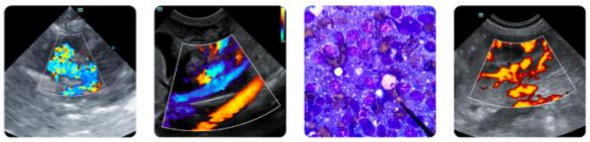


PATIENT

Oscar Sargent

SPECIES

Canine

BREED

Terrier Mix

SEX

Neutered Male

AGE

15.5

WEIGHT

5.45 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Haley Harasimowicz

HOSPITAL NAME

Peak Veterinary Referral Center

REFERRING VET

Haley Harasimowicz

INVOICE

22719

DATE

3-21-26

PRESENTING CLINICAL SIGNS

History: Presented on 3/19 for hematochezia of 24-hour duration. Appetite WNL and no vomiting. History of eating table scraps but no other known dietary indiscretion. Owners declined all diagnostics at that time aside from fecal testing (negative - see below). Patient given SQ fluids and bland diet/probiotic trial.

Presented today due to no improvement over the last 2 days. Owners also think that his abdomen seems more distended and uncomfortable. Owners mentioned that over the last several months, p has been pacing, panting and possibly anxious in the evenings.

Abnormal PE/Chem/CBC/UA Results: 3/17/26: Fecal - negative 3/21/36: CBC: WNL Chem: ALP - 3488, Lip - 288, TG - 165, Na - 155 snap CPL: Abnormal

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 is normal.

The region of the prostate is not visualized due to its pelvic location.

The left kidney is normal in size (4.34 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild loss of corticomedullary distinction. Several cortical cysts are seen, one of which is multiseptated (measuring 0.94 x 0.64 cm). Several hyperechoic shadowing diverticular foci are observed. Trace pyelectasia is present (0.13 cm in the longitudinal plane). There is no evidence of infarcts or hydronephrosis.

The right kidney is normal in size (4.60 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild loss of corticomedullary distinction. Several, small, cortical cysts are seen. Several hyperechoic shadowing diverticular foci are observed. Trace pyelectasia is present (0.17 cm in the longitudinal plane). There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.80 cm at cranial pole) (0.65 cm at caudal pole) with swollen peripheral contours. An approximately 1.6 x 0.6 cm irregular, lobulated, hyperechoic nodule occupies the majority of the gland. Surrounding vasculature appears normal.

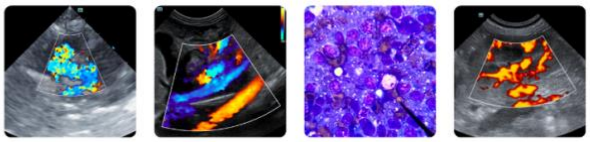
The right adrenal gland is mildly enlarged (1.26 cm at cranial pole) (0.72 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.02 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 prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic 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.



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The gallbladder lumen is moderately distended. The wall is thin and smooth. A small amount of aggregated, echogenic, partially dependent debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is mildly distended with ingesta. 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 colonic wall is normal. There is no evidence of an obstructive pattern.

Pancreas

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely hyperechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Lymph Nodes

The abdominal lymph nodes are normal/not visible.

Free Abdomen

There is no obvious evidence of free fluid.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- 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.
- The gallbladder changes could be consistent with cholestasis, fasting, or an emerging mucocele.
- Bilateral adrenomegaly. The left adrenal nodule could be consistent with focal nodular hyperplasia, adenoma, emerging adenocarcinoma, pheochromocytoma, other.

Secondary Findings

- Bilateral nonspecific age-related renal changes with dystrophic mineralization, trace pyelectasia, and cortical cysts

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the GI signs, consider the following:

1. Despite the negative fecal evaluation, prophylactic deworming with fenbendazole is recommended.
2. Supportive care for hemorrhagic gastroenteritis is also recommended, including a probiotic, fiber supplement, and other supportive measures.

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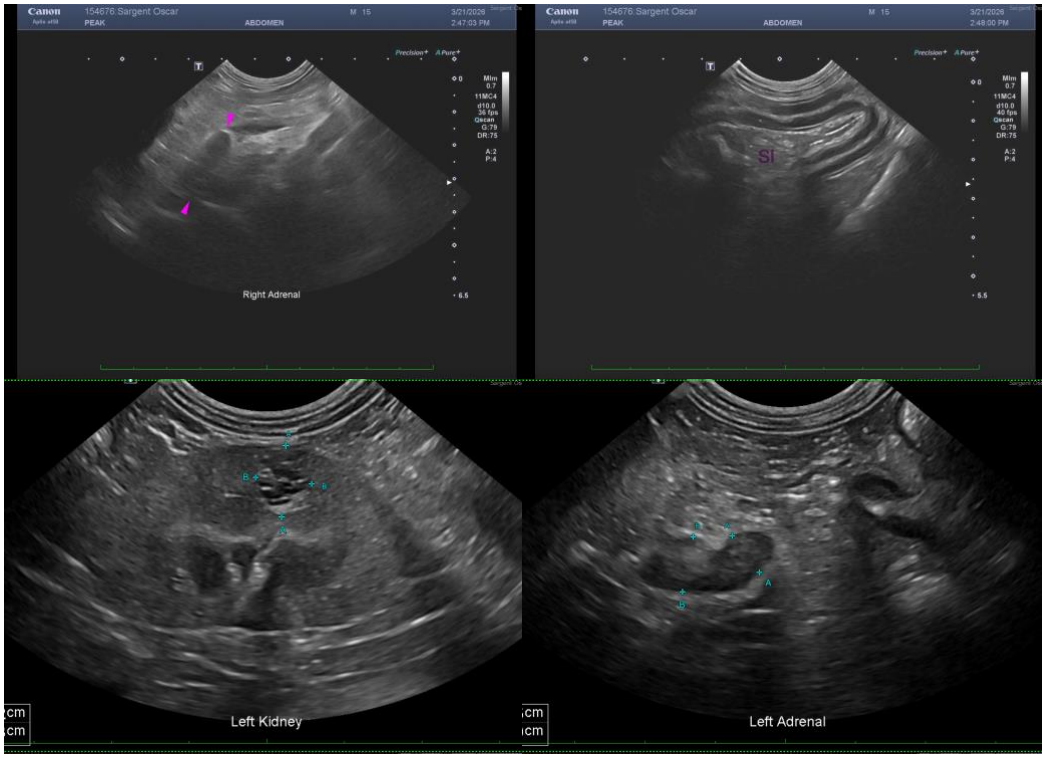
3. If clinical signs persist despite medical management, further GI workup (i.e., GI panel, resting cortisol level, GI biopsies) may be indicated.

- Serial monitoring (i.e., every 3-4 months) of the patient's liver values is recommended. If liver values continue to increase, a repeat abdominal ultrasound +/- hepatic tissue sampling may be warranted.

- Regarding the adrenal changes, consider the following:

1. Baseline blood pressure measurement
2. Further testing for a functional tumor (i.e., low-dose dexamethasone suppression test, urine/blood catecholamine levels) particularly if clinical suspicion for disease is high
3. Three-view thoracic radiographs are recommended to assess for pulmonary metastases.



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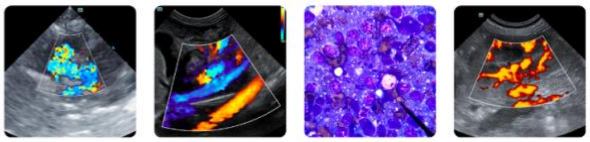

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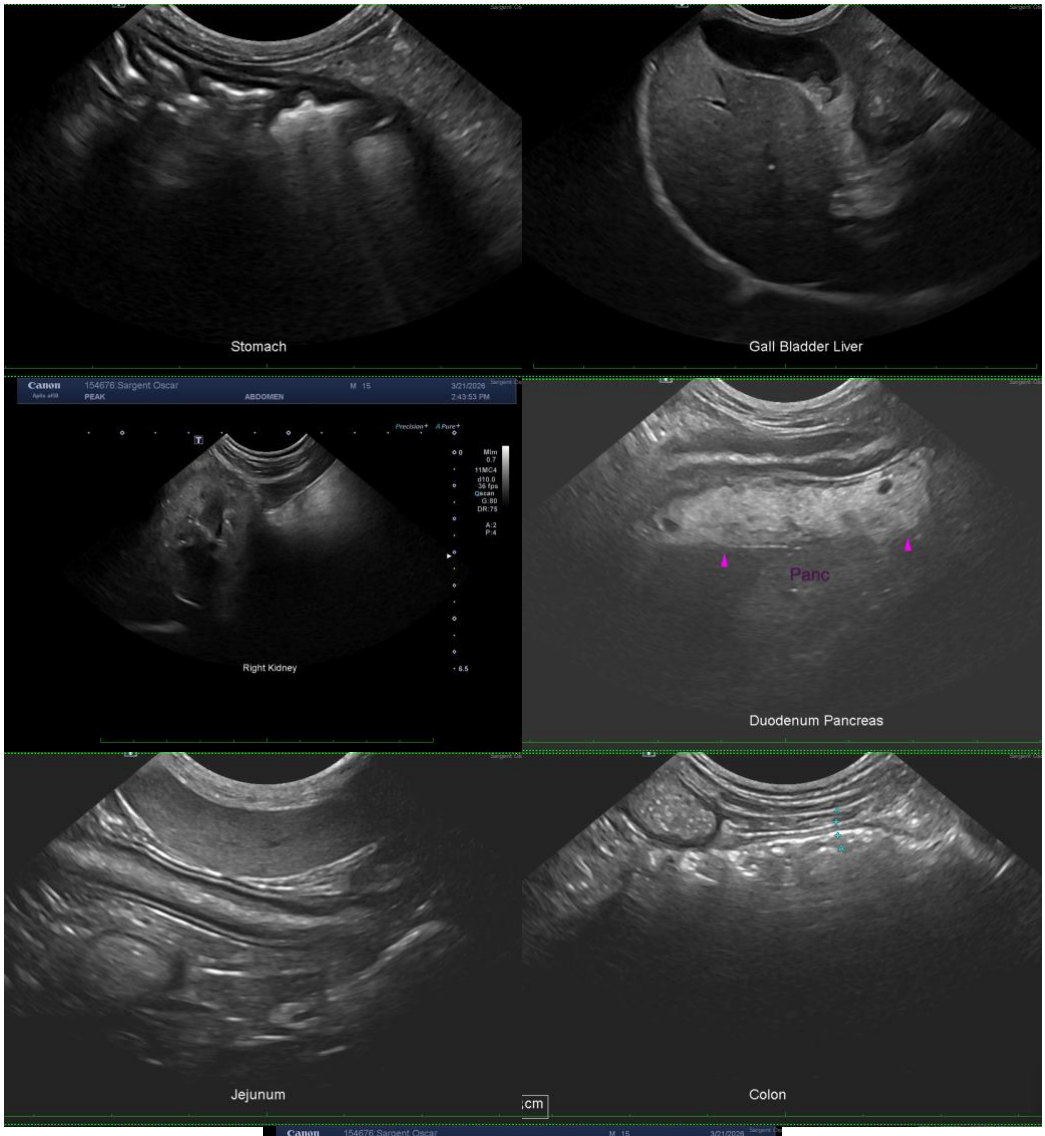

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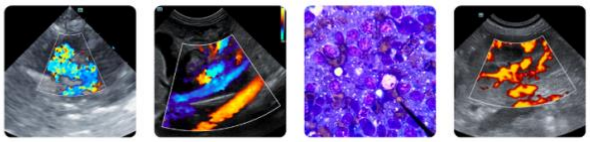

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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