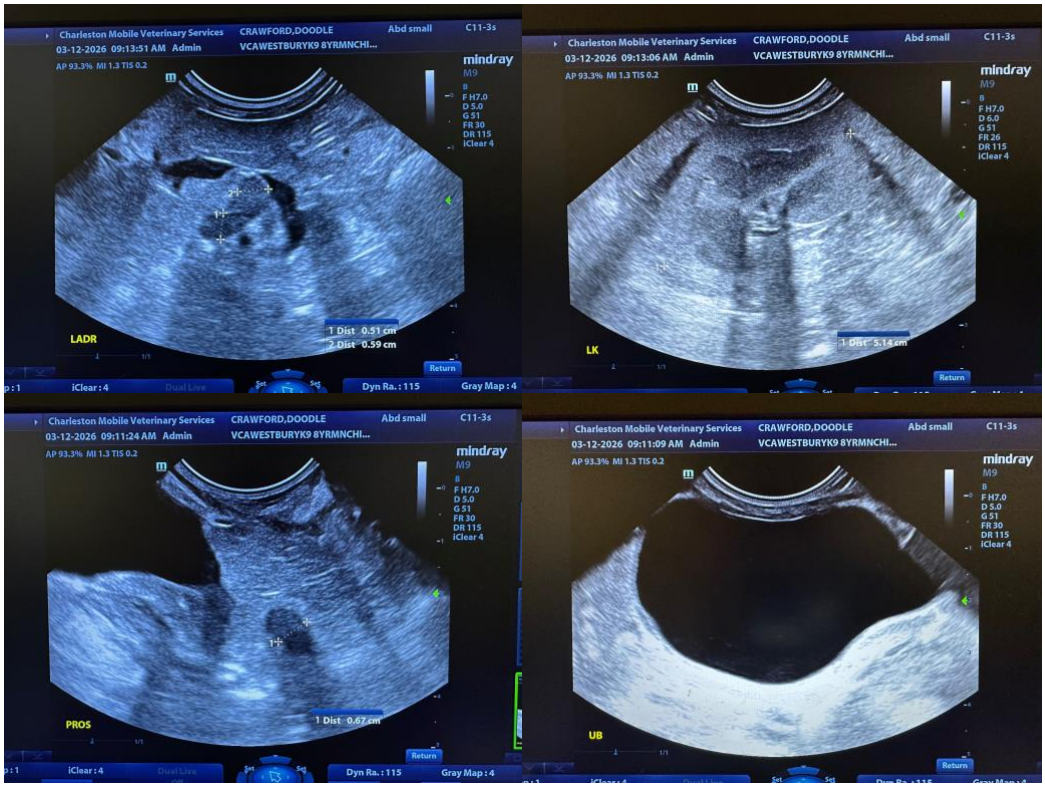

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com