



PATIENT

Micky McClellan

SPECIES

Canine

BREED

Pitbull

SEX

Intact Male

AGE

3/14/2016

WEIGHT

55 lbs

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Andrea Nicastro,
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HOSPITAL NAME

Flowertown AH

REFERRING VET

Dr. Kline

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PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Moderate lethargy with pale MM. Moderate pitting edema on right hindlimb. Dribbling urine

Abnormal Lab Work Values: 80,000 Neutrophils (CBC stated monocytosis; manual count confirmed neutrophils). 12,000 PLT (confirmed by manual count). 359 ALP. K- 3.1 (3.5-5.8)

Current Medications: Baby aspirin and Denamarin (got yesterday; not on regularly)
Radiographic Findings: Normal thorax. Hepatomegaly. Splenomegaly. Normal pelvic limbs.

Fine Needle Aspirates: Client did not approve sedation nor FNA

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is smooth. The bladder is 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 2 cm, are normal.

The prostate is enlarged (5.85 cm in width), with a slightly irregular shape. The parenchyma is hyperechoic relative to surrounding omental fat and mildly heterogenous in appearance with a few small ill-defined cystic areas. The prostatic urethra is not overtly dilated.

The left kidney presented normal size (7.78 cm in length), with a normal shape and architecture with 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 presented normal size (7.77 cm in length); normal shape and architecture with 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 size (0.45 at cranial pole; 0.62 cm at caudal pole; 2.70 cm in length) with a 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 caudal pole of the right adrenal gland is well visualized and is normal in size (0.49 cm in width) with a normal shape, glandular echogenicity and detail. The phrenicoabdominal vein and surrounding vasculature are normal. The remainder of the gland is also unremarkable.

Spleen

The spleen is subjectively enlarged (2.48 cm in width at the level of the hilus) with swollen peripheral margins and rounding at the poles. The parenchyma is diffusely mottled in appearance. A 1.57 cm



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hypoechoic nodule is observed. Splenic vasculature appears normal with no evidence of thrombosis.

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Liver

The liver is subjectively enlarged with slightly swollen peripheral contours. The parenchyma is hypoechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of aggregated echogenic partially dependent debris is observed within the lumen. The cystic and common bile ducts are normal/not seen. The portal vein to caudal vena cava ratio is approximately 1:1.

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The gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal.

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Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is mildly distended with ingesta. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The small intestinal lumen is segmentally dilated with chyme. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. No obstructive or overt infiltrative disease is noted.

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Pancreas

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

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Free Abdomen

There is no evidence of free fluid. Several prominent to enlarged irregular hypoechoic lymph nodes are observed in the cranial, mid, and caudal abdomen. The largest node is the right medial iliac lymph node, which measures 4.28 cm in length.

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Other

The left testicle measures 3.22 x 2.47 cm. The right testicle measures 3.64 x 2.37 cm.

The testicles are subjectively normal in size and symmetrical, with homogenous parenchyma.

No distinct focal lesions are observed.

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

ULTRASONOGRAPHIC FINDINGS

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Primary Findings

- The splenic changes, including the nodule, are most concerning for infiltrative neoplasia. Lymphoma is the top differential.
- The diffuse abdominal lymphadenopathy is also concerning for infiltrative neoplasia (i.e., lymphoma). However, reactive lymphadenitis or lymphoid hyperplasia cannot be completely excluded.

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- The mild hepatomegaly may be secondary to infiltrative neoplasia, inflammatory disease, congestion, lymphoid hyperplasia, or other hepatopathy.

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Secondary Findings

- The pancreatic changes are suggestive of mild pancreatitis.
- The prostate changes are consistent with benign prostatic hyperplasia with small parenchymal cysts. Concurrent bacterial prostatitis is also possible. Correlation with urinalysis findings is recommended.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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- Ideally, fine-needle aspirates of the spleen and enlarged abdominal lymph nodes, as well as the prominent left popliteal lymph node would be performed. However, the patient's thrombocytopenia precludes this procedure. Therefore, consider referral to a board-certified oncologist to discuss administration of a platelet-rich plasma transfusion followed by fine-needle aspirates or an L-asparaginase trial (to further assess for lymphoma). A CBC with a clinical pathology review, may also be beneficial.

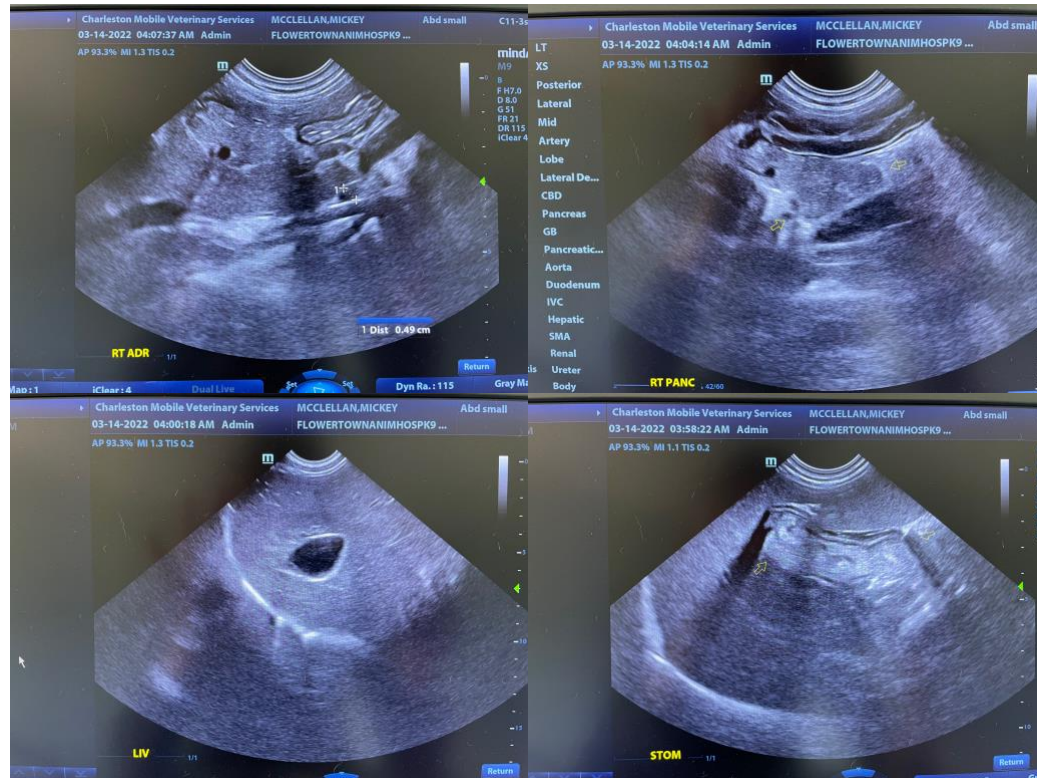
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- A comprehensive tick panel (send to NC State) should also be considered.
- If palliative care is to be pursued in lieu of further diagnostics, consider corticosteroids in conjunction with doxycycline and other broad-spectrum antibiotics as well as symptomatic care.

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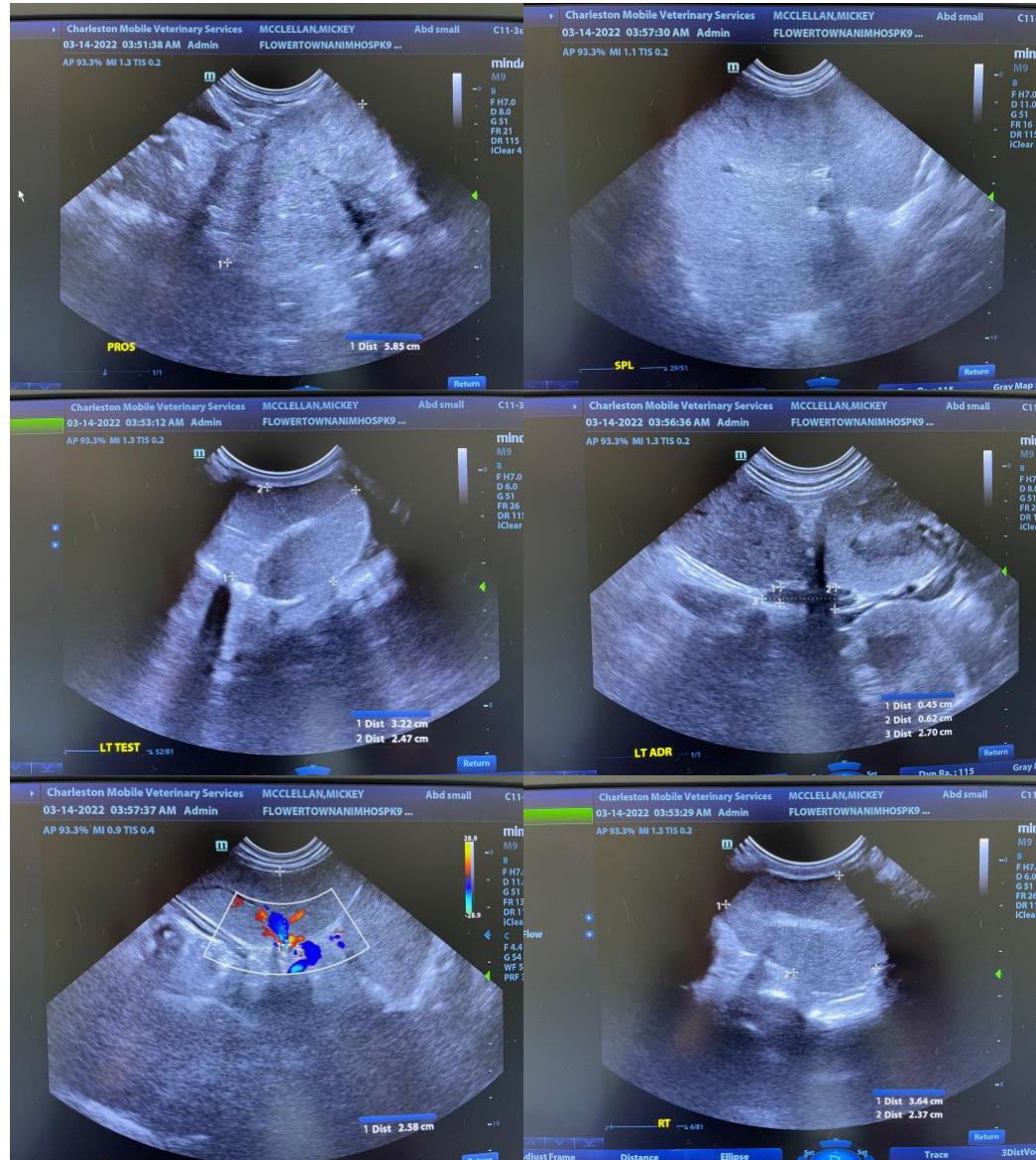
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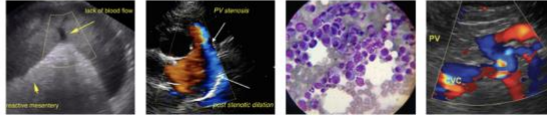
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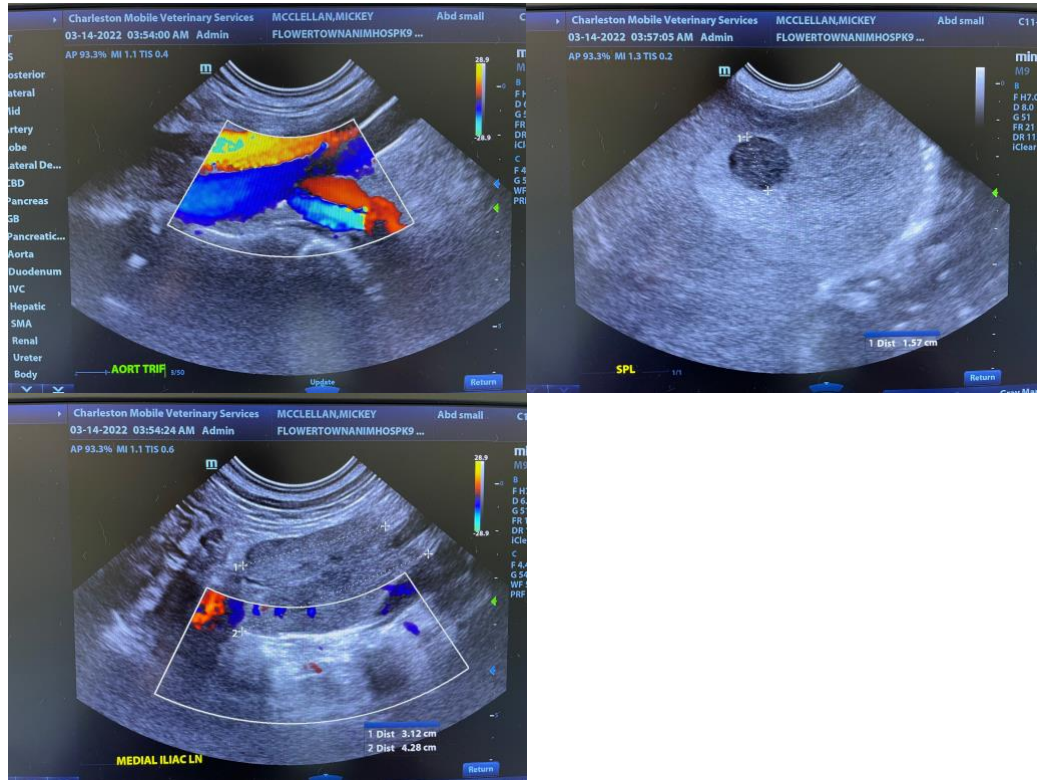
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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