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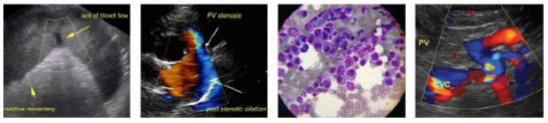


IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Chewy Evans

SPECIES

Canine

BREED

Brussels Griffon

SEX

Neutered Male

AGE

14years

WEIGHT

12.2 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, RVT LVT

HOSPITAL NAME

Alpine AH

REFERRING VET

Dr. Lindsay Sjloin

INVOICE

10628

DATE

3/29/22

PRESENTING CLINICAL SIGNS

History: follow up from last AUS 10/11/21 - increased abdominal breathing effort during the scan Abnormal PE/Chem/CBC/UA Results: UPC 3.5, significant proteinuria, wll concentrated Worsening ALP, mild hyerkalemia, mild hypercholesterolemia, mild thrombocytosis

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 prostate is normal in size (0.64 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 (3.68 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is minimal loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. Mild pyelectasia is present (0.30 cm in the longitudinal plane). There is no evidence of infarcts or hydroureter.

The right kidney is normal size (3.90 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. A small cortical cyst is observed. Trace pyelectasia is suspected. There is no evidence of infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal size (0.34 cm at cranial pole) (0.45 cm at caudal pole) (1.37 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 caudal pole of the right adrenal gland is visualized and is normal size (0.35 cm in width), with a normal shape, glandular echogenicity and detail. Surrounding vasculature appears normal.

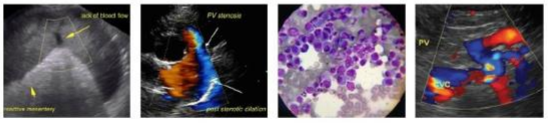
Spleen

The spleen is normal in size (1.12 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A 1.23 x 0.75 cm irregular, hypoechoic nodule, with an ill-defined hyperechoic center is observed at the cranial aspect. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with slight rounding of the caudal contour in some areas. 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.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A moderate amount of echogenic debris is observed within the lumen, most of which is gravity dependent, and some of which



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is suspended. The cystic and common bile ducts are normal.

Gastrointestinal
The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is not distended. The gastric wall and pylorus are 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 colonic wall is normal. No obstructive or overt infiltrative disease is noted.

Pancreas
The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely hypoechoic 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.

Free Abdomen
The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

Other
A brief echocardiogram reveals no evidence of pericardial effusion.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Gall bladder debris, non-mucocele.
- The splenic nodule could be consistent with an emerging tumor or a benign focus of lymphoid hyperplasia, extramedullary hematopoiesis, inflammation, other. The nodule is similar in size, to slightly larger, compared to the previous sonogram.

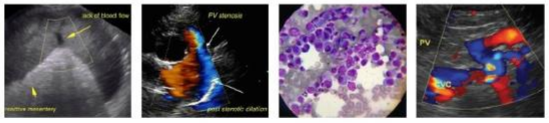
**An obvious cause for the patient's elevated ALP is not identified in this study. This finding is likely secondary to a benign hepatopathy (i.e., vacuolar hepatopathy or microscopic regenerative nodular hyperplasia). The previous-observed swelling in the tip of the right lateral lobe is not appreciated on today's scan.

Secondary Findings

- Age-related pancreatic remodeling +/- fibrosis. Low-grade pancreatitis may also be present, particularly if the patient exhibits a positive Murphy's sign.
- Bilateral minor age-related renal changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider a fine-needle aspirate of the splenic nodule if accessible and if clotting status is appropriate. Otherwise, consider serial sonographic monitoring (i.e., every 4-6 weeks, to assess for growth. Alternatively, a splenectomy with submission of the spleen for histopathology can



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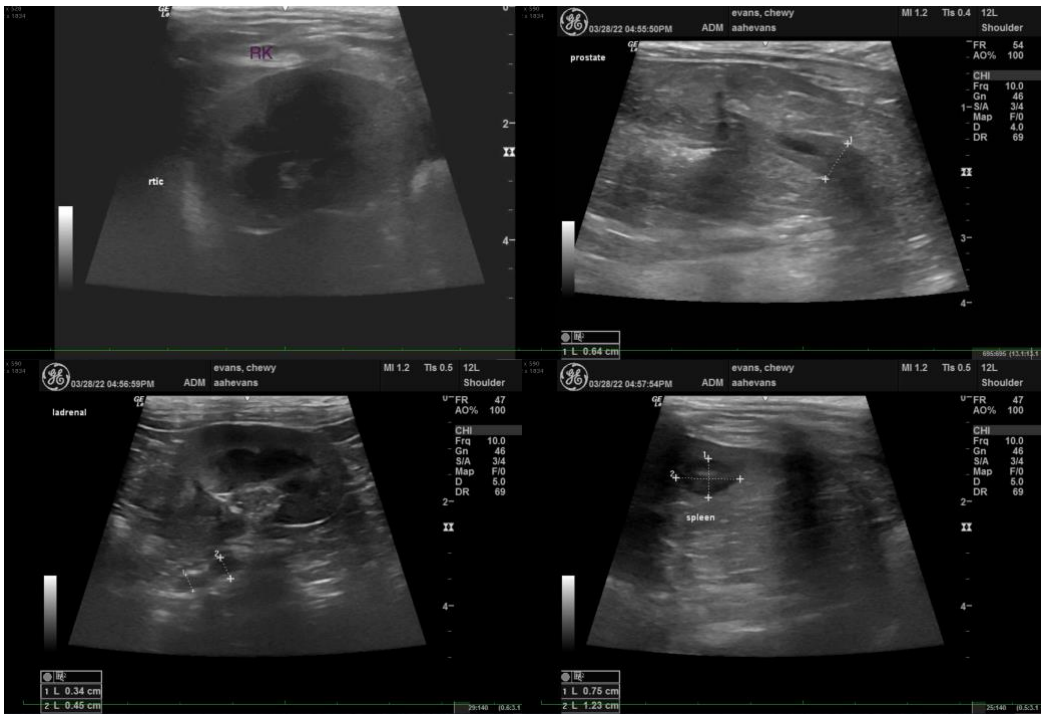
be considered. If surgery is pursued, thoracic radiographs are recommended to assess cardiopulmonary status prior to anesthesia.

- Continued serial monitoring (i.e., every 3-4 months) of the patient's liver values is recommended. If values continue to increase, a repeat abdominal ultrasound +/- hepatic tissue sampling may be indicated.
- Given the patient's proteinuria, consider the following:
    1. Further testing for infectious diseases (i.e., tick-borne, heartworm, Leptospirosis) that may be associated with the patient's proteinuria.
    2. Angiotensin II receptor blocker (e.g., telmisartan)
    3. Antithrombotic (e.g., clopidogrel at 2.5 mg/kg PO q 24 hours)
    4. Omega-3 fatty acids (65 mg/kg of DHA and EPA combined daily)
    5. Prescription renal diet
    6. Baseline blood pressure measurement with serial monitoring thereafter
    7. Routine monitoring of UPC and bloodwork (CBC, chemistry panel) to assess for progressive disease



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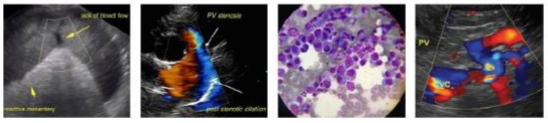

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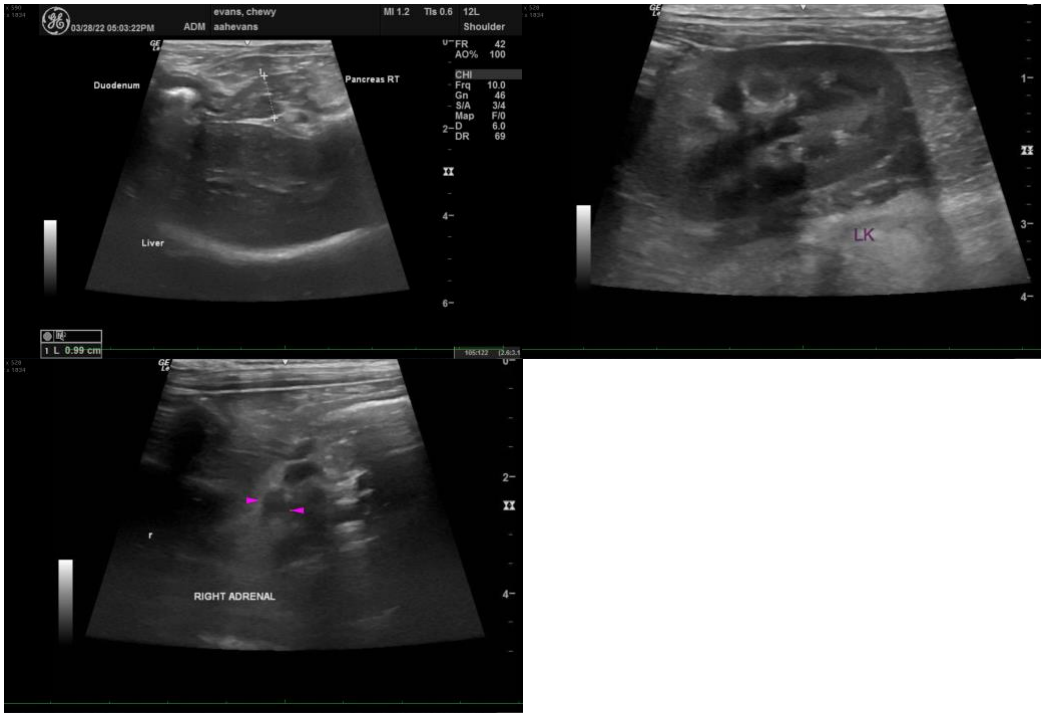

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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