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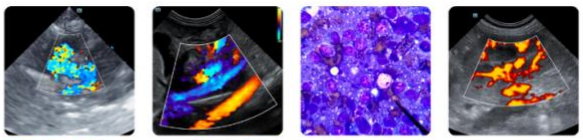

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Jona Mingoia

SPECIES

Canine

BREED

Springer Spaniel

SEX

Neutered Male

AGE

01/15/2010

WEIGHT

54lbs

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

VCA Westbury AH

REFERRING VET

Jessica Cantrell

INVOICE

23219

DATE

6-18-26

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Anorexia, vomiting and diarrhea, weight loss - non-responsive to supportive care

Abnormal lab-work values:
Alk Phos 351H
PSL 160 H
T4 L 0.6
USPG 1.052, 3 + proteinuria and 2+ bilirubin, normal sediment

Current Medications: Cerenia, Sucralfate, Metronidazole, Proviable paste
Radiographic Findings: Normal abdomen

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 cm, are normal.

The prostate is normal in size (1.26 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 (6.31 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 (6.18 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 (1.05 cm at cranial pole) (0.71 cm at caudal pole) with a slightly irregular shape. A 1.71 x 0.8 cm hyperechoic nodule is observed at the cranial- to mid-aspect, with some extension into the caudal pole. The remaining glandular echogenicity and detail are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.88 cm at cranial pole) (0.61 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 (2.01 cm in width at the level of the hilus) with a normal capsular contour. The parenchyma is subtly mottled in appearance. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is normal- to prominent-in-size, with smooth peripheral contours. The parenchyma is isoechoic relative to the spleen, and subtly mottled in appearance. A 5.3 x 4.2 cm hyperechoic- to heterogenous mass is observed approximately mid-liver adjacent to the diaphragm. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is

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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.

Gastrointestinal

The gastric lumen is mildly distended with ingesta. 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 segment fluid-distended (mild). The duodenum is corrugated. The duodenal and jejunal walls are 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 ascending colon contains unformed fecal material. There is no obvious evidence of an obstructive pattern.

Pancreas

The base and limbs of the pancreas are visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Lymph Nodes

A 1.64 x 0.8 cm medial iliac lymph node is visualized. A few, enlarged, irregular, hypoechoic mesenteric lymph nodes are visualized (one measuring 2.6 x 1.3 cm). At least two of the nodes have cysts within the parenchyma.

Free Abdomen

There is no obvious evidence of free fluid.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Gastrointestinal ileus, the cause of which is unclear. Primary gastrointestinal (i.e., dietary indiscretion, toxicity, infectious/parasitic disease) and metabolic causes should be considered.
- The abdominal lymphadenopathy could be consistent with infiltrative neoplasia, lymphadenitis, or lymphoid hyperplasia.
- Liver mass. considerations include a large regenerative nodule, inflammatory focus, emerging tumor (i.e., adenoma, adenocarcinoma, round cell tumor, other).

Secondary Findings

- Mild bilateral nonspecific age-related renal changes
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The left adrenal nodule could be consistent with focal nodular hyperplasia, adenoma, emerging adenocarcinoma, pheochromocytoma, other.
- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or antigenic stimulation with a lower possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).

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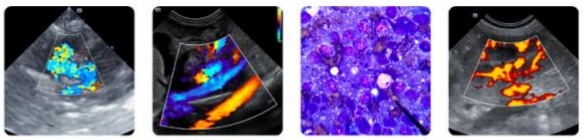

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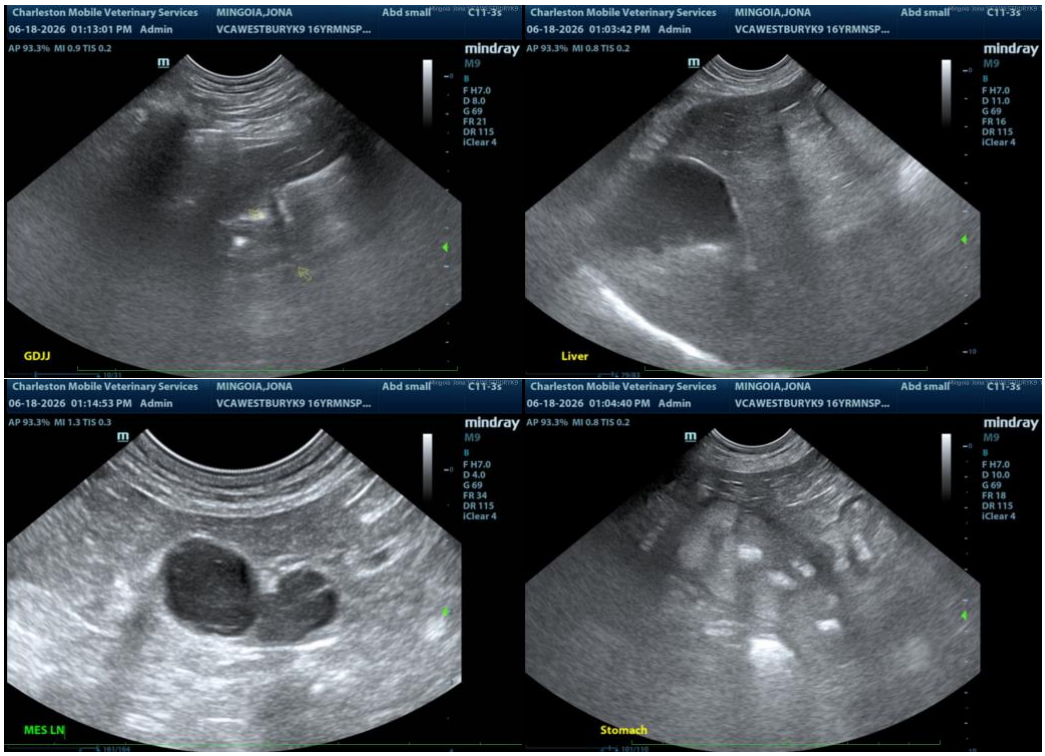
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the GI signs:

  1. Consider fine-needle aspiration of one of the enlarged mesenteric lymph nodes (assuming normal clotting status). A 25-gauge needle should be used.
  2. Also consider prophylactic deworming with fenbendazole.
  3. Supportive care for acute gastroenteritis should be continued.
  4. If clinical signs persist despite medical management, further GI work-up (i.e., GI panel, resting cortisol level, endoscopic or surgical GI biopsies) may be indicated.

- Regarding the liver mass consider the following:

  1. Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
  2. Excisional biopsy (once the patient's current clinical conditions has stabilized). An abdominal CT scan would be useful in presurgical planning. If surgery is not pursued, consider a recheck ultrasound in 2-3 months to assess for growth of the lesion.



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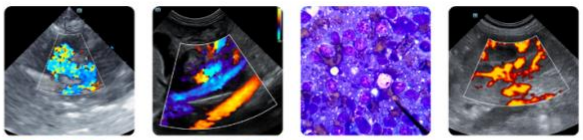

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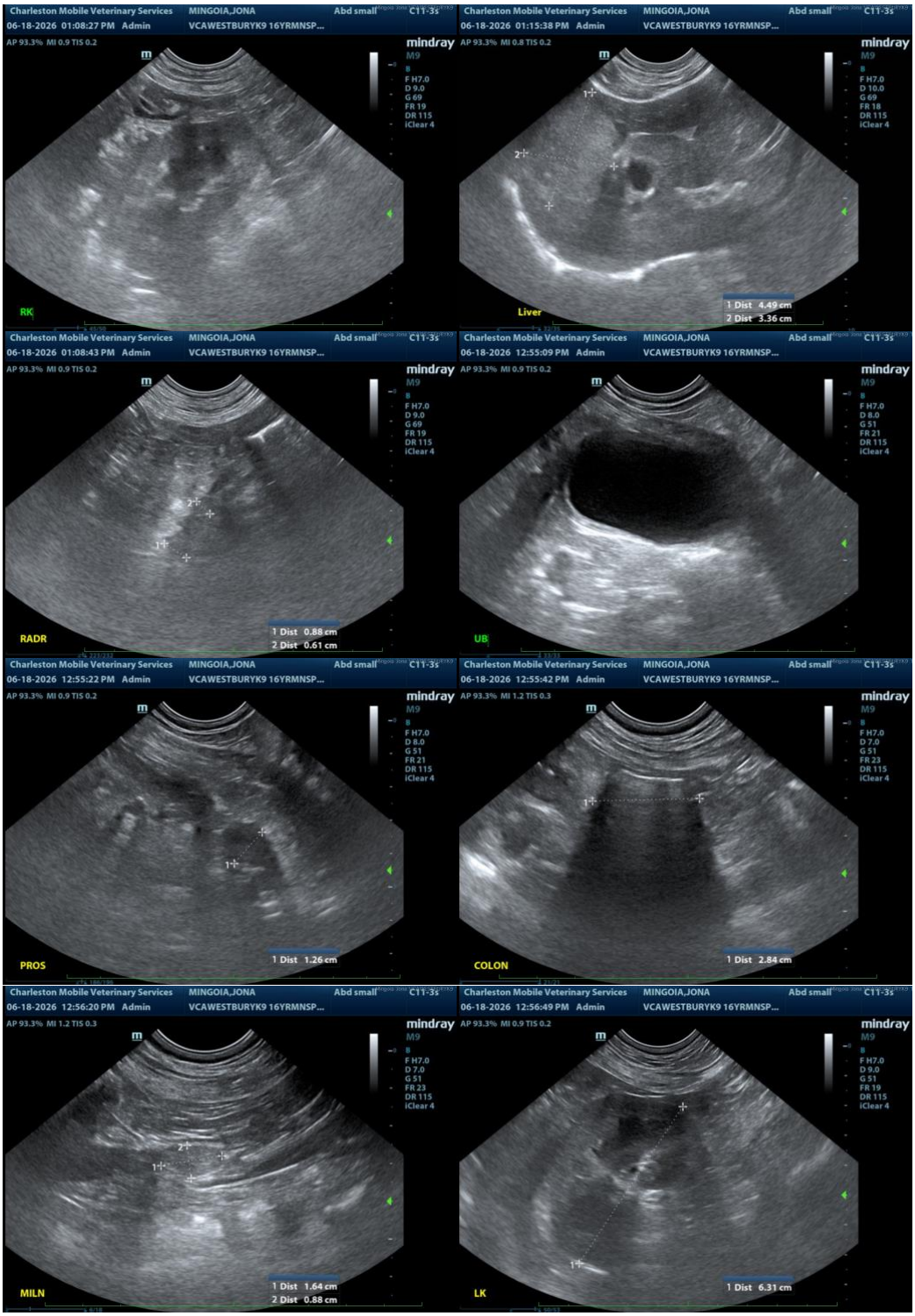

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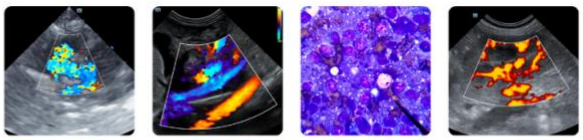

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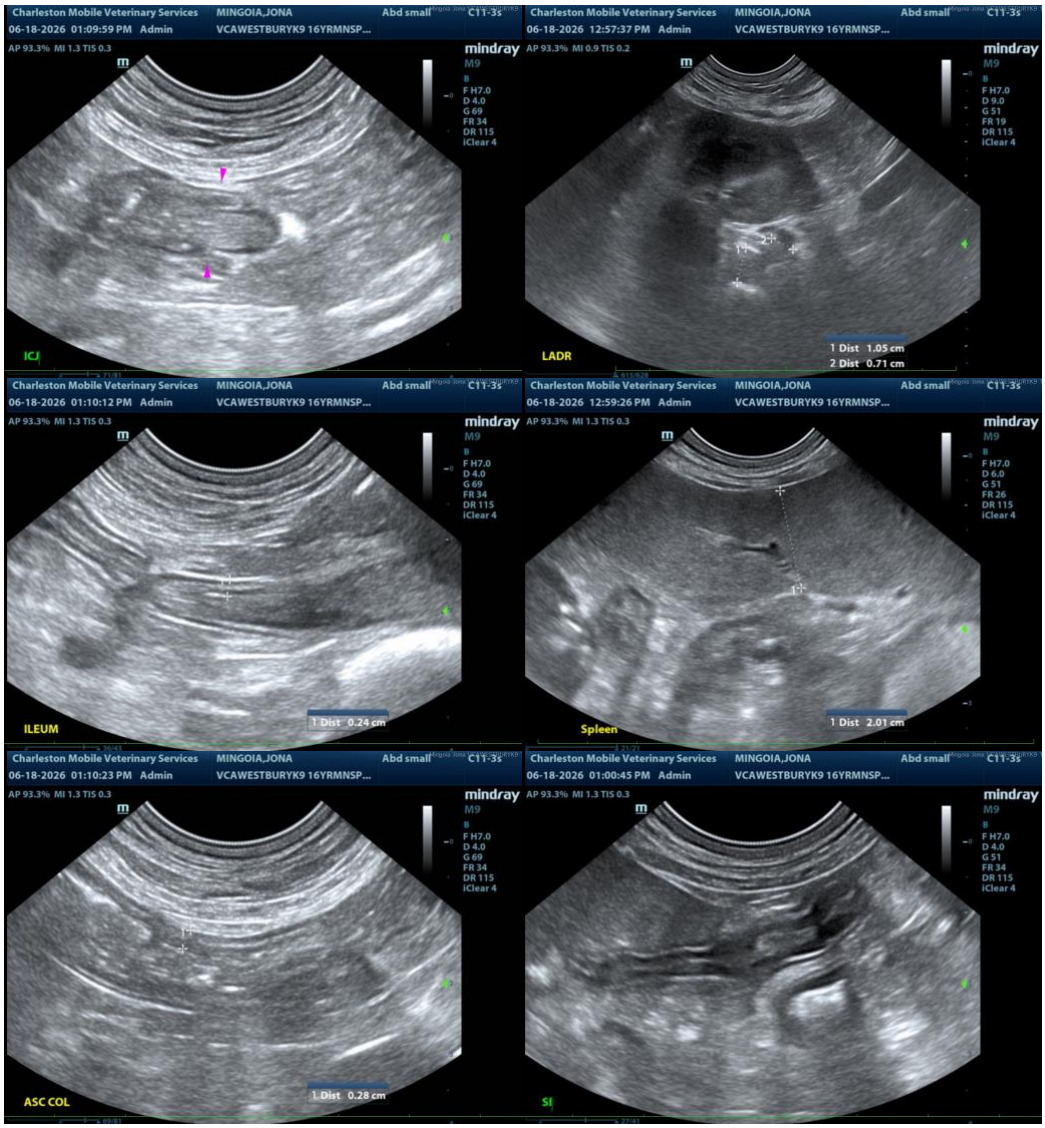

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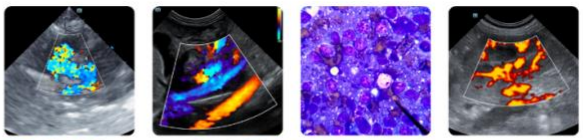

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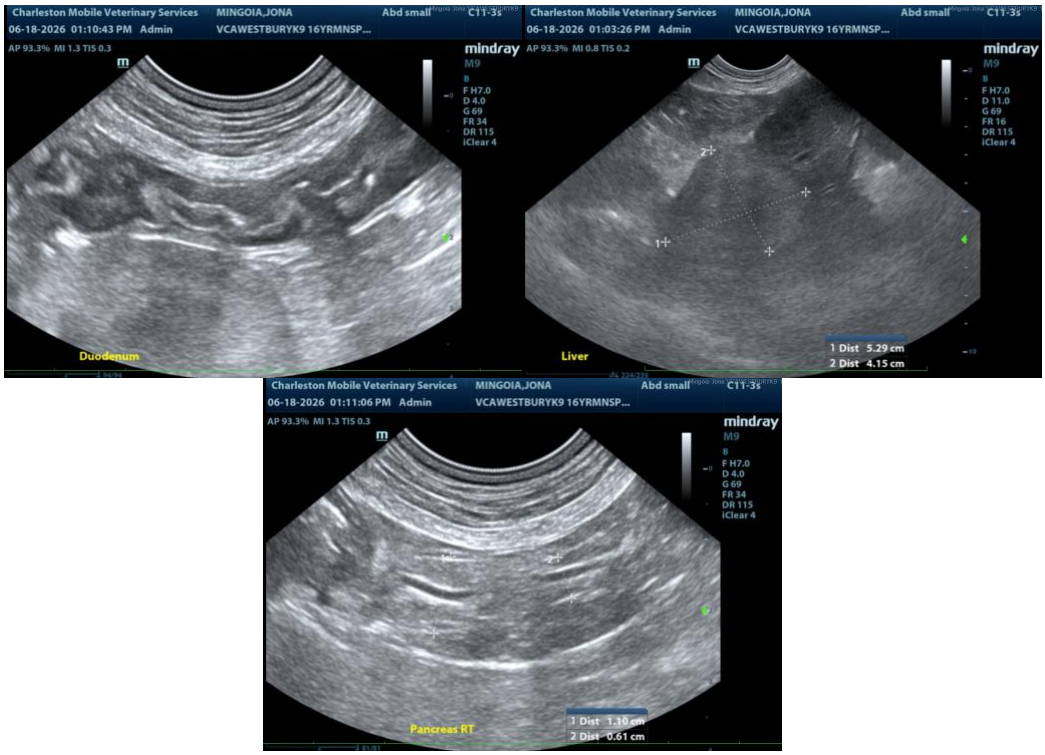

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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