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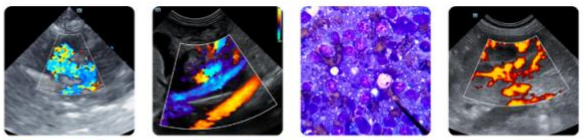

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

**PATIENT**

Sumter Good

**SPECIES**

Canine

**BREED**

Labrador Retr Mix

**SEX**

Neutered Male

**AGE**

1.20.16

**WEIGHT**

Not Provided

**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**

Ashley Pines AH

**REFERRING VET**

Dr Andi Winney

**INVOICE**

23051

**DATE**

5-21-26

## PRESENTING CLINICAL SIGNS

Patient has had a 2-day-history of anorexia. Previously had an ALP around 280, but it is currently around 500. ALT is currently 125, and was previously normal.

## 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 2.0-3.0 cm, are normal.

The prostate is normal in size (0.85 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 (7.57 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 (7.95 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 normal in size (0.75 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.

The right adrenal gland is normal in size (1.30 cm at cranial pole) (0.82 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 (2.64 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A 1.9 x 1.4 cm hypoechoic nodule is observed approximately mid-body. Splenic vasculature is normal.

### *Liver*

The liver is subjectively normal in size with normal contours and structure. 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 portal vein to caudal vena cava ratio is approximately 1: 1.

The gallbladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are mostly anechoic. The cystic and common bile ducts are normal/not seen.

### *Gastrointestinal*

The gastric lumen is minimally fluid-distended. 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

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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 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.

***Lymph Nodes***
A 1.43 x 0.71 cm medial iliac lymph node is visualized. One- to two prominent mesenteric lymph nodes are also seen (one measuring 1.19 x 0.66 cm).

***Free Abdomen***
There is no obvious evidence of free fluid.

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

## ULTRASONOGRAPHIC FINDINGS

- The splenic nodule could be consistent with a benign focus (i.e., lymphoid hyperplasia or similar). Alternatively, an emerging tumor is possible.
- Minor bilateral age-related renal changes
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

*An obvious cause for the patient's inappetence is not identified in this study. Broad considerations include underlying metabolic issue, primary enteropathy, occult neoplasia, orthopedic or neurologic disease, other.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the splenic nodule, fine-needle aspiration can be considered assuming normal clotting status. A 25-gauge needle should be used. If tissue sampling is not pursued at this time, consider a recheck ultrasound in 1-2 months to assess for growth of the lesion.
- Regarding the inappetence, consider the following:
  - Orthopedic and neurologic examinations are recommended.
  - Regarding the elevated liver values, consider Leptospirosis testing (i.e., blood and urine PCR, serology), particularly if the clinical suspicion for disease is high.
  - Three-view thoracic radiographs can also be considered to assess for occult pathology in the chest.
  - While awaiting test results, symptomatic care is recommended, with recheck bloodwork next week. If liver values are continuing to increase, further work-up (i.e., hepatic tissue sampling) may be warranted.

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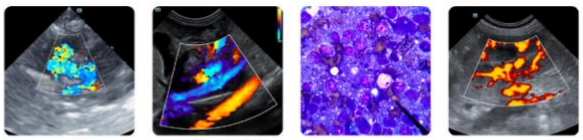

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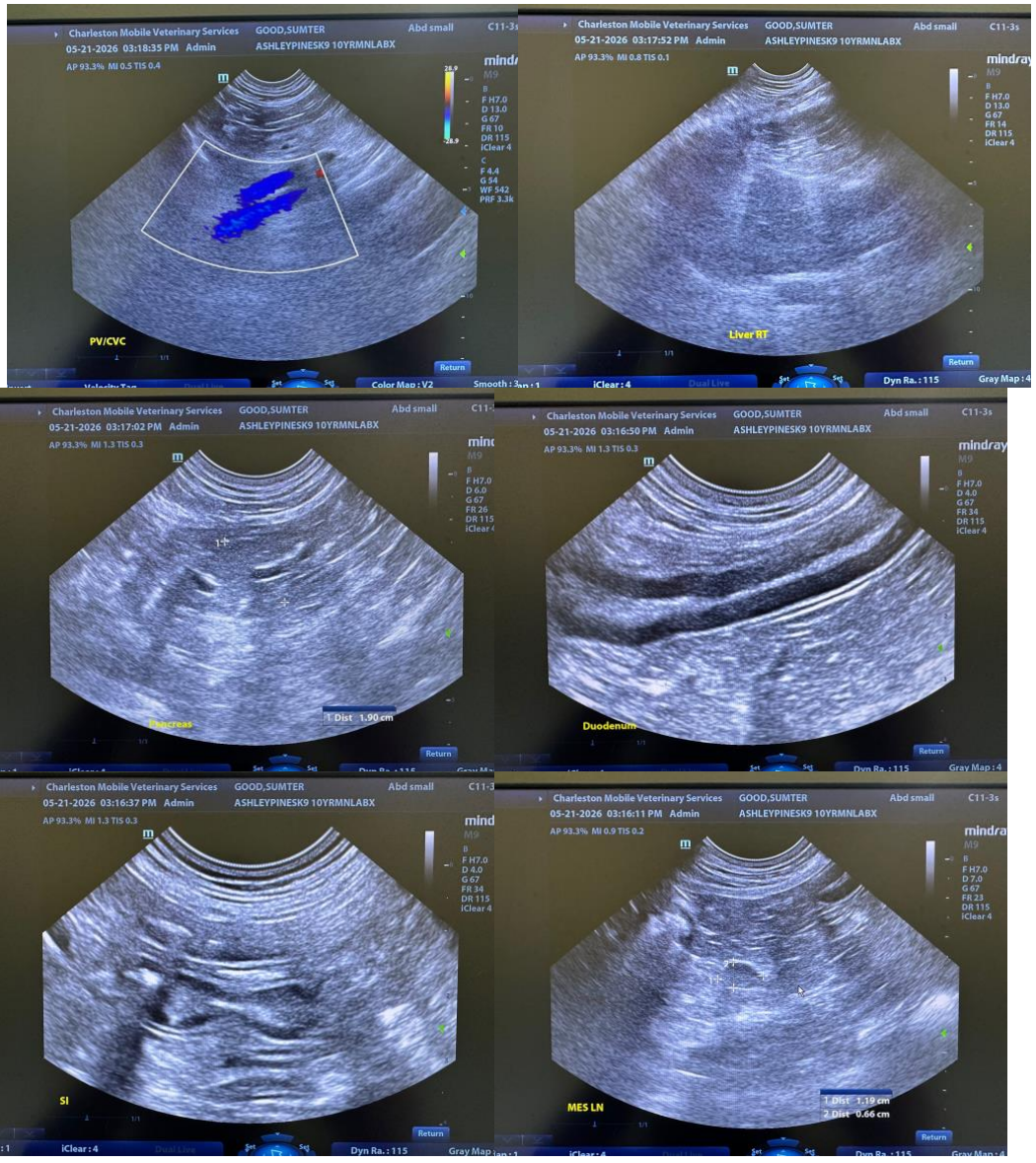

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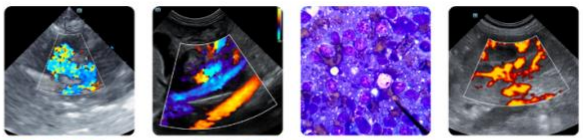

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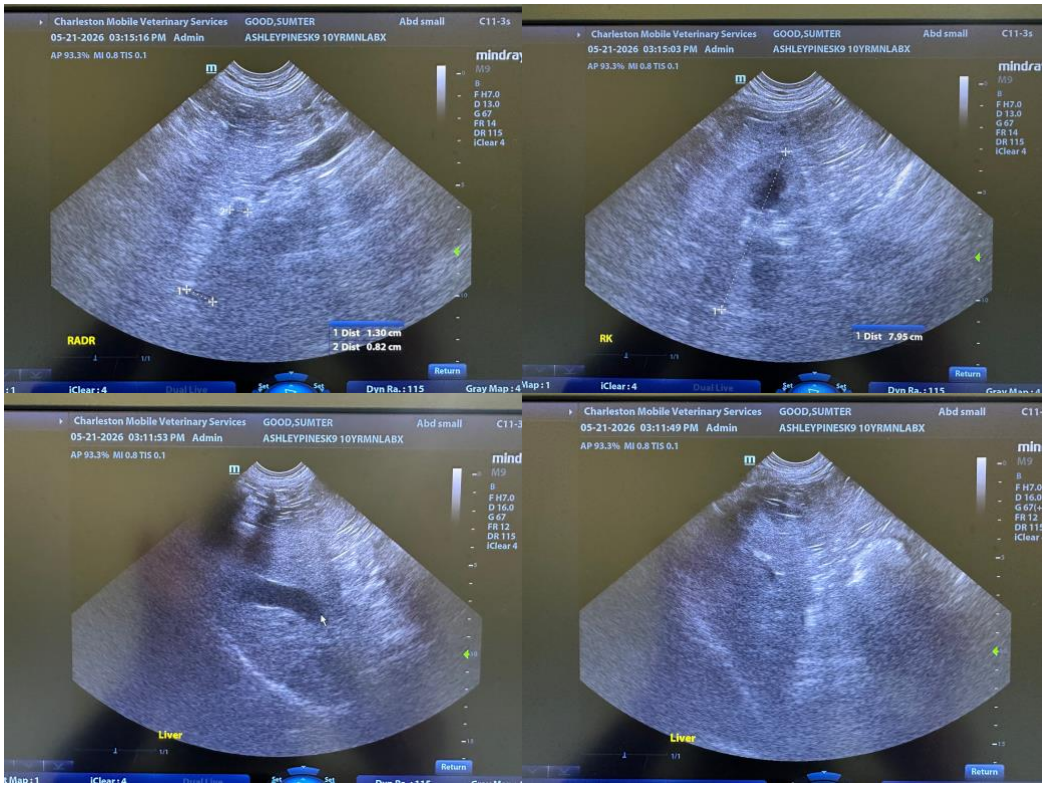


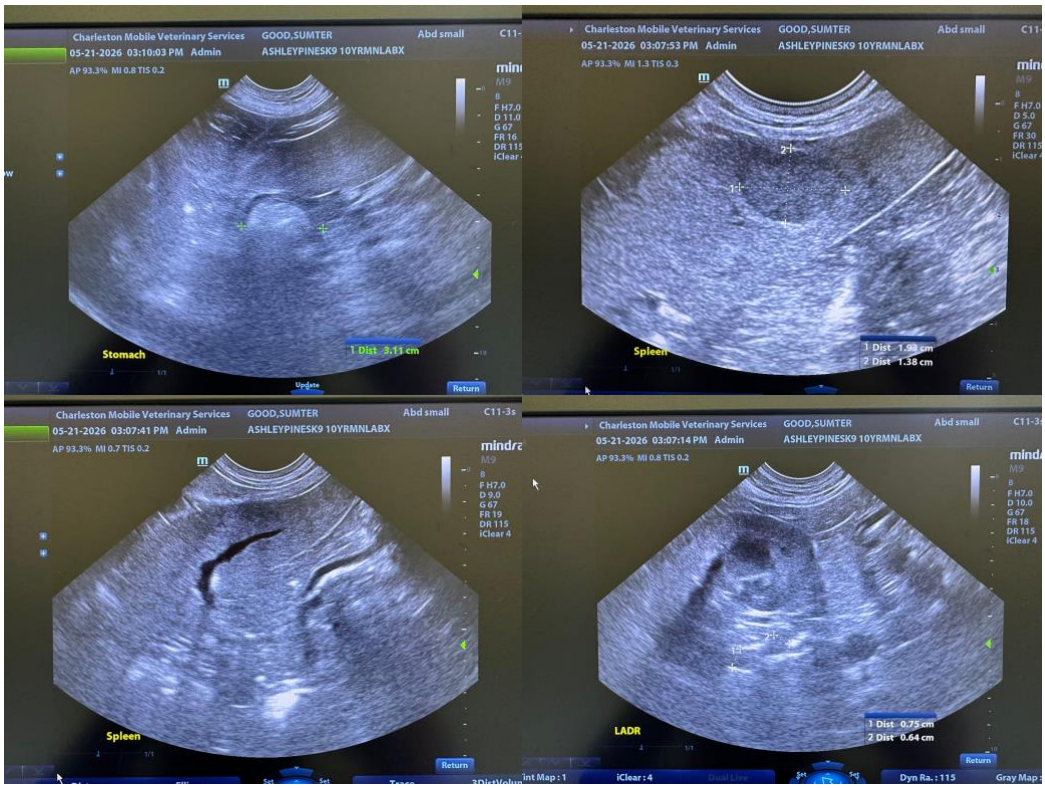

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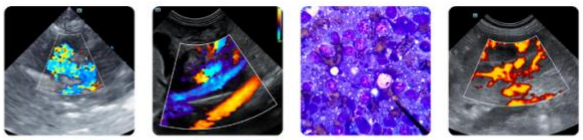

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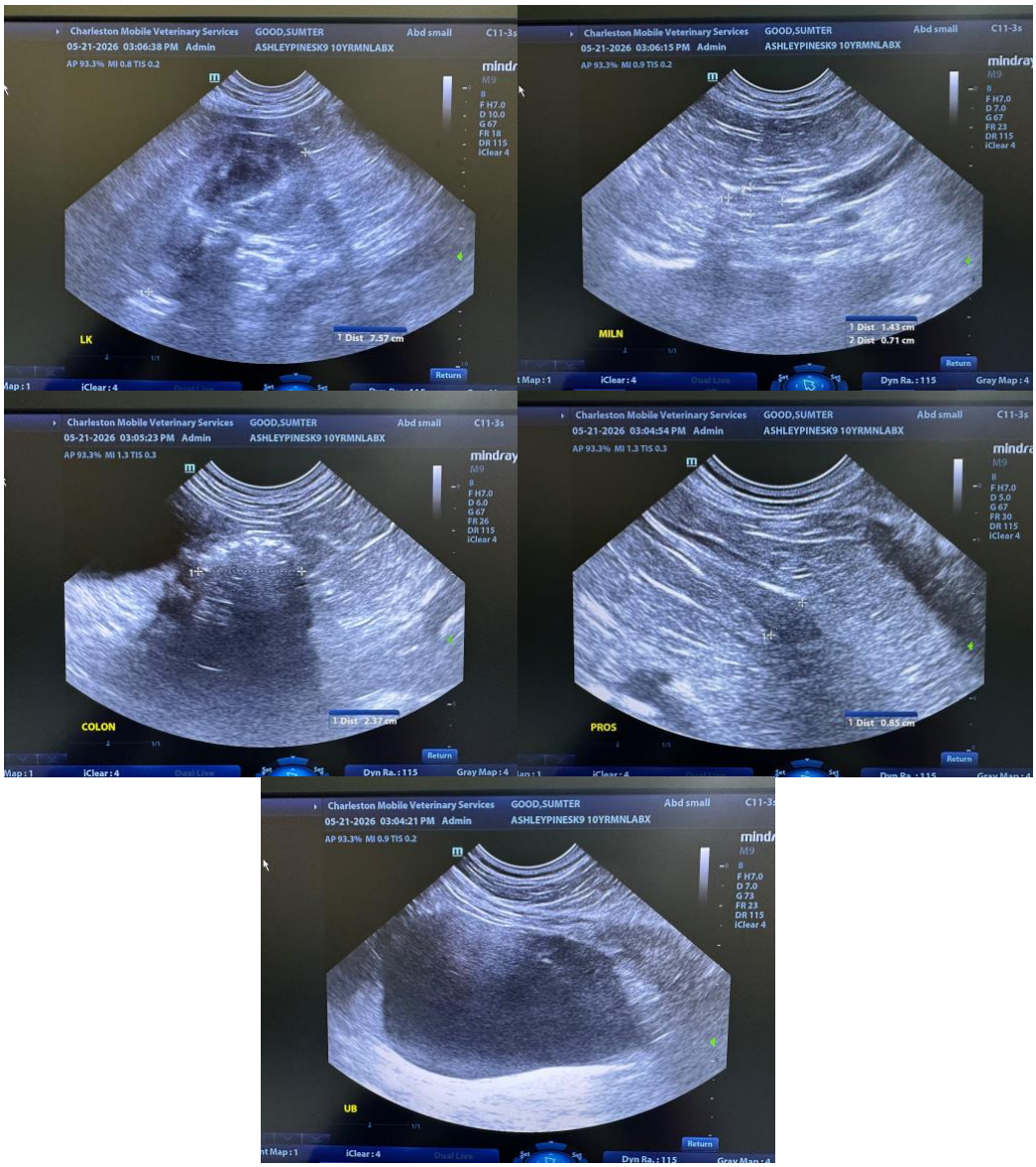


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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)
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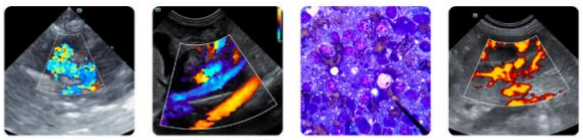

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