



PATIENT

Fluffy Santana

SPECIES

Canine

BREED

Mix

SEX

Intact Female

AGE

7 years

WEIGHT

31.8 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. G. Ferrer, DVM

HOSPITAL NAME

Paseos VC

REFERRING VET

Dr. F. Ortiz Vidal,
DVM

INVOICE

10598

DATE

3/23/22

PRESENTING CLINICAL SIGNS

History: Presented for an abdominal ultrasound to evaluate vomiting. This patient was fasted for over 12 hrs prior to the study. Patient has sporadic vomits since December 2021, vomits appearance is yellow. Patient has history of crystals on urine and bladder calculi. On February 16, 2022 a cystotomy was performed uneventfully. PT is currently on urinary diet.

Abnormal PE/Chem/CBC/UA Results: PE: no major abnormalities noticed BW: Feb 16th, 2022 CBC: EOS 1.36 K/ μ L (0.06 - 1.23) Chem: PHOS 2.3 mg/dL (2.5 - 6.8) Rest of BW was WNL.

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 lumen is moderately distended with anechoic urine. 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 left kidney presented normal size (5.73 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 hydroureter.

The right kidney presented normal size (5.14 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 hydroureter.

Adrenal Glands

The left adrenal gland is normal size (0.38 cm at cranial pole) (0.61 cm at caudal pole) (2.04 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 normal size (0.41 cm at cranial pole) (0.41 cm at caudal pole) (2.47 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 (1.44 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 normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed.



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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 gastric lumen is moderately distended with ingesta and a small amount of gas and fluid, despite fasting. 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 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 left limb is visible, with minimal deviation from the normal peripheral contours. The parenchyma is largely isoechoic to slightly hyperechoic relative to surrounding omental fat and subtly mottled in appearance. Within this region, a 0.62 x 0.57 cm hypoechoic nodule is present. It is unclear whether the lesion is arising from the pancreas or adjacent to it. The pancreatic duct is not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

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Free Abdomen

There is no evidence of free fluid. A 1.87 cm medial ileac lymph node is visualized. The node is normal in shape and echogenicity. Two to three prominent mesenteric lymph nodes are also seen, the largest measuring 2.45 cm in length. These nodes also exhibit a normal shape and echogenicity.

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Other

The uterine body is visible (0.78 cm in width). No obvious pathology is seen.

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ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The hypoechoic nodule in the region of the left limb of the pancreas may represent a benign pancreatic nodule (i.e., nodular hyperplasia), an emerging tumor, granuloma, or may represent a regional lymph node or mesenteric lesion. Its significance is unknown with regard to the patient's clinical signs.
- The presence of ingesta in the gastric lumen despite fasting is suggestive of delayed gastric emptying (i.e., due to underlying gastrointestinal disease or a primary gastric motility disorder).
- The lymph node changes are most consistent with reactive lymphadenitis or lymphoid hyperplasia.

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**An obvious cause for the patient's chronic intermittent vomiting is not identified in this study. Considerations include microscopic gastrointestinal disease, low-grade pancreatitis, underlying metabolic issue, occult neoplasia, other.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for occult esophageal disease.

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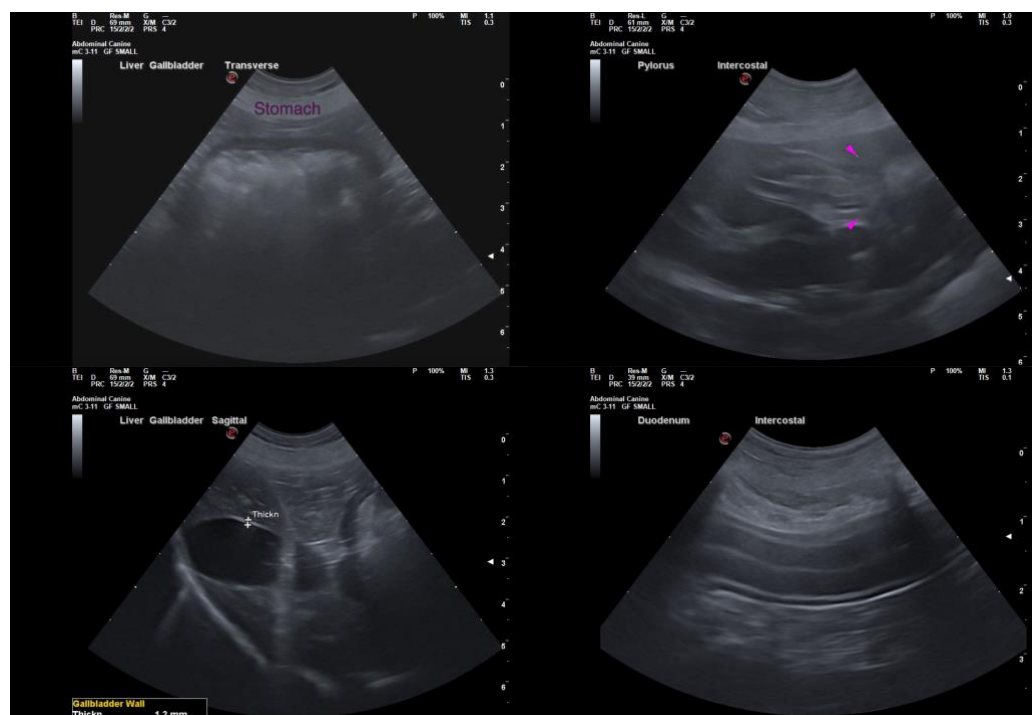
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- Also consider empirical treatment for a primary gastrointestinal motility disorder with metoclopramide. If there is no improvement in the patient's clinical signs within 5-7 days of initiating therapy, the medication should be discontinued.
- Other diagnostic/therapeutic considerations include the following:
 1. 6-week hypoallergenic diet trial
 2. Fecal evaluation for ova and Giardia
 3. GI panel (i.e., serum cobalamin and folate, TLI and PLI)
 4. Resting cortisol level to screen for hypoadrenocorticism
 5. Ultimately endoscopic or surgical gastrointestinal biopsies may be necessary to get a definitive diagnosis.





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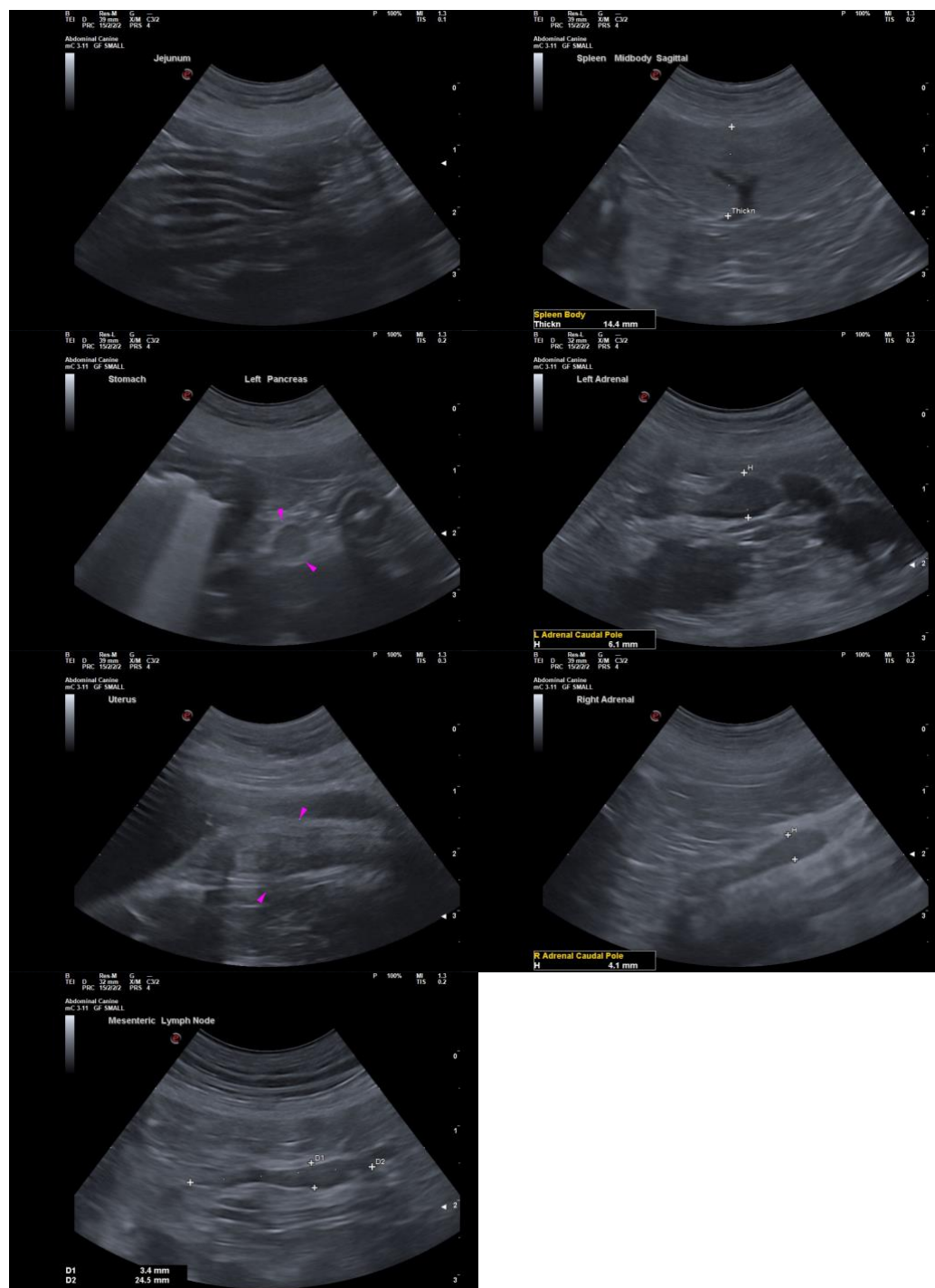
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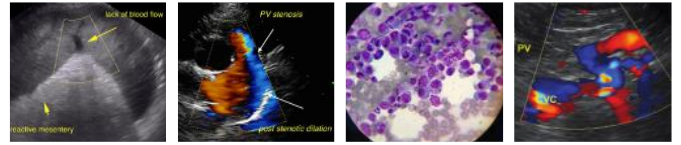
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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