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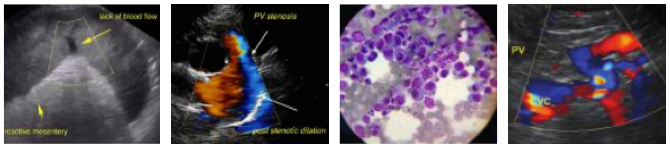

PATIENT
Bugsy Bailey

SPECIES
Canine

BREED
Boston Terrier

SEX
Neutered Male

AGE
10 years

WEIGHT
32 lbs

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

IMAGING PERFORMED BY
Christina Sitton

HOSPITAL NAME
Sherwood Family PC

REFERRING VET
Christina Sitton

INVOICE
12856

DATE
4.26.23

PRESENTING CLINICAL SIGNS

History: presented for second opinion on diarrhea, non-responsive to metro or fortiflora

Abnormal PE/Chem/CBC/UA Results: heart murmur, arrhythmia noted during exam (suspected previous syncopal episode) periodontal disease BW from previous vet on 4/19/2023 CBC: wnl USG 1.050, ph 6.5, otherwise urine wnl Chem: ALT 181, ALP 993, phosphorus 5.3; otherwise wnl fecal/giardia test pending

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder and visible portion of the pelvic urethra are normal for the degree of luminal distension. The urine is anechoic with no evidence of debris. Cystic calculi and discrete masses are not observed. The region of the trigone and visible portion of the proximal urethra are normal.

The prostate is subjectively normal in size (0.95 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 (5.17 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. The cortex is isoechoic relative to the spleen. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis.

The right kidney is normal in size (5.57 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. The cortex is isoechoic relative to the spleen. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.72 cm at cranial pole) (0.70 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 in normal size (1.16 cm at cranial pole) (0.64 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 (0.99 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A few ill-defined myelolipomas are observed in the region of the hilus. Splenic vasculature is normal.

Liver

The liver is subjectively enlarged with swollen/irregular peripheral contours. The parenchyma is hyperechoic relative to the spleen and diffusely heterogenous in appearance. A 2.60 cm heterogenous nodule/mass is observed on the right side. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The gall bladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No cholelithsare observed. The cystic and common bile ducts are normal/not seen.

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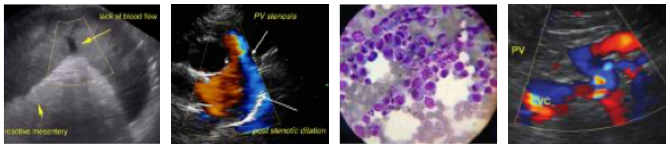

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Gastrointestinal
The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is mildly distended with ingesta. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is segmentally dilated with chyme. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

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
An area of reactive mesentery is observed in the left midabdomen. There is no obvious evidence of free fluid. The abdominal lymph nodes are normal/not visible.

Other
A brief visualization of the thorax reveals several ringdown lesions. There is suspected trace pleural effusion.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The hepatic mass/lesion on the right side could be consistent with a tumor, regenerative nodule, inflammatory focus, granuloma, other. The diffuse hepatic parenchymal changes could be consistent with a benign, age-related process (i.e., regenerative nodular hyperplasia, vacuolar hepatopathy), inflammatory disease (less likely), infiltrative neoplasia or other hepatopathy.
- The etiology of the reactive mesentery in the left midabdomen is unclear. Considerations include focal peritonitis secondary to mild pancreatitis, small intestinal disease, other.

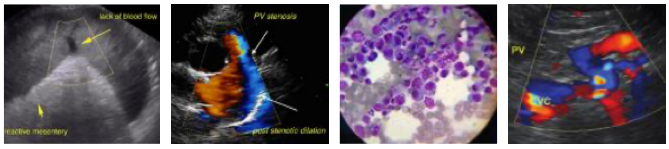
Secondary Findings

- Bilateral chronic renal changes with dystrophic mineralization
- Mild left adrenomegaly

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the hepatic changes, consider fine-needle aspirates (if clotting status is appropriate). Twenty-five gauge-needles should be used. If accessible, an aspiration of the liver mass on the right side should be obtained.
- With regard to the history of diarrhea, consider the following:

1. Prophylactic deworming with Fenbendazole
2. Malabsorption panel, including serum cobalamin and folate, TLI, PLI and resting cortisol level (send to Texas A&M).
3. 2-4-week limited antigen or hydrolyzed protein diet trial
4. Initiation of a fiber supplement in conjunction with the current probiotic



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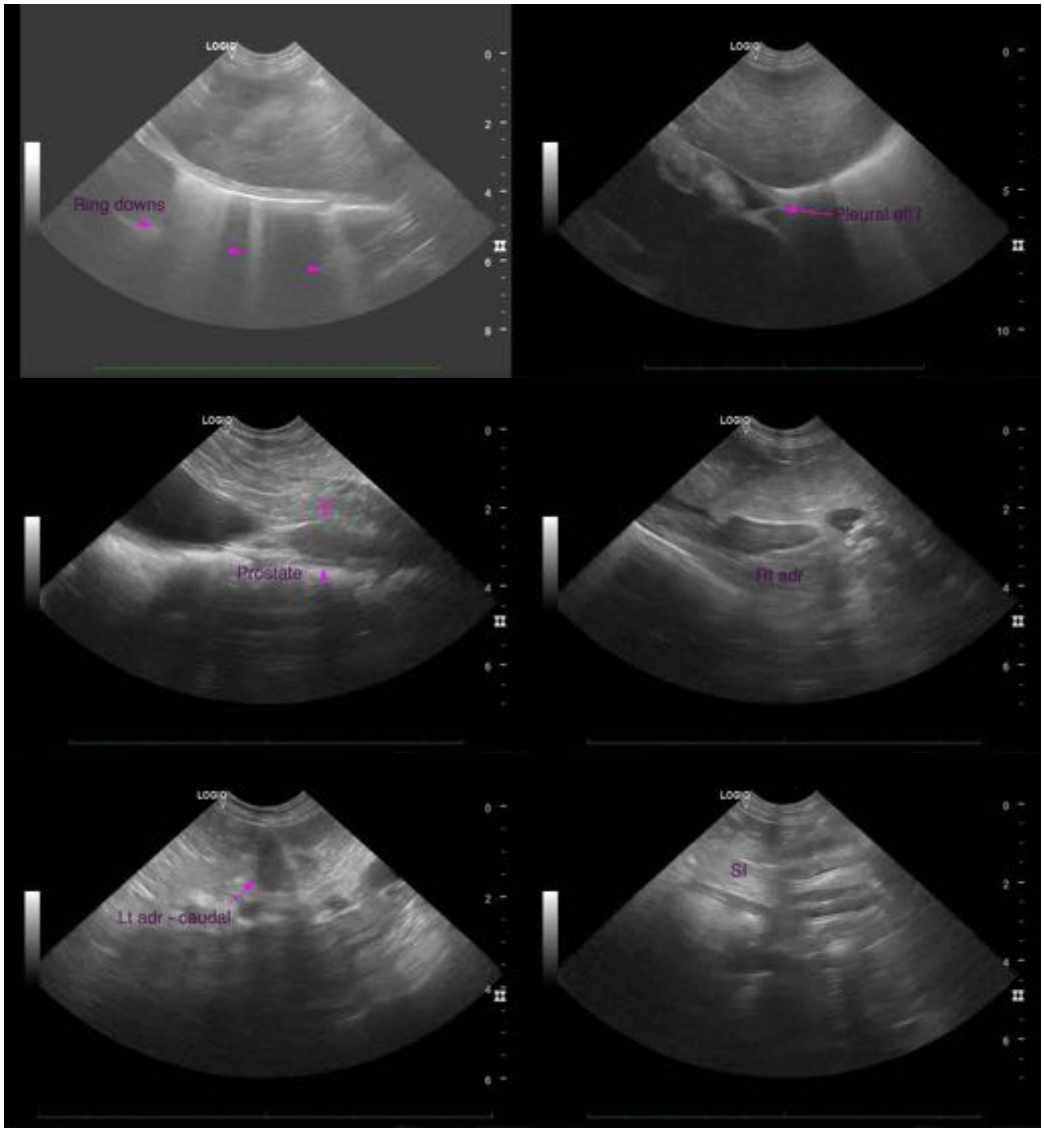
5. Ultimately, endoscopic or surgical gastrointestinal biopsies may be necessary to get a definitive diagnosis.

- Given the ringdown lesions and possible pleural effusion, three-view thoracic radiographs are recommended to assess cardiopulmonary status. Depending on the results, further cardiac workup may be warranted.



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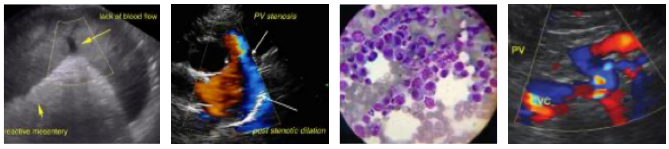

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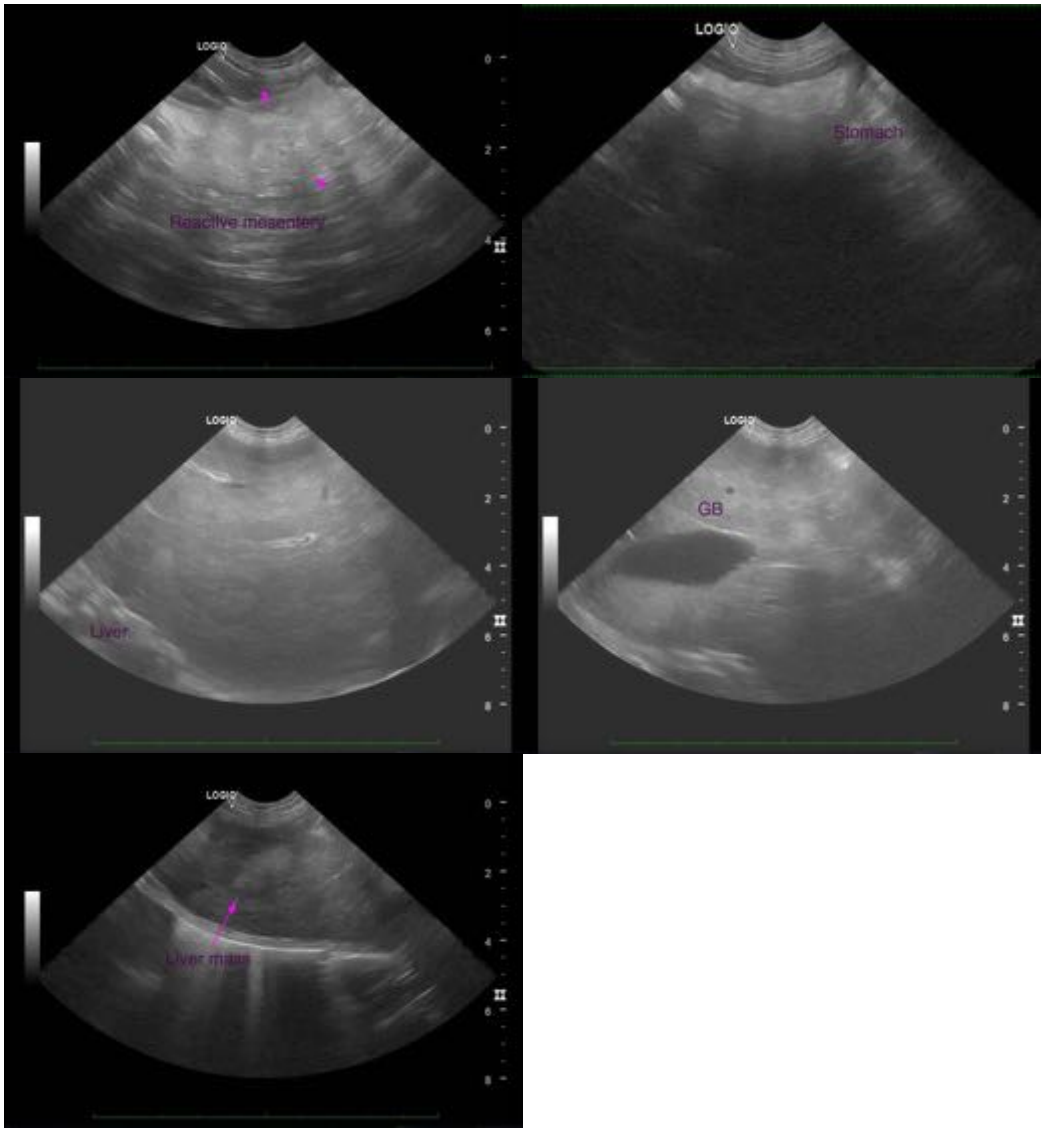

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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