



PATIENT PRESENTING CLINICAL SIGNS

Diamond Ross

History: Reason for imaging: Recent vomiting and inappetence. History: Seen 5/4/23 for vomiting. Started vomiting a couple days before hand and didn't want to eat. Vomiting after eating. Had not eaten the 2 days before appointment. Vomited in hospital. Treated with Cerenia, Famotidine, fluids. Lab work run see below. Ate the next day and then has not eaten now since 5/5/23. Lost 0.6# since 5/4/23. Very lethargic as well. Current medications: none

SPECIES

Canine

BREED

Pekingese Mix

Abnormal PE/Chem/CBC/UA Results: PE: BCS 4/9, 6-8% dehydrated, comfortable on abdominal palpation, new 4/6 left systolic HM, eupneic, severe dental tartar/gingivitis CBC/Chem/T4/UA/fecal 5/4/23 ALP high 602 GGT high at 18 Sodium high 157 Chloride high 124 PSL high 145 CPK low 43 White blood cell high 16.8 Neutrophils high 13,944 Monocytes high 1008 Thyroid low normal 0.8 Waiting on fecal and Unremarkable abdomen

SEX

Female Spayed

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.

AGE

13 years, 10 mos

The left kidney is normal in size (4.69 cm in length) with a normal shape, architecture and smooth peripheral margins. The cortex is isoechoic relative to the spleen. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

WEIGHT

17.8 lbs

The right kidney is normal in size (4.64 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.

INTERPRETED BY

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

Adrenal Glands

The left adrenal gland is normal in size (0.29 cranially, 0.38 cm caudally) 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.

IMAGING PERFORMED BY

Lucas Budden

The right adrenal gland is in normal size (0.53 cranially, 0.38 cm caudally) 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.

HOSPITAL NAME

Frontier VH

Spleen

The spleen is subjectively normal in size (0.73 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A few small hyperechoic nodules are visualized (the largest measuring 0.46 cm in diameter). One of the nodules at the lateral aspect causes slight capsular expansion. Splenic vasculature is normal.

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Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen. An approximately 3.80 cm hyperechoic-to-heterogenous mass is observed adjacent to the diaphragm. Intrahepatic biliary stones are present. Hepatic vasculature is of normal volume with no evidence of congestion.

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The gall bladder lumen is moderately distended. The wall is thin and smooth. A moderate amount of aggregated, echogenic debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

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Canine

Gastrointestinal

The gastric lumen is mildly fluid-distended. The gastric wall is normal to moderately thickened (up to 0.79 cm) with questionable retention of the normal layering pattern. The pyloric outflow tract appears patent. The small intestinal lumen is mildly fluid-distended. One bowel segment is mildly plicated. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecolic junction and colonic wall are normal. There is no obvious evidence of an obstructive pattern.

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Pekingese Mix

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.

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Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

AGE

13 years, 10 mos

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The gastric wall thickening could be consistent with gastritis or emerging neoplasia (i.e., lymphoma).
-
- The hepatic mass could be consistent with a regenerative nodule, emerging tumor, granuloma, inflammatory focus, other.

WEIGHT

17.8 lbs

Secondary Findings

- Intrahepatic biliary stones - incidental
- Bilateral chronic age-related renal changes
- The hyperechoic splenic nodules trend toward the benign (i.e., myelolipomas) with a lower possibility a neoplastic process.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider a fine-needle aspirate of the thickened portion of gastric wall (if accessible and if clotting status is appropriate). A 25-gauge needle should be used. If the cytology results are inconclusive or if the area is inaccessible, symptomatic care for acute gastroenteritis is recommended along with a fecal evaluation for ova and Giardia, +/- a malabsorption panel, including serum cobalamin and folate, TLI and PLI.
- Three-view thoracic radiographs are also recommended to assess for occult esophageal disease and aspiration pneumonia.
- Continued symptomatic care is recommended. If the above diagnostics are inconclusive or if the patient does not improve with supportive care, endoscopic or surgical GI biopsies may be necessary to get a definitive diagnosis.

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- Regarding the hepatic mass, consider a fine-needle aspirate or biopsies. If tissue sampling is not pursued at this time, consider a recheck ultrasound in 4-6 weeks to assess for growth.

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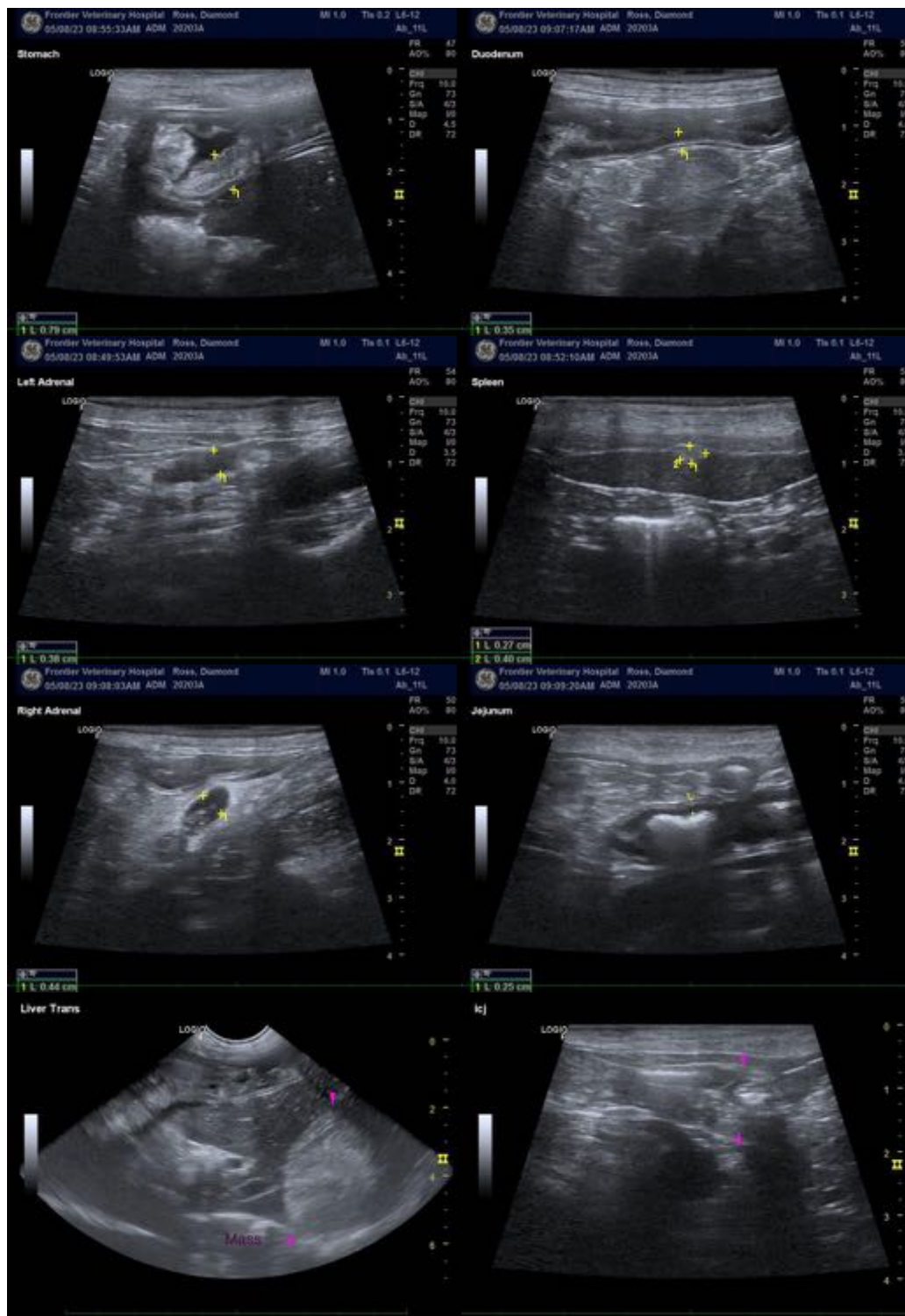
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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.

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