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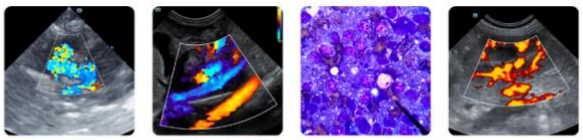

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Leroy Tremont

SPECIES

Canine

BREED

Maltese

SEX

Male Neutered

AGE

5

WEIGHT

3.15 kg

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

BluePearl MP ER

REFERRING VET

Dr Danielle Fraser

INVOICE

22963

DATE

5-3-26

PRESENTING CLINICAL SIGNS

Patient has had a week-long-history of diarrhea, which became bloody mid-week. Initiatially went to VEG. Was treated symptomatically and improved, but symptoms recurred after her went home. Initial bloodwork revealed a high hematocrit. Amylase and Lipase also high. Repeat bloodwork yesterday unremarkable. Fecal negative. Has had two prior episodes of diarrhea in the past year. Previous fecals also negative.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is mildly 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 cm, are normal.

The prostate is normal in size (0.52 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 (2.98 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. A few small, nonobstructive mineralized foci are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (3.47 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. A few 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 (0.41 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.

The right adrenal gland is normal in size (0.40 cm at cranial pole) (0.40 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 (0.89 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A 0.96 x 0.66 cm hypoechoic nodule is observed in the mid- to caudal aspect. 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. A moderate amount of suspended echogenic debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

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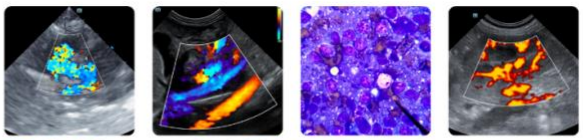

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Gastrointestinal

The gastric lumen is not distended. The gastric wall 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 ileocecocolic junction and colonic wall are normal. The lumen of the descending colon contains some nonformed fecal material. There is no obvious evidence of an obstructive pattern.

Pancreas

The pancreas is diffusely visible, with minimal deviation from the normal peripheral contours. The parenchyma is slightly hypoechoic relative to surrounding omental fat. The pancreatic duct is not overtly dilated. The mesentery effacing the serosal surface is subtly hyperechoic.

Lymph Nodes

A 0.83 x 0.48 cm lymph node is observed in the left- mid- to caudal aspect. One- to two prominent mesenteric lymph nodes are also seen (one measuring 1.82 x 0.48 cm).

Free Abdomen

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

Other

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Equivocal pancreatitis
- Splenic nodule. Considerations include an emerging tumor (i.e., round cell, sarcoma) or a benign focus (i.e., lymphoid hyperplasia).

Secondary Findings

- Bilateral nonobstructive nephrolithiasis
- Gall bladder sludge, non-mucocele
- 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 clinical signs is not definitively identified in this study. Considerations include dietary indiscretion, toxicity, food allergy/intolerance, infectious/parasitic disease, inflammatory bowel disease, underlying metabolic issue, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the GI signs, consider the following:

1. Consider a fecal PCR infectious disease panel (if not already performed).
2. Also consider prophylactic deworming with fenbendazole.

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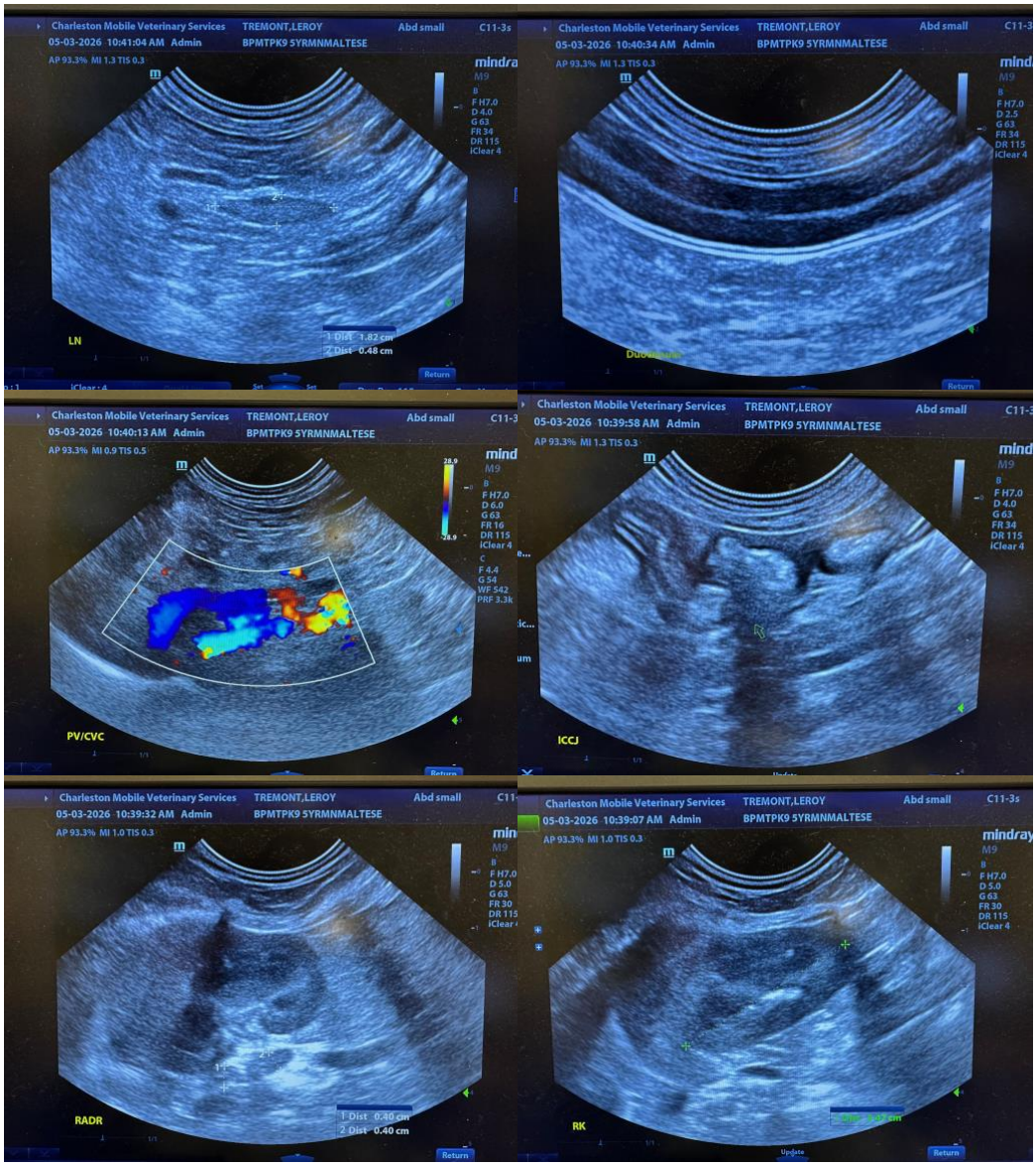
3. A GI panel including serum cobalamin and folate, TLI, PLI and resting cortisol level is also recommended.
4. Consider a three-to-four-week limited antigen or hydrolyzed protein diet trial (when the patient is eating again) to assess for food allergies.
5. Ultimately, endoscopic or surgical GI biopsies may be necessary to get a definitive diagnosis .

- Regarding the splenic nodule, consider fine-needle aspiration (assuming normal clotting status). A 25-gauge needle should be used. Alternatively, consider a recheck ultrasound in one- to two months to assess for growth of the lesion.



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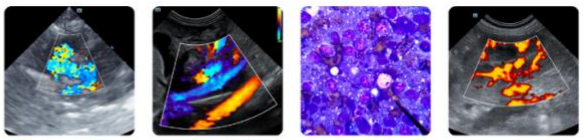

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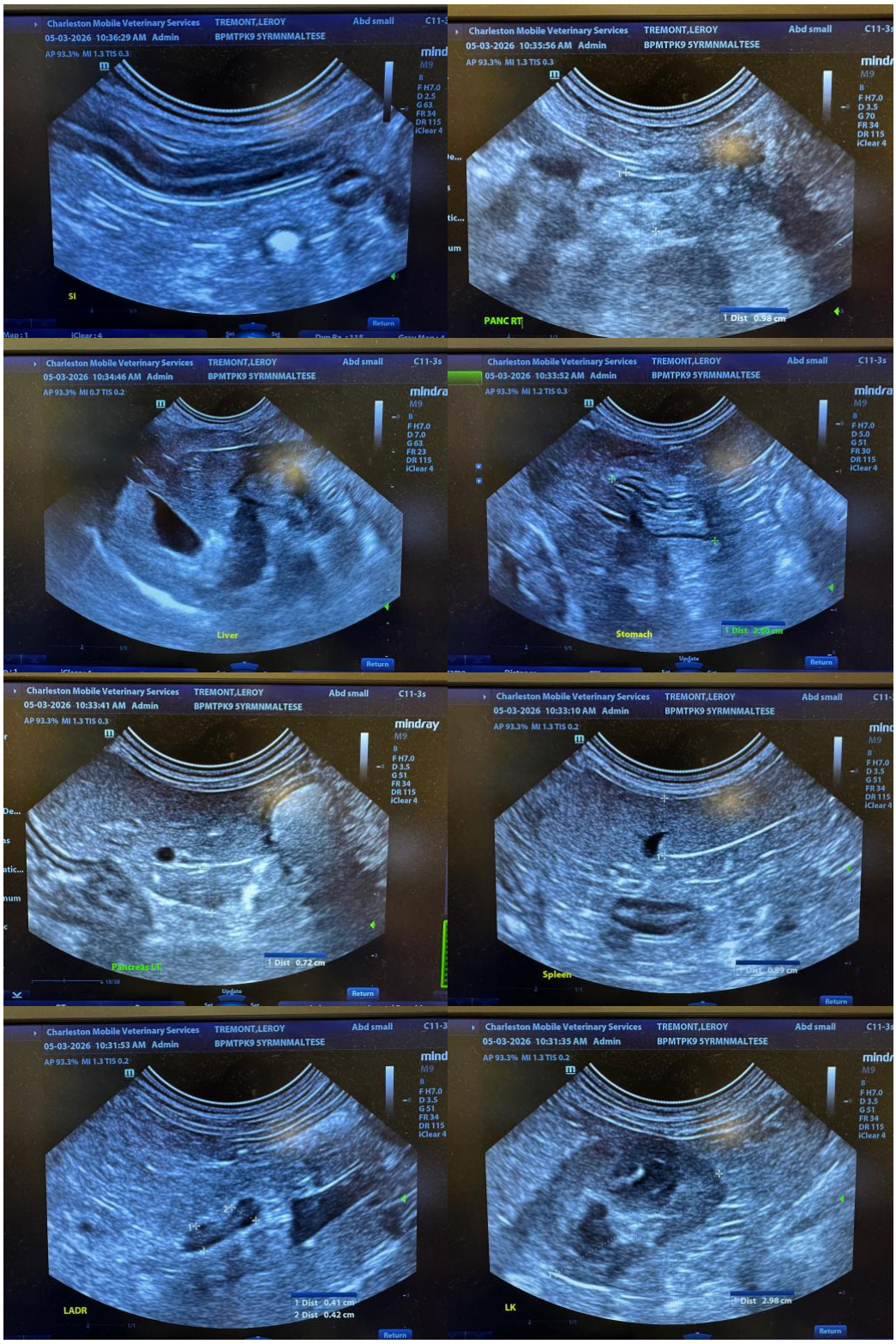

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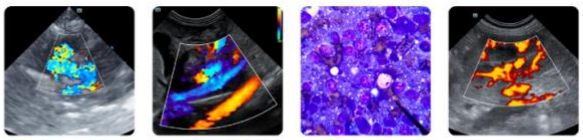

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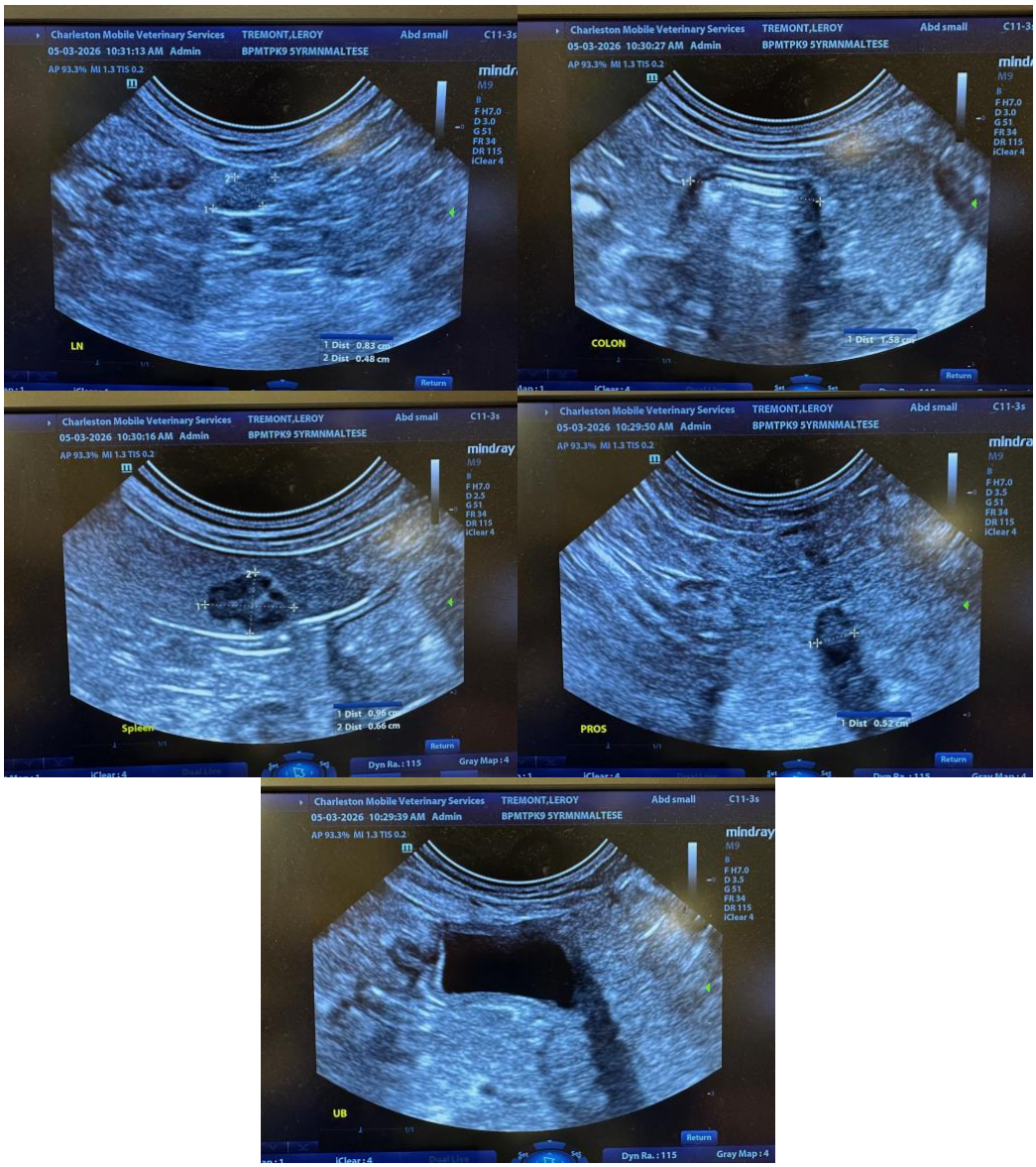

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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