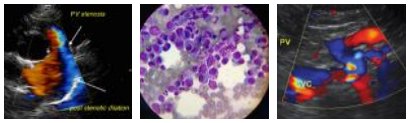
IMAGING PERFORMED BY

IntraPet.com



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DATE

4/13/2022

PATIENT

Mia Hartle

SPECIES

Canine

BREED

Beagle

SEX

Spayed Female

AGE

5/24/2009

WEIGHT

28.4lbs

INTERPRETED BY

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

HOSPITAL NAME

Banfield Westminster

REFERRING VET

Dr. Stephens

INVOICE

10729

PRESENTING CLINICAL SIGNS

Lethargic since O got home yesterday afternoon, pacing around, panting, seems uncomfortable when lying down, keeps moving from side to side, putting hind end up in air, O thinks stomach is painful. Ate yesterday morning, did not e/d last night, drank a little water early this morning
has urinated but has not defecated that O knows of. BAR, T: 101.5 P: 170 PANTING, MM pk; CRT < 2.0 sec, HL: No murmurs or arrhythmias, lungs clear, femoral pulses are strong and synchronous. Oral: MODERATE-HEAVY TARTAR AND DISCOLORATION; PULPITIS 104/204, EENT: EPIPHORA OU, NUCLEAR SCLEROSIS OU, No aural/nasal discharge, INT: 0.25 CM RAISED FIRM PINK GROWTH BACK OF NECK AND DORSUM; APPROX 2.5 CM FIRM ADHERED FATTY LUMP RIGHT THORAX (NO CHANGE SINCE LAST VISIT), 2 MM BLACK GROWTH LOWER MIDDLE LEFT EYELID. ABDOMEN: Soft and comfortable on palpation; CRANIAL ORGANOMEGALY, URO/GEN: No discharge, urination normal, MS: BILATERALLY LUXATING PATELLA GRADE 2, PERIPHERAL Lymph nodes: wnl. Brief neurologic exam: mobile x 4, no CP deficits, MILD SHAKING NOTED IN HINDLEGS
6/9 body score. ABOVE IDEAL.

Current Medications: Gabapentin 300mg BID for 7 days.
Radiographs: There appears to be a 6.9 x 9.4 mm bright bone dense mass in the left dorsal caudal lung lobe; there is also ventral displacement of the colon on lateral abdomen; spleen appears enlarged
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.

Imaging Performed By: Andi Parkinson, RDMS.

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 (5.52 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (5.97 cm in length); with a slightly irregular shape There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. A 1.21 x 1.14 cm cortical cyst is observed at the lateral aspect. The cyst causes slight capsular expansion. Mild pyelectasia is present (0.29 cm in the transverse plane. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is upper limits of normal size (0.60 cm at cranial pole) (0.69 cm at caudal pole) (2.38 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 borderline enlarged (0.80 cm at cranial pole) (0.71 cm at caudal pole) (2.27 cm in length); with a slightly irregular shape. A 1.41 x 0.79 cm hyperechoic to slightly heterogenous nodule is observed in the cranial- to mid-aspect. Glandular echogenicity and detail at the caudal aspect are normal. The phrenicoabdominal vein and surrounding vasculature appear normal.

Spleen

The spleen is normal in size (1.36 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 prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits mild heterogeneity. No distinct focal lesions are observed. Hepatic vasculature and biliary tracts are of normal volume with no evidence of congestion.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A scant amount of echogenic debris is adhered to the luminal surface. The cystic and common bile ducts are normal.

Gastrointestinal

The gastric lumen is not distended. The gastric wall in the region of the fundus is normal in thickness with a normal layering pattern. The pylorus is mildly thickened (up to 0.71 cm) with a prominent muscularis layer. 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. The colonic wall is normal. No obstructive or overt infiltrative disease is noted.

Pancreas

The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional 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.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Minor age-related renal changes with right pyelectasia and a cortical cyst. The pyelectasia may be secondary to age-related remodeling or pyelonephritis.

- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory disease and infiltrative disease are considered less likely. However, correlation with the patient's liver values is recommended.

- The right adrenal nodule is most consistent with benign nodular hyperplasia. However, and emerging tumor cannot be completely excluded.

Secondary Findings

- The pyloric wall thickening could be consistent with hypertrophy, inflammation, normal variation, or less likely, emerging neoplasia.

  **An obvious cause for the patient's discomfort is not identified in this study, although right pyelonephritis is a possibility. Also consider orthopedic or neurologic pain as possible causes for the patient's clinical signs.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

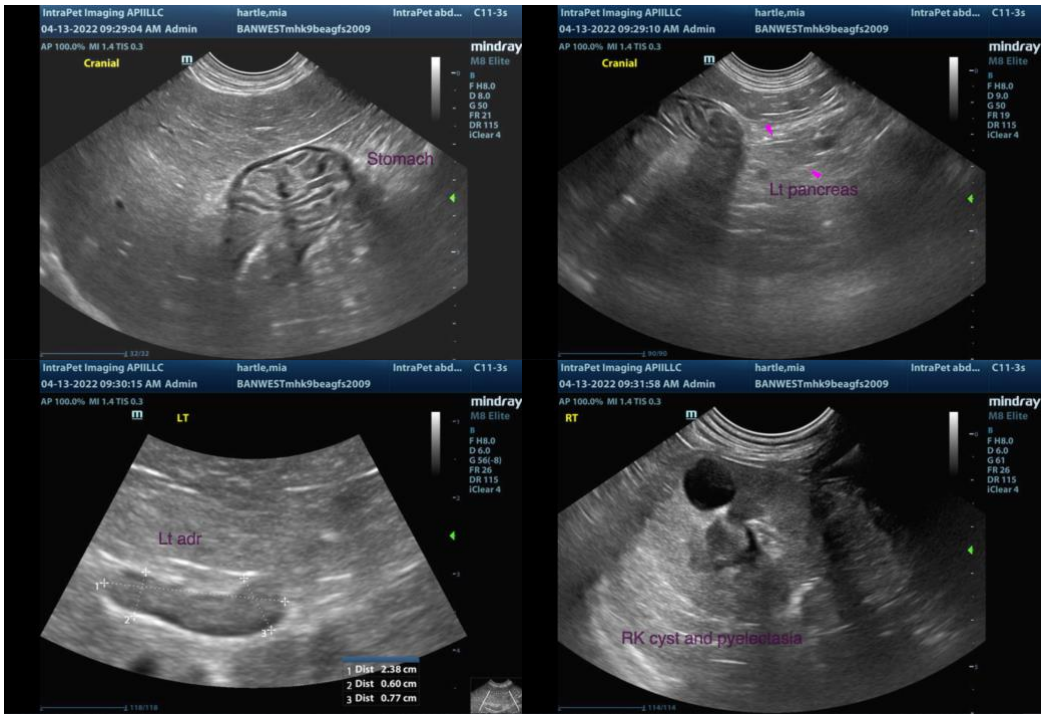
Baseline lab-work, including a CBC chemistry panel, urinalysis and T4 is recommended, if not already performed.

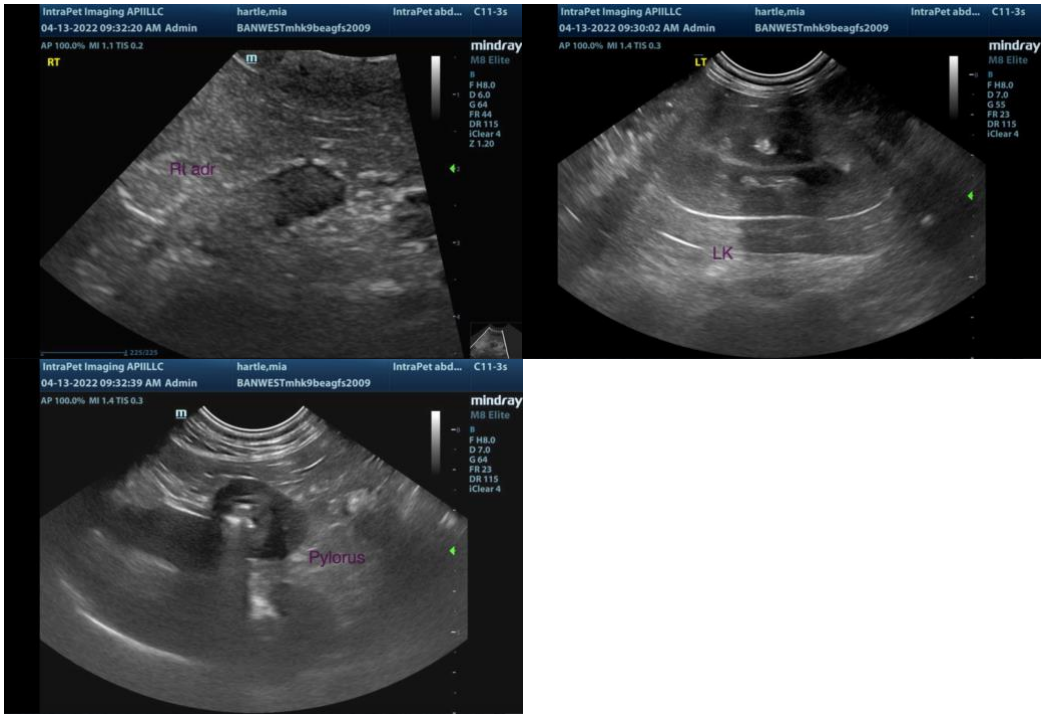
A urine culture and sensitivity is recommended to assess for pyelonephritis.

Thorough orthopedic and neurologic evaluations are also recommended to assess for non-metabolic causes of pain. Consultation with a board-certified orthopedic surgeon may be warranted.

Also consider a rectal examination to assess for anal gland/distal rectal abnormalities.

A cPLI can also be considered to assess for low-grade pancreatitis although there is no sonographic evidence of pancreatic inflammation.





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, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com