Charleston Mobile Veterinary Services
IN PARTNERSHIP WITH SONOPATH VETERINARY ULTRASOUND

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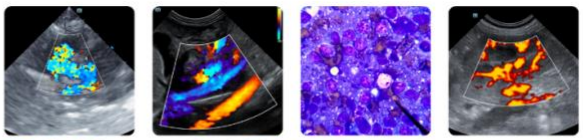

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Stubby Bryant

SPECIES

Canine

BREED

CKC Spaniel

SEX

Neutered Male

AGE

12

WEIGHT

17.5 lbs

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

Animal Hospital of SC

REFERRING VET

Dr Victor Getson

INVOICE

22843

DATE

4-7-26

PRESENTING CLINICAL SIGNS

Acute onset of vomiting yesterday, as well as dyspnea. Went to the ER overnight. Thoracic radiographs revealed cardiomegaly. Unremarkable lungs. Patient is dyspneic and on oxygen. Previous history of degenerative valve disease and is on pimobendan.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is distended. Luminal contents are mostly anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (0.73 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 (4.86 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal- to mild 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 (5.66 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal- to 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 mildly enlarged (0.70 cm at cranial pole) (0.71 cm at caudal pole) with slightly swollen peripheral contours. The parenchyma is hypoechoic with some loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is mildly enlarged (1.09 cm at cranial pole) (0.72 cm at caudal pole) with slightly swollen peripheral contours. The parenchyma is hypoechoic with some loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature are normal.normal.

Spleen

The spleen is normal in size (0.79 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. Pinpoint hyperechoic- to mineralized foci are observed throughout the organ. Splenic vasculature is normal.

Liver

The liver is prominent-in-size with slightly swollen peripheral contours. The parenchyma is hypoechoic relative to the spleen, and homogenous in appearance. Hepatic vasculature and intrahepatic 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 variably thickened (up to 0.28 cm) and hyperechoic. A few, small, polypoid-like lesions are arising from the mucosal surface. A moderate amount of aggregated, echogenic, partially dependent- to suspended sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

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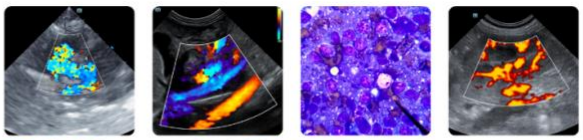

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Gastrointestinal

The gastric lumen is not distended. The gastric wall is normal- to borderline thickened (up to 0.46 cm) 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. The colonic lumen contains some shadowing fecal material. There is no evidence of an obstructive pattern.

Pancreas

The pancreas is diffusely prominent- to enlarged with slightly irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and homogenous in appearance. The pancreatic duct is not overtly dilated. Surrounding mesentery is mildly hyperechoic.

Lymph Nodes

A 1.91 x 0.92 cm periportal lymph node is visualized.

Free Abdomen

There is no obvious evidence of free fluid.

Other

In the visualized portion of the thorax, several B-lines are visualized. In the right cranial thorax, a consolidated lung lobe is visualized.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The pancreatic changes are most consistent with mild pancreatitis, with subtle adjacent peritonitis.
- The B-lines in the thorax are suggestive of pulmonary parenchymal disease.
- Lung lobe consolidation on the right side

Secondary Findings

- The gastric wall changes may be a normal variant for this patient or could suggest gastritis.
- Bilateral adrenomegaly
- Splenic dystrophic mineralization. This is likely a benign incidental finding often associated with endocrinopathies.
- The gallbladder wall changes are suggestive of cholecystitis. The excessive sludge pattern suggests and emerging mucocele.
- Mild hepatomegaly
- Mild bilateral nonspecific age-related renal changes
- The prominent periportal lymph node is likely reactive, with a lower possibility of emerging neoplasia.

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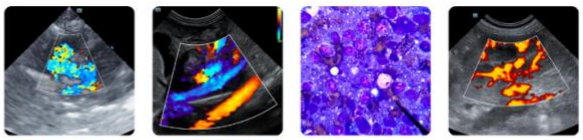

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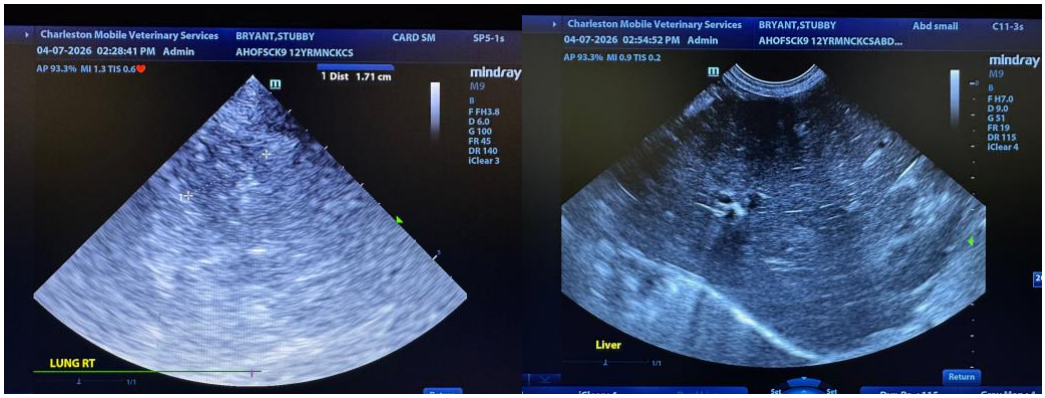
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Repeat thoracic radiographs are recommended to assess for emerging aspiration pneumonia.
- Supportive care for pancreatitis is recommended including IV fluid therapy, gastric protectants, antiemetics, pain medication as needed, +/- fresh frozen plasma.
- Given the gall bladder changes, Ursodeoxycholic acid (Ursodiol) is recommended. Serial sonographic monitoring (e.g., every 4-6 weeks) of the gall bladder is recommended to assess for progression to a fully formed mucocele. If progression occurs, a cholecystectomy may be warranted.
- Consider testing for hyperadrenocorticism with a low-dose dexamethasone suppression test or ACTH stimulation test if clinical signs (i.e., PU/PD) develop in the future.



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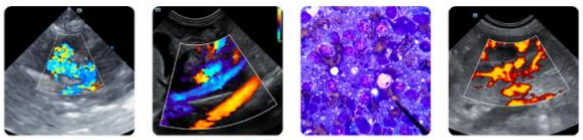

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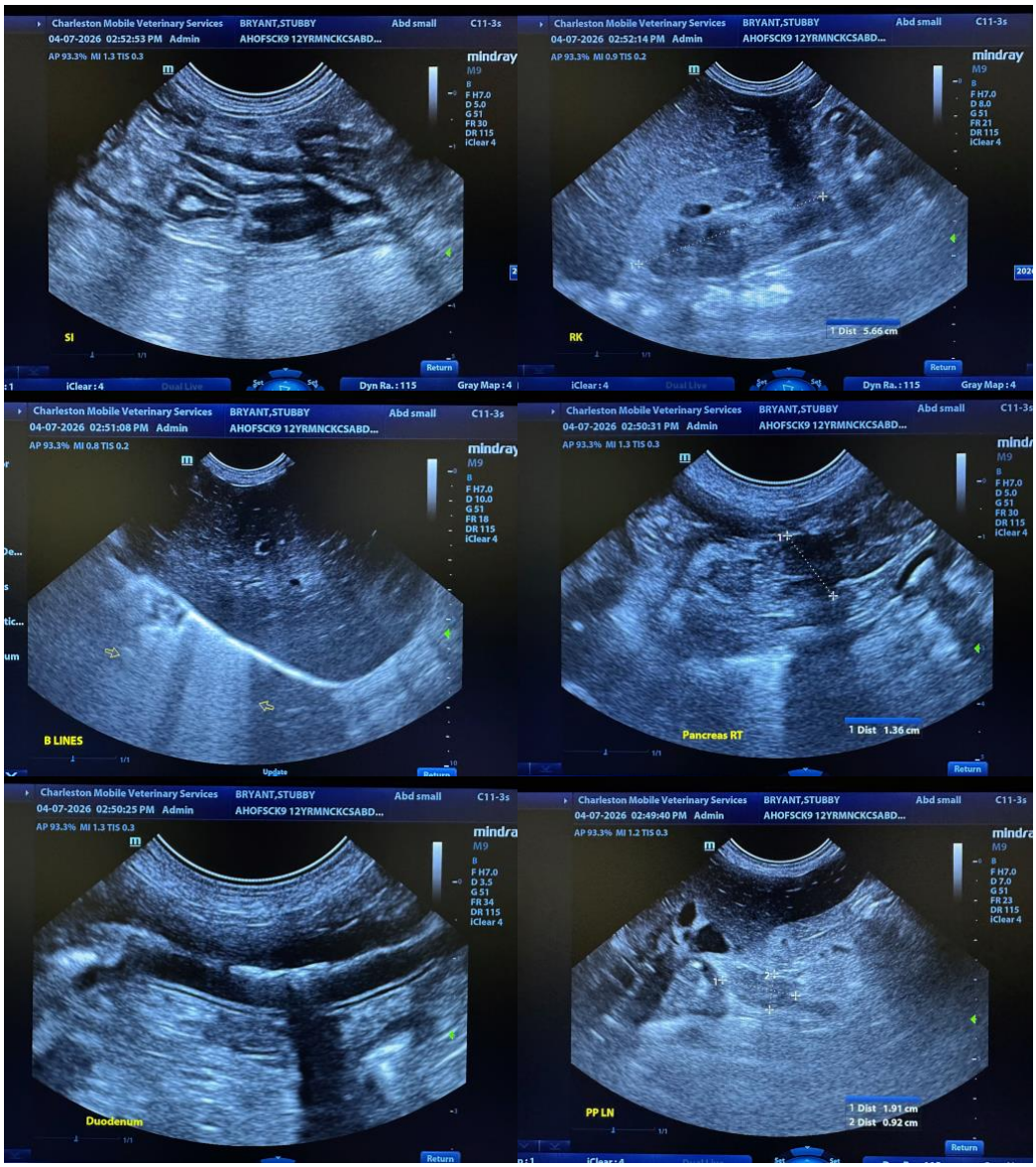

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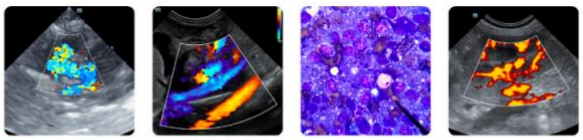

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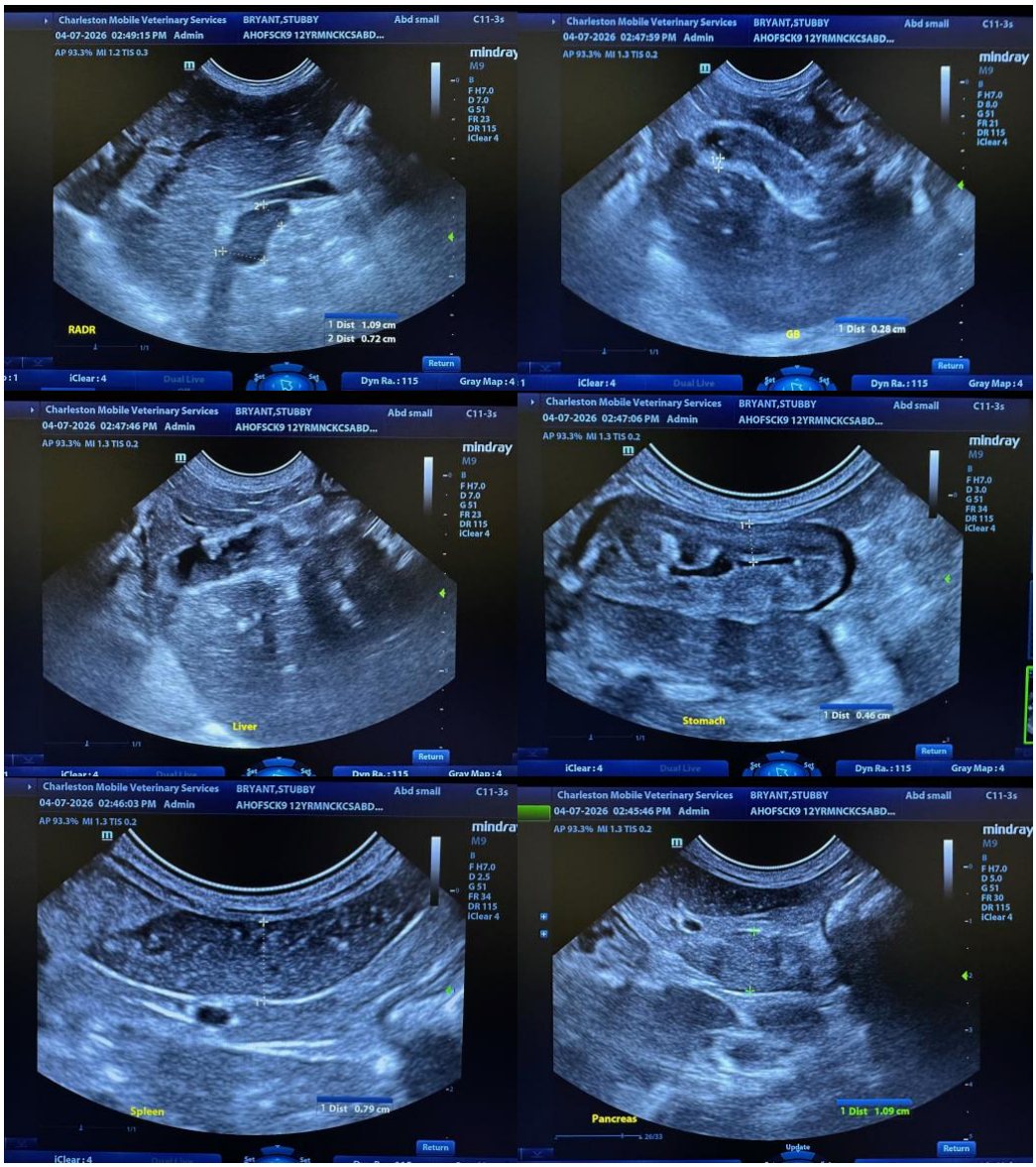

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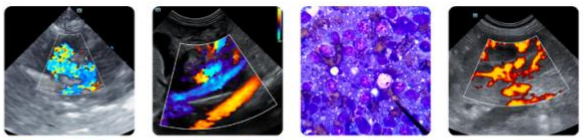

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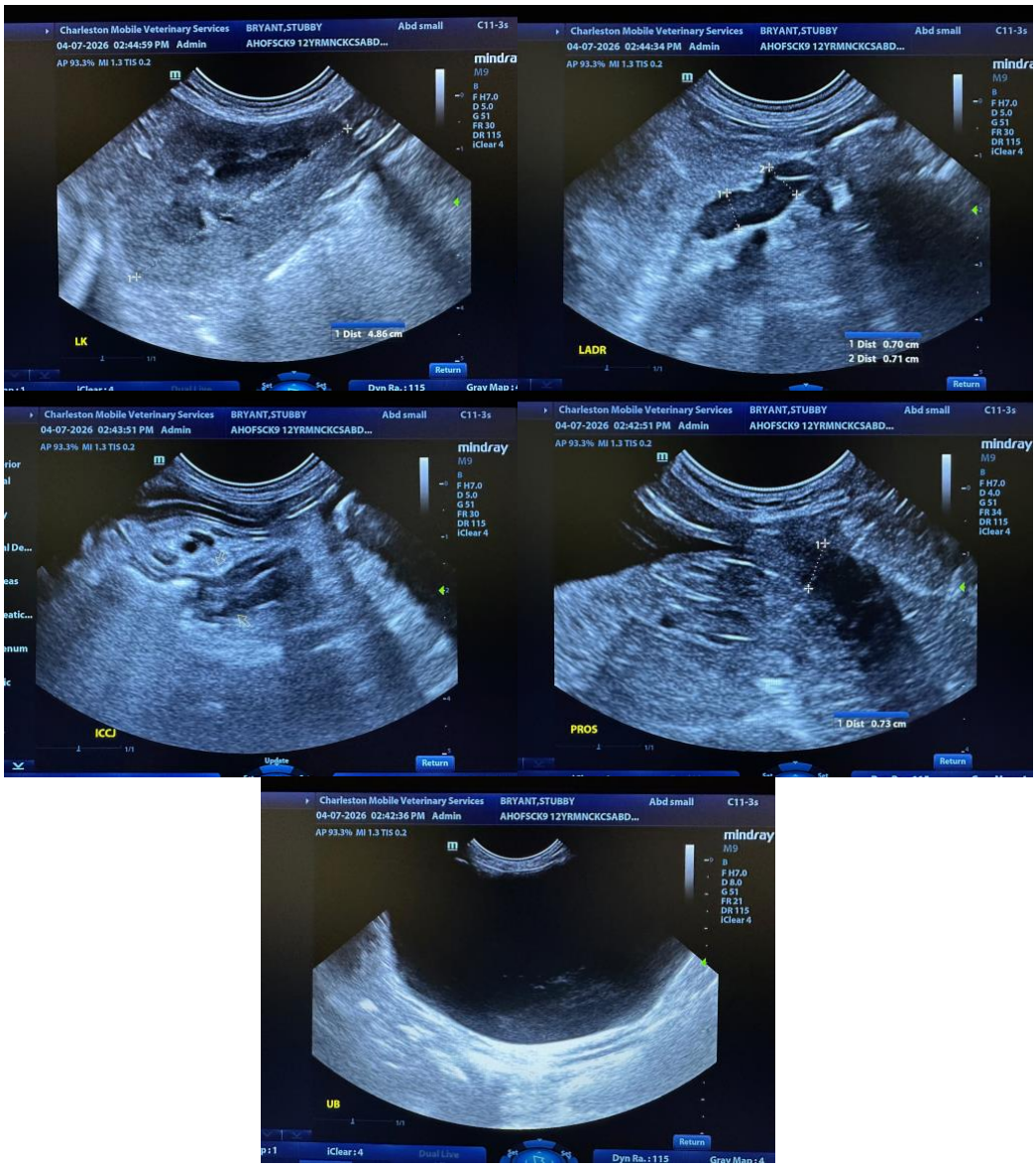

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com