PATIENT

Chloe Sharkey

SPECIES

Canine

BREED

Mini Schnauzer

SEX

Female Spayed

AGE

13

WEIGHT

10.9 lbs

INTERPRETED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

IMAGING PERFORMED BY

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Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME

Central VH Summerville

REFERRING VET

Dr. Reynolds

INVOICE

22773

DATE

3-30-26

PRESENTING CLINICAL SIGNS

Presented on March 17th for vomiting frequently and acting lethargic. Re-presented on March 26 for inappetence and heavy breathing. Still vomiting. Also has brown, red, skin lesions and a fever. Bloodwork revealed a suspected thrombocytopenia and neutrophilia. Albumin 2.2. ALP 155. Elevated pancreatic enzymes. T4 1.0.

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 mostly anechoic No cystic calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The left kidney is normal in size (4.38 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. Hyperechoic shadowing diverticular foci are visualized. Trace pyelectasia is present (0.15 cm in the longitudinal plane). There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (4.55 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.42 cm at cranial pole) (0.46 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 normal in size (0.61 cm at cranial pole) (0.42 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 (1.37 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A few, small, hyperechoic nodules are visualized (one measuring 0.61 cm in its longest dimension). Splenic vasculature is normal.

Liver

The liver is subjectively enlarged with slightly swollen peripheral contours. The parenchyma is isoechoic 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 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- to moderate amount of gravity-dependent, echogenic- to mineralized debris/sand is observed within the lumen. The cystic and common bile ducts are normal/not seen.

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 small intestinal lumen is not dilated. In one

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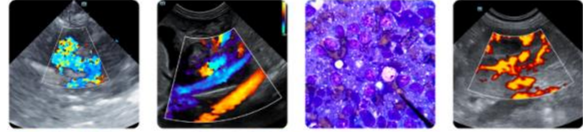

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segment of jejunum, the wall is thickened (up to 0.75 cm) with loss of the normal layering pattern. There appears to be disruption of the serosal surface in this region. The remaining small intestinal segments are normal in thickness with a normal layering pattern. There is evidence of mucosal speckling +/- striations in several segments. The ileocecocolic junction and colonic wall are normal. There is no obvious evidence of and obstructive pattern.

Pancreas
The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic 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
A few enlarged, rounded, hypoechoic mesenteric lymph nodes are visualized (one measuring 1.48 x 1.16 cm). A 1.06 x 0.56 cm medial iliac lymph node is also seen.

Free Abdomen
The mesentery throughout the abdomen is hyperechoic. A moderate amount of echogenic free fluid is seen.

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

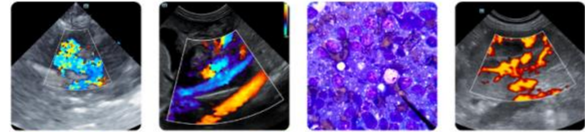
ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The jejunal wall thickening is concerning for infiltrative neoplasia (i.e., mast cell tumor, lymphoma, adenocarcinoma, other) with a lower possibility of a focal inflammatory process.
- The diffuse small intestinal changes, in conjunction with hypoalbuminemia suggest a protein-losing enteropathy (i.e., lymphangiectasia, inflammatory bowel disease, infiltrative neoplasia, infectious/parasitic disease, other). Histopathology would be necessary to get a definitive diagnosis.
- The abdominal lymphadenopathy is also concerning for a infiltrative neoplasia. However, lymphadenitis or lymphoid hyperplasia cannot be excluded.
- Diffuse peritonitis

Secondary Findings

- Bilateral nonspecific age-related renal changes with left dystrophic mineralization and trace pyelectasia
- The hyperechoic splenic nodules likely represent benign myelolipomas, with a lower possibility of more insidious splenic pathology.
- Mild hepatomegaly
- Gallbladder debris/sand, non-mucocele
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.



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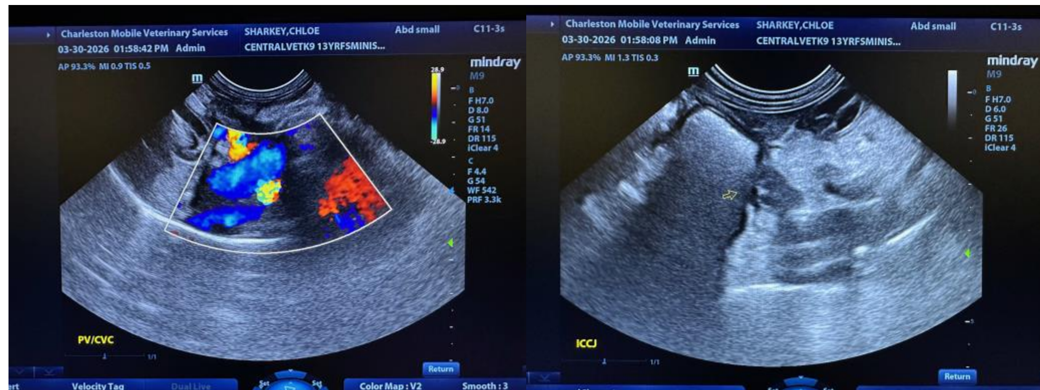
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider submission of the abdominal fluid for cytologic evaluation (assuming normal clotting status). A 25-gauge needle should be used. The patient should be pretreated with diphenhydramine to reduce the risk of mast cell degranulation with aspiration.

- Other considerations include the following:

  1. Three-view thoracic radiographs to assess cardiopulmonary status (if not already performed)
  2. Fine-needle aspiration of the thickened bowel segment (if accessible). There is more risk associated with aspiration of the bowel segment due to the concern for possible mast cell disease and degranulation with the procedure.



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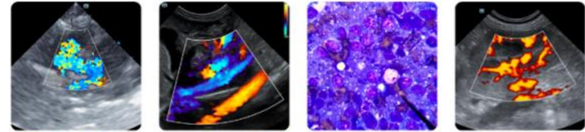

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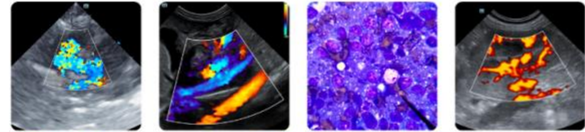

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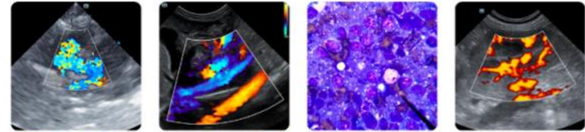

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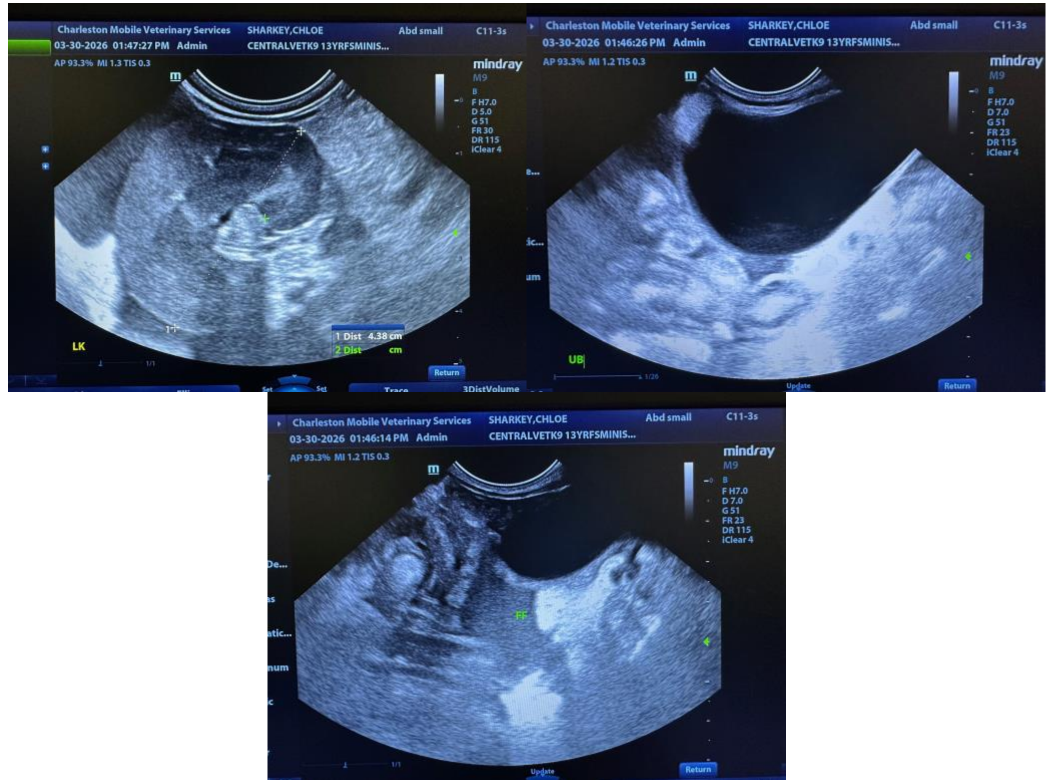

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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