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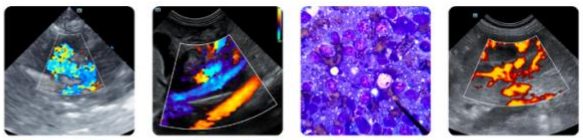

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Louie Spencer

SPECIES

Canine

BREED

Yorkshire Terrier

SEX

Neutered Male

AGE

10

WEIGHT

5.2

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

Meadowlawn Loris

REFERRING VET

Dr Phillip Graham

INVOICE

23053

DATE

5-22-26

PRESENTING CLINICAL SIGNS

Patient has had a couple-month-history of weight loss and a low albumin. Did recently change the diet from a chicken-based diet to lamb and rice. Had vomiting and diarrhea yesterday, but has not been a long-standing issue for the patient. Had a similar episode of weight loss a few years ago which was worked up in Wilmington. Ultrasound at that time was unremarkable per owner. Currently, the albumin is 2.3. CBC reveals a thrombocytosis and monocytosis. T4 1.0. 4dx negative.

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 normal in size (0.74 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 (3.09 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. Several small, nonobstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (3.51 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. A few small, nonobstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.44 cm at cranial pole) (0.47 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 (0.48 cm at cranial pole) (0.42 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 overall normal in size (0.77 cm in width at the level of the hilus). A 1.20 x 0.74 cm hypoechoic- to slightly heterogenous, mildly expansile nodule is observed approximately mid-body. The remaining parenchyma is homogenous. Splenic vasculature is normal with no evidence of thrombosis.

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

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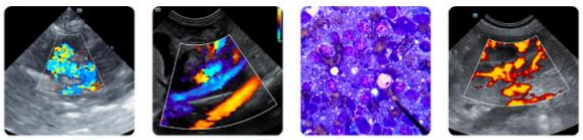

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Gastrointestinal
The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal 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.

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

Lymph Nodes
The abdominal lymph nodes are normal/not visible.

Free Abdomen
The peritoneal cavity is normal. There is no evidence of inflammation or effusion.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

The splenic nodule could be consistent with an emerging tumor (i.e., round cell, sarcoma) or a benign focus (i.e., lymphoid hyperplasia or similar).

Secondary Findings

Minor bilateral nonspecific age-related renal changes with nonobstructive nephrocalcinosis

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the GI changes, consider the following:

  1. Texas GI panel including serum cobalamin, folate, PLI, TLI and resting cortisol level
  2. A fecal evaluation for ova/Giardia
  3. Prophylactic deworming with fenbendazole.
  4. A 3-4-week hypoallergenic or hydrolyzed protein diet trial
  5. Also consider initiating a probiotic with a high colony count +/- fiber supplement (i.e., psyllium).
  6. Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be warranted.
  7. Three-view thoracic radiographs should be performed prior to any anesthetic event.

- Regarding the splenic nodule, fine-needle aspiration would be difficult due to its subcostal location. If a conservative approach is desired, consider a recheck ultrasound in 1-2 months to assess for growth. Alternatively, a splenectomy with submission of the spleen for histopathology can be considered. If pursued, GI biopsies should also be obtained at the time of surgery.

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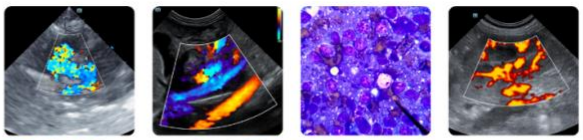

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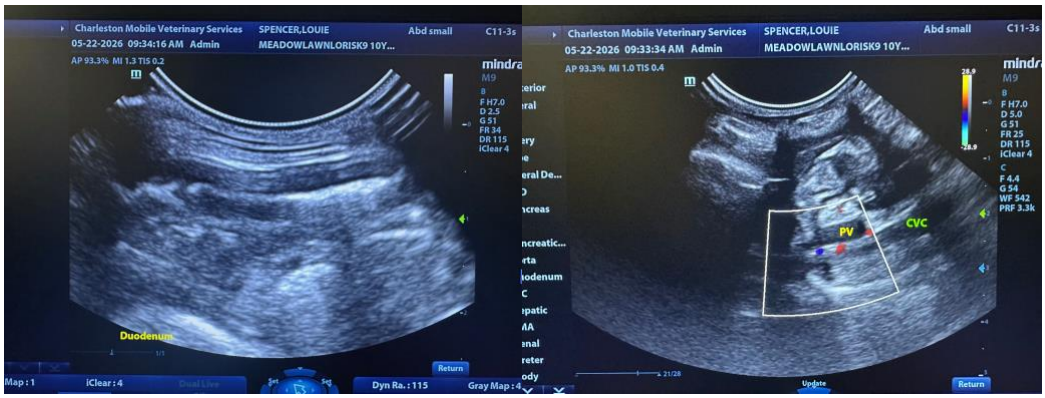

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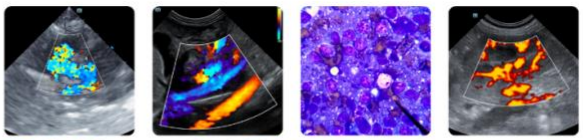

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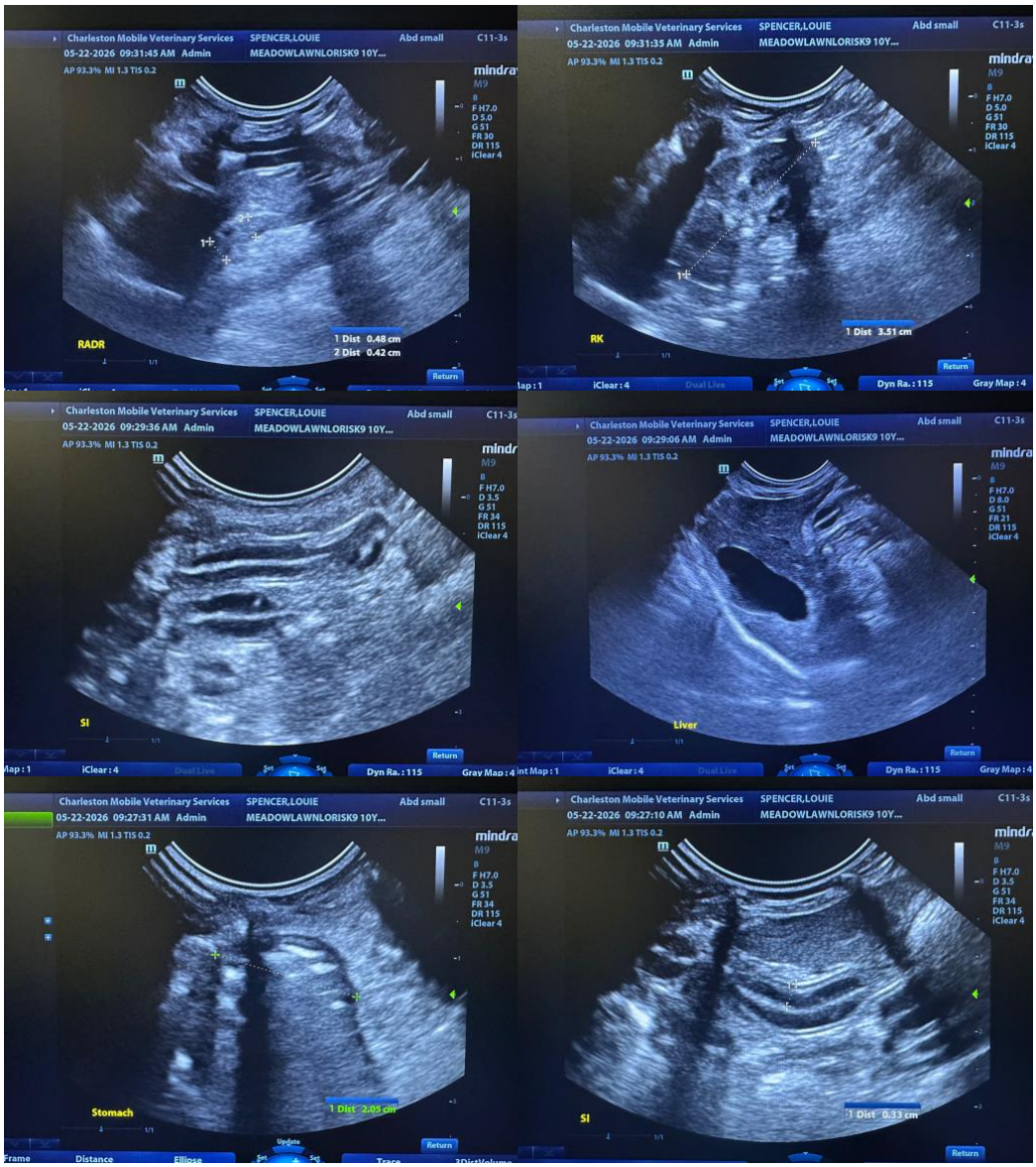

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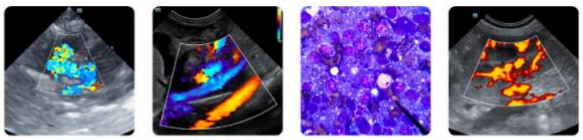

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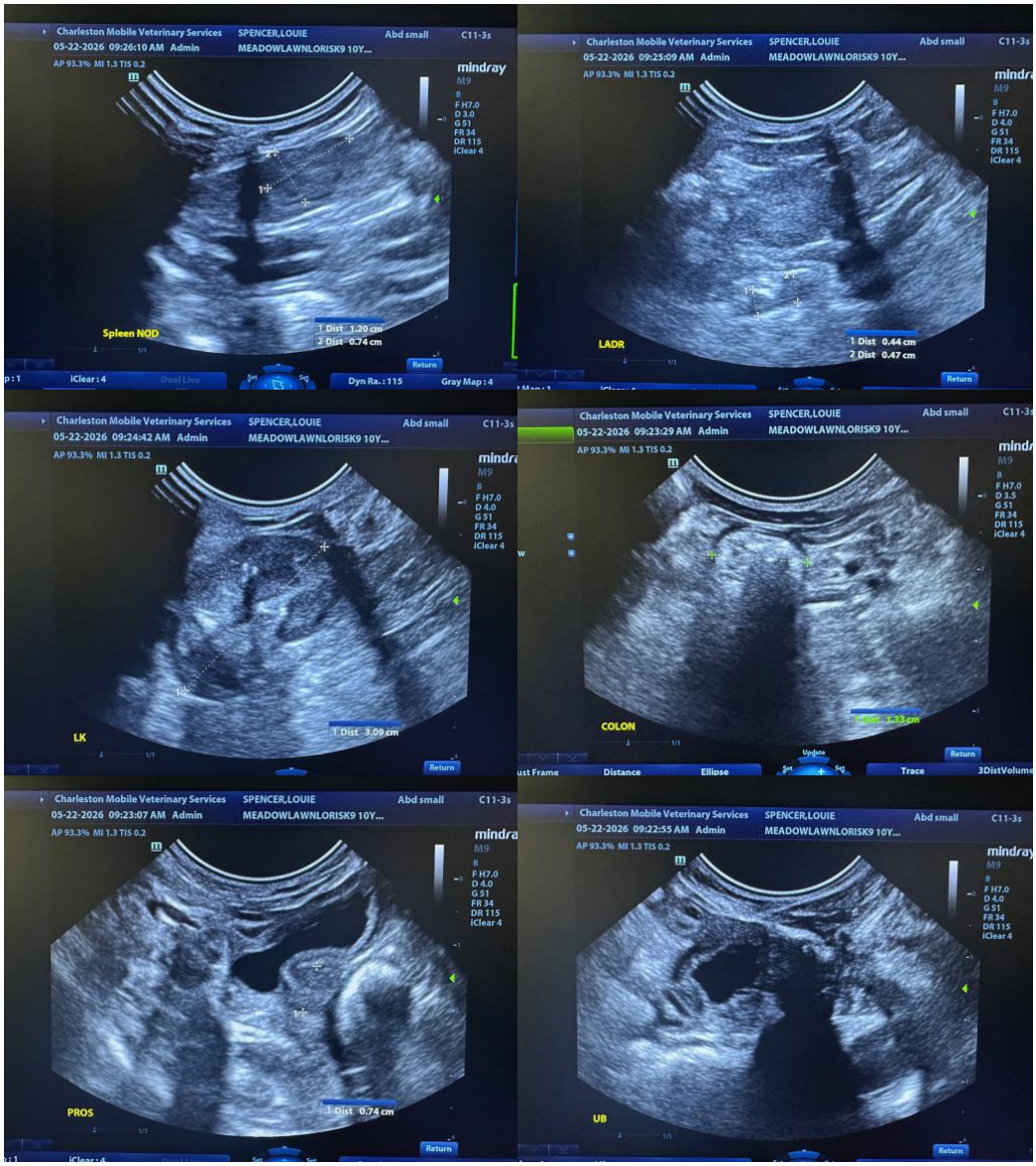

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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