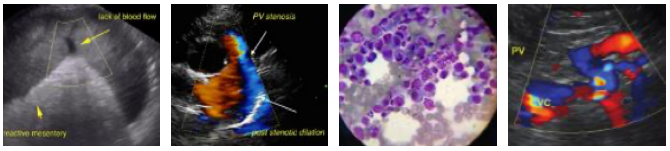
SonoPath
Clinical Sonography & Telecytology
EDUCATIONAL TELECONSULTATION SERVICES™



SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Fufi Figueroa

SPECIES
Canine

BREED
Miniature Schnauzer

SEX
Male, neutered

AGE
14 Yrs.

WEIGHT
14.4 lbs.

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

IMAGING PERFORMED BY
Dr. Ferrer

HOSPITAL NAME
Paseos VC

REFERRING VET
Dr. Torres

INVOICE
14788

DATE
4/10/23

PRESENTING CLINICAL SIGNS

History: The patient presented as a referral for an abdominal ultrasound. Presented on February 7th with frequent vomiting. Partial response of sucralfate Cerenia, Famotidine, dietary change. The actual diet is z/d dry and canned hydrolyzed protein + Mirtazapine PRN. The patient is atopic and uses Cytopoint every 4-6 weeks. Has shown adverse reactions to previous diets. Medications: Pimobendan 2.5mg AM/ 1.25mg PM Famotidine 10mg SID AM Metacam SID PM Cytopoint
Abnormal PE/Chem/CBC/UA Results: PE: Heart murmur

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly distended. The wall is of appropriate thickness for the level of repletion. The mucosal surface is slightly irregular. A few tiny cystic calculi are observed within the lumen. The region of the trigone is normal. A few tiny calculi are also observed within the prostatic urethra, the largest measuring 0.27 cm in diameter.

The prostate is mildly enlarged (1.38 cm in width) with a slightly irregular shape. The parenchyma is homogeneous. No distinct focal lesions are observed. Small calculi are observed within the prostatic urethra.

The left kidney is normal in size (4.55 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. A few small non-obstructive nephroliths are visualized. A 0.57 cm irregular cortical cyst is observed at the caudomedial aspect. Trace pyelectasia is present. There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (4.58 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. A few small non-obstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.59 cm at cranial pole) (0.57 cm at caudal pole) (1.76 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.

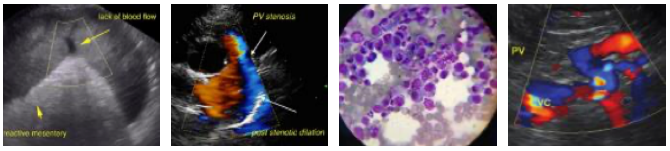
The right adrenal gland is mildly enlarged (0.50 cm at cranial pole) (0.67 cm at caudal pole) (1.70 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is subjectively prominent in size (1.41 cm in width at the level of the hilus) with a slightly irregular medial contour. The parenchyma is subtly mottled in appearance. No distinct focal lesions are observed. Splenic vasculature appears normal with no evidence of thrombosis.

Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and slightly mottled in appearance. No distinct focal lesions are observed. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of



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congestion. The gall bladder lumen is moderately distended. The wall is thin and smooth. A moderate amount of partially dependent debris/sludge 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 is variably thickened (up to 1.21 cm) and irregular with a suspected loss of the normal layering pattern in some regions. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. The ileocecocolic junction and colonic wall are normal. No obvious obstructive disease is noted.

Pancreas

The left limb of the pancreas is prominent in size with slightly irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and subtly mottled in appearance. No distinct focal lesions are observed. The pancreatic duct is not overtly dilated. See also *Other.*

Free Abdomen

There is no obvious evidence of free fluid.

Lymph Nodes

See *Other.*

Other

2-3 small round hypoechoic nodules are observed in the cranial abdomen, the largest measuring 0.41 cm in diameter.

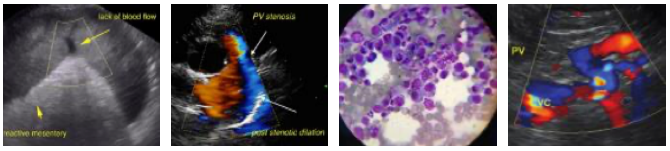
ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The gastric wall changes could be consistent with infiltrative neoplasia (i.e., lymphoma, adenocarcinoma), severe gastritis or less likely, hypertrophy.
- The hypoechoic nodules in the cranial abdomen may represent prominent lymph nodes or pancreatic nodules. Regardless, a benign process is favored.
- The splenic parenchymal changes could be consistent with lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia (i.e., lymphoma), antigenic stimulation or splenitis.
- The prostatomegaly could be consistent with emerging neoplasia (i.e., adenocarcinoma, transitional cell carcinoma), hyperplasia (if neutered late in life), prostatitis, other.

Secondary Findings:

- Tiny cystic calculi.
- Bilateral chronic renal changes with non-obstructive nephrolithiasis.
- Mild bilateral adrenomegaly.



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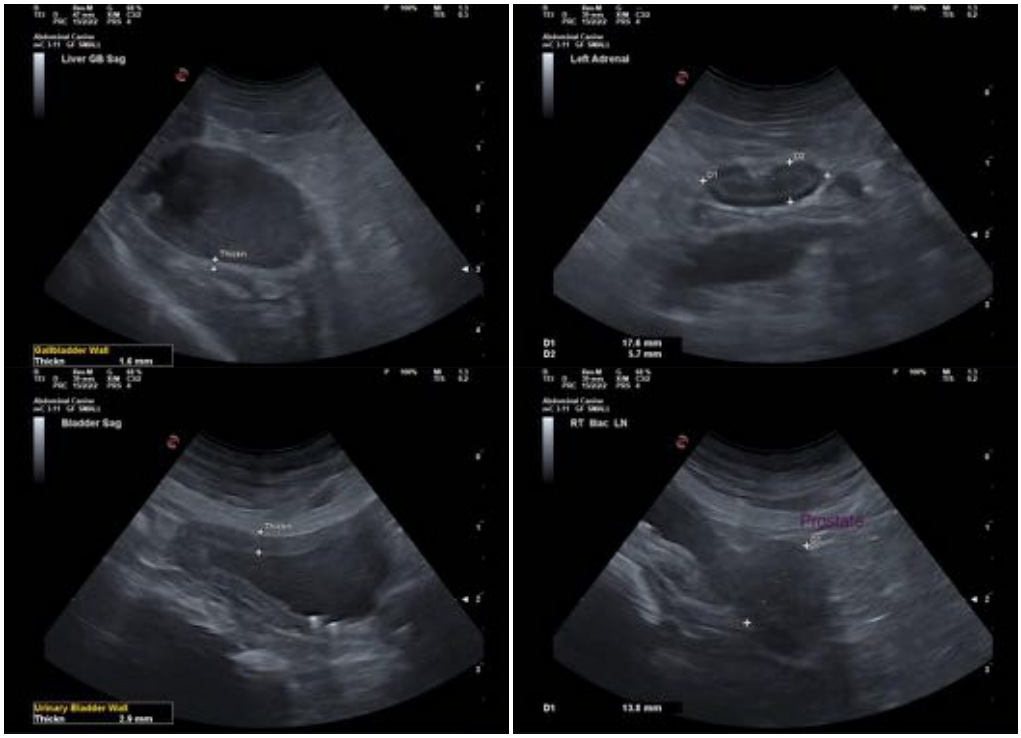
- The hepatic parenchymal changes are non-specific and could be associated with age-related remodeling or a more insidious hepatopathy. Correlation with the patient's liver values is recommended.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Baseline labwork including a CBC chemistry panel, urinalysis and T4 is recommended, if not already performed.
- Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
- If gastric and splenic cytology results are inconclusive, consider endoscopic or surgical gastrointestinal biopsies. If surgery is pursued, consider cystotomy at the time of surgery with stone removal, analysis and culture.
- Also consider a PLI +/- a full malabsorption panel to assess for concurrent maldigestion/malabsorption and underlying pancreatic disease.



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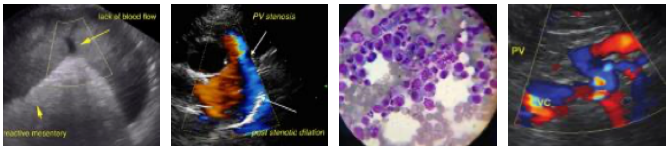

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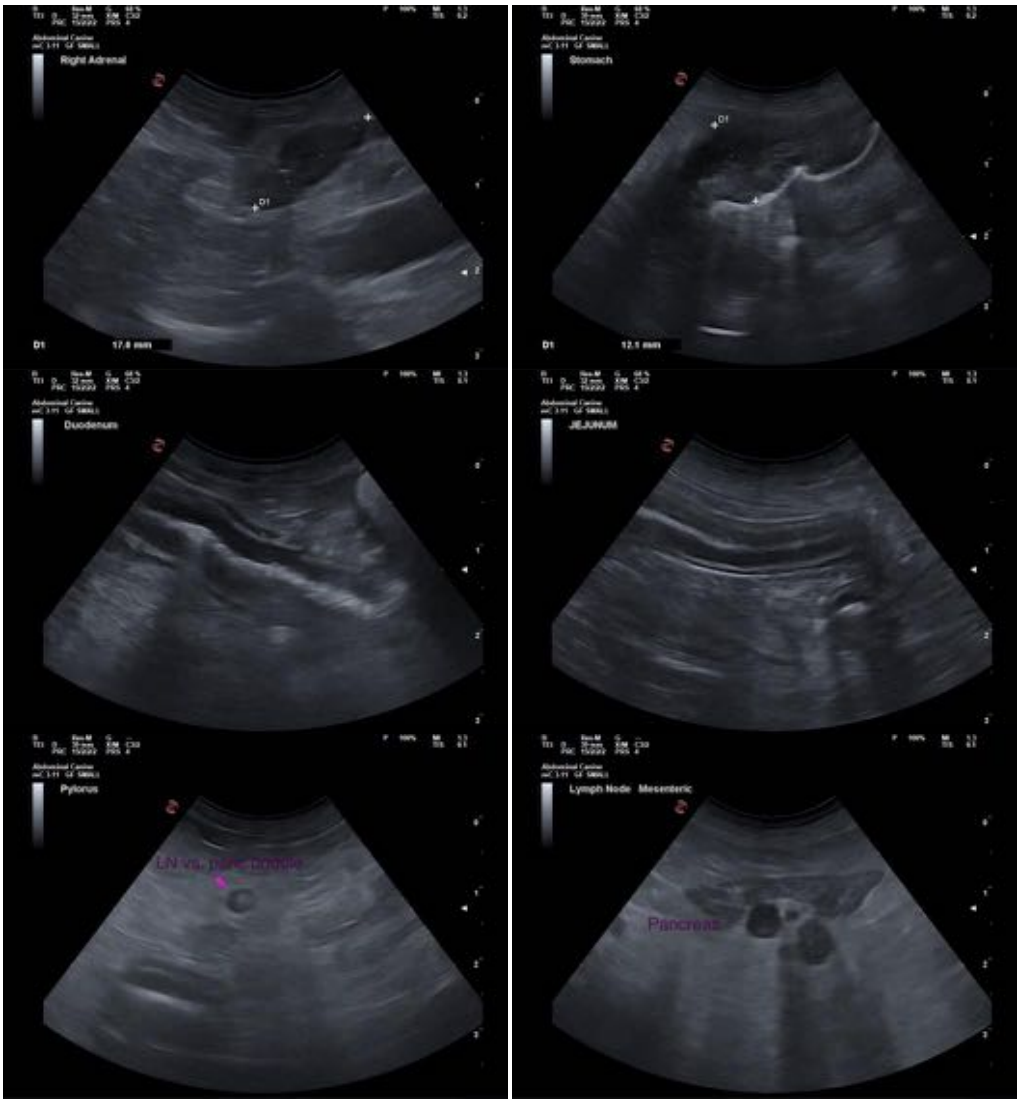

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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