Charleston Mobile Veterinary Services
IN PARTNERSHIP WITH SONOPATH VETERINARY ULTRASOUND

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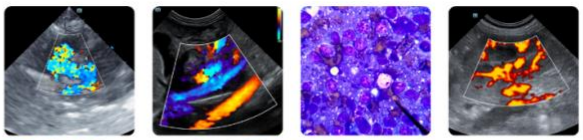

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Finnigan Smith

SPECIES

Canine

BREED

Welsh Terrier

SEX

Male Neutered

AGE

7/4/2012

WEIGHT

23.3lb

INTERPRETED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

IMAGING PERFORMED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME

Central VH Summerville

REFERRING VET

Dr Karen Miller

INVOICE

22652

DATE

3-5-26

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Not eating well since end of February 2026. PU/PD.

Abnormal lab-work values:
Total Protein 6.4 5.0-7.4 g/dL
Albumin 2.4 2.7-4.4 g/dL LOW
Globulin 4.0 1.6-3.6 g/dL HIGH
A/G Ratio 0.6 0.8-2.0 LOW
ALT (SGPT) 72 12-118 IU/L
Alk Phosphatase 558 5-131 IU/L HIGH
WBC 17.5 4.0-15.5 103/mL HIGH
RBC 4.8 4.8-9.3 106/mL
HGB 10.6 12.1-20.3 g/dL LOW
HCT 35 36-60 % LOW

Current Medications: 2/27/26 started Simplicef and Galliprant
Radiographic Findings: none

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 and the proximal urethra, visible to a depth of 4 cm, are normal.

The prostate is normal in size (1.10 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 (5.00 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal in size (4.75 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.57 cm at cranial pole) (0.62 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 (0.89 cm at cranial pole) (0.51 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 overall normal in size (0.71 cm in width at the level of the hilus) with irregular undulating peripheral contours. The parenchyma is subjectively hypoechoic, and homogenous. Splenic vasculature is normal with no evidence of thrombosis. The perisplenic fat is mildly hyperechoic.

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Liver

The liver is subjectively enlarged, with swollen peripheral contours. The parenchyma is isoechoic- to hypoechoic relative to the spleen and heterogenous in appearance, with at least two ill-defined, hyperechoic, nodules (one measuring 2.2 x 1.7 cm). 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.

The gallbladder lumen is moderately distended. The wall is thin and smooth. A small amount of suspended echogenic debris 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. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

The right limb is prominent-in-size with slightly irregular peripheral contours. The parenchyma is hypoechoic- relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is not overtly dilated. The mesentery effacing the serosal surface is hyperechoic.

Lymph Nodes

A 1.43 x 0.53 cm medial iliac lymph node is visualized.

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion.

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The pancreatic changes could be consistent with mild, acute pancreatitis, chronic active pancreatitis, or resolving pancreatitis. There is some evidence of parenchymal remodeling.
- The splenic parenchyma changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis or splenitis with a lower possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia). Mild adjacent peritonitis is present.

Secondary Findings

- The hepatic changes are nonspecific and could be secondary to inflammatory disease (i.e., cholangiohepatitis, chronic hepatitis), Leptospirosis, hepatotoxicosis, infiltrative neoplasia (i.e., lymphoma), vacuolar hepatopathy, regenerative nodular hyperplasia, other hepatopathy, or some combination thereof. The hyperechoic hepatic nodules trend toward the benign (i.e., myelolipomas, regenerative nodules) with a lower possibility of more insidious hepatic pathology.
- Bilateral nonspecific age-related renal changes with subtle dystrophic mineralization
- The prominent medial iliac lymph node is likely reactive, with a lower possibility of emerging neoplasia.

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* It is unclear whether the patient's clinical signs are secondary to pancreatitis and/or if a concurrent issue (i.e., primary enteropathy, underlying metabolic disease) is present.

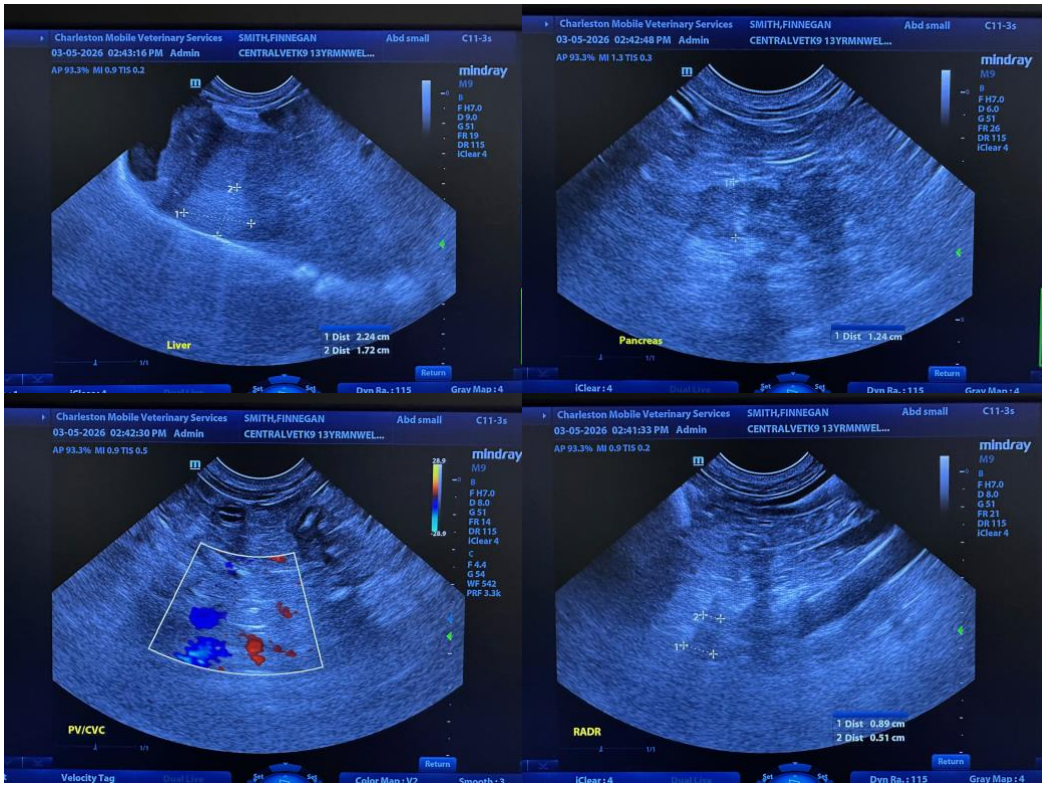
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Supportive care for pancreatitis is recommended including IV fluid therapy, gastric protectants, antiemetics, pain medication as needed, +/- fresh frozen plasma.

- To further investigate for causes of hypoalbuminemia, consider the following:

  1. Fecal evaluation for ova and Giardia
  2. GI panel including serum cobalamin and folate, TLI, PLI and resting cortisol level
  3. UPC if proteinuria is present on the urine dipstick
  4. Pre- and postprandial serum bile acids
  5. Depending on the results of the above diagnostics further testing may be warranted.
  6. If further testing is not pursued, consider empirical treatment for pancreatitis and recheck bloodwork in 2-3 weeks.

- Regarding the splenic changes, consider a recheck ultrasound in 2-3 months to assess progression.



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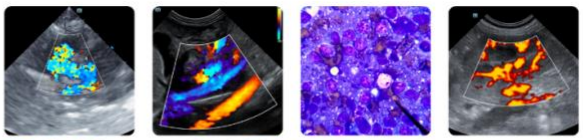

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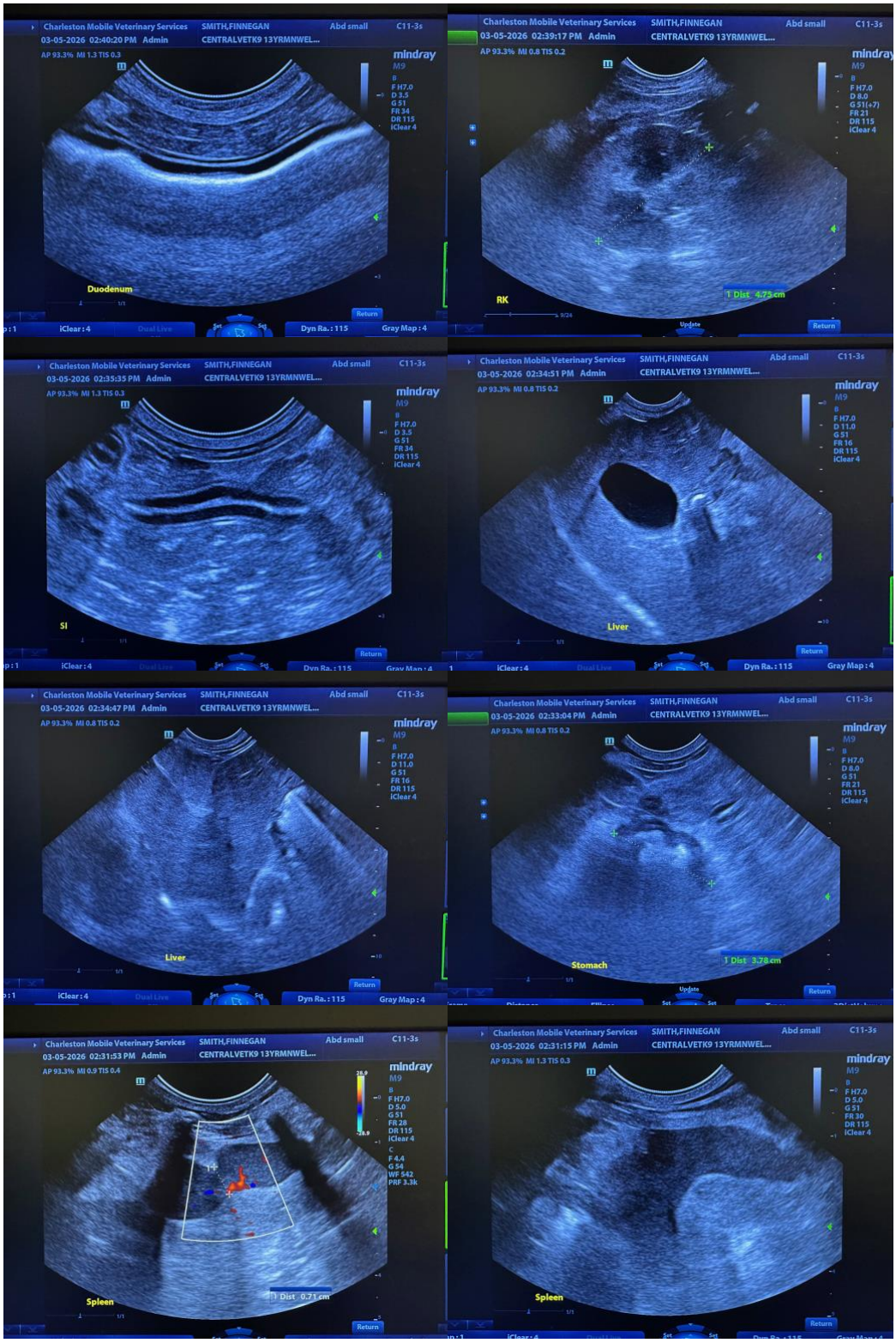

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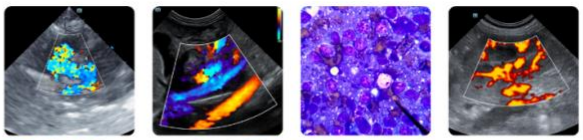

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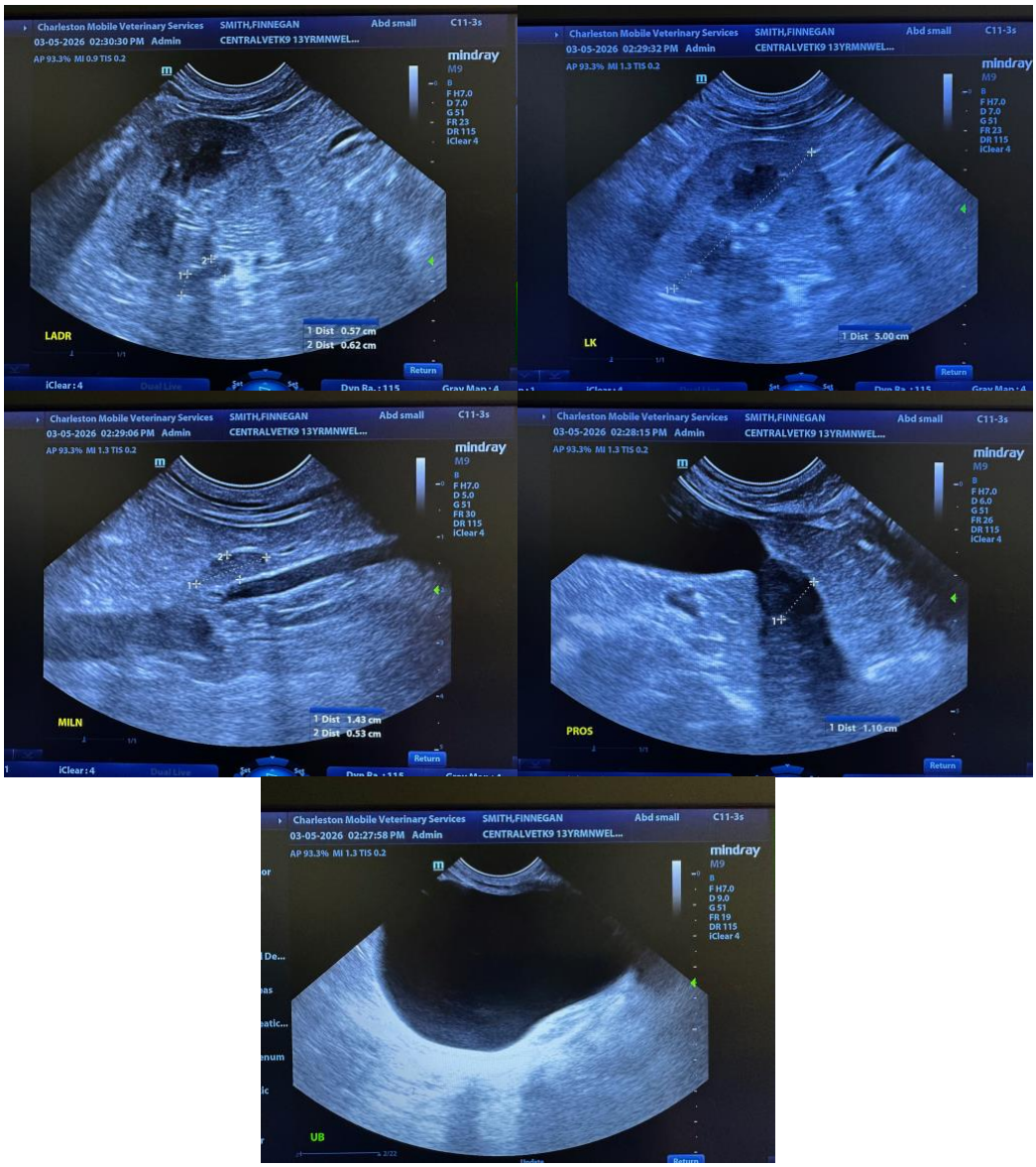

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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