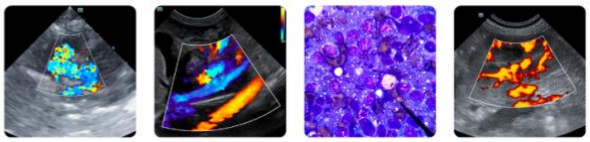


PATIENT

Tubby Miller

SPECIES

Canine

BREED

Labrador Retr

SEX

Neutered Male

AGE

11

WEIGHT

25.4 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Lindsay Powell, CVT

HOSPITAL NAME

Hershey AEC

REFERRING VET

Dr. Shally Gastelu

INVOICE

23111

DATE

6-2-26

PRESENTING CLINICAL SIGNS

History: Tubby 11y MN Choc lab presents 6/2 day as a transfer for pancreatitis management. Incidentally noted weight loss (8lbs 1yr). Went to rDVM this morning for acute lethargy, anorexia and vomiting, with one month history of pu/pd. Historic seizures, hypothyroid, elevated liver enzymes, and skin allergies. Managed with phenobarbital, thyrotabs, Denamarin, doxycycline and temaril P.

Abnormal PE/Chem/CBC/UA Results: PE: 6-8% dehydration, abdominal pain with cranial organomegaly, moderate cachexia, pendulous abdomen with prominent fat pads bilateral flank and base of tail, grade 2/6 heart murmur rDVM (Gettysburg Pike Animal Clinic) diagnostics 6/2: CBC: NSF; Hct 49.5 N, WBC 12.0 N, Lym 0.35 L, Mon 1.35 H, Plt 270 N Chem: Glu 309 H, Creat 0.4 L, ALT 1156 H, ALP --, GGT H, Lipase 1897 H, Cl 108 L Osm 308 N qPL: 558 H TT4: 1.2 N Phenobarb 11.5 N HAEC intake diagnostics 6/2: EPOC: pH 7.298 L, Bicarb 10.2 L, pCO2 20.9 L, BE -16.2 L, KCl 3.2 L, Glu 376 H PCV/TS: 53/7.6 ALP: 4,076 H BP: 143/93 (102) Ketones: 4.5 H UA - collection with ucath pending

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly- to moderately distended. The wall in the region of the apex is mildly- to moderately thickened (up to 0.62) with an irregular mucosal surface. The wall tapers to a normal thickness as it extends towards the cystourethral junction. A small- to moderate amount of echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone is prominent.

The prostate is normal in size (0.92 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 (7.48 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. A thin, hyperechoic medullary band is observed at the corticomedullary junction. Hyperechoic shadowing diverticular foci are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (7.78 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. A thin, hyperechoic medullary band is observed at the corticomedullary junction. Hyperechoic shadowing diverticular foci are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

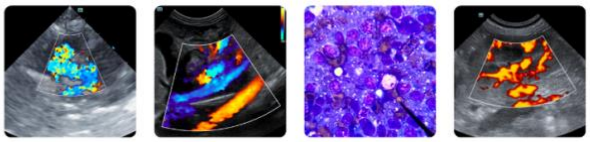
Adrenal Glands

The left adrenal gland is subjectively normal in length (0.37 cm at cranial pole) (0.39 cm at caudal pole) with a slightly flattened contour. Glandular echogenicity and detail are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.59 cm at cranial pole) (0.50 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 (2.08 cm in width at the level of the hilus) with a normal capsular contour. The parenchyma is subtly mottled in appearance. A 1.6 x 1.5 cm hypoechoic- to heterogenous, slightly expansile nodule is observed medially at the caudal aspect. Splenic vasculature is normal.



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Liver

The liver is subjectively enlarged, with smooth peripheral contours. The parenchyma is hyperechoic relative to the spleen, mottled, and attenuating. No focal lesions are observed. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The gallbladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. A few polypoid-like lesions are arising from the mucosal surface. No choleliths are observed. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is not distended. The gastric wall is normal in thickness with a normal layering pattern. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness with a normal layering pattern. There is evidence of mucosal striations in a few segments. Discreet masses are not identified. The colonic wall is normal. There is no obvious evidence of an obstructive pattern.

Pancreas

The base and limbs of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely hypoechoic 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

The abdominal lymph nodes are normal/not visible.

Free Abdomen

There is no obvious evidence of free fluid.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The hepatic changes are nonspecific and could be secondary to inflammatory disease (i.e., cholangiohepatitis, chronic hepatitis), Leptospirosis, hepatotoxicosis, infiltrative neoplasia (i.e., lymphoma), vacuolar hepatopathy, regenerative nodular hyperplasia, other hepatopathy, or some combination thereof.
- Gallbladder debris, non-mucocele
- The pancreatic changes could suggest mild acute or chronic pancreatitis with parenchymal remodeling.
- The splenic nodule is concerning for a neoplastic process (i.e., round cell tumor, sarcoma). However, a focal benign lesion (i.e., lymphoid hyperplasia) cannot be excluded. The diffuse 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).
- The small intestinal mucosal striations are suggestive of lymphangiectasia. However, correlation with the patient's clinical history is recommended.
- The prominent trigone may be a normal variant for this patient or could represent focal inflammation or emerging neoplasia. The urinary bladder wall changes in the region of the apex are suggestive of cystitis.

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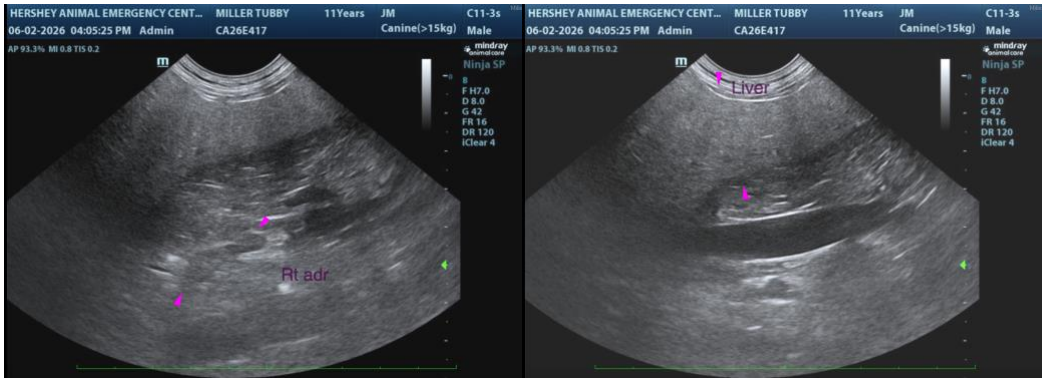
- The bilateral renal changes are most consistent with a diabetic nephropathy with subtle dystrophic mineralization.
- The flattened left adrenal gland may be a normal variant for this patient or may be secondary to atrophy resulting from corticosteroid use.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A urine culture and sensitivity is recommended to assess for occult infection, particularly given the patient's new diabetic status.
- Consider Leptospirosis testing (i.e., blood and urine PCR, serology), particularly if the clinical suspicion for disease is high.
- Regarding the hepatic changes, consider hepatic tissue sampling (i.e., aspirates or biopsies) assuming normal clotting status. If biopsies are pursued, aerobic and anaerobic bile cultures and hepatic copper quantitation should also be performed
- If a conservative approach is desired, consider empirical treatment for bacterial cholangiohepatitis/ Leptospirosis (amoxicillin-clavulanic acid, Denamarin). If no improvement in the liver values is seen within 7-10 days of initiating therapy, antibiotics should be discontinued, and hepatic tissue sampling reconsidered. If liver values improve, continue therapy for at least 4-6 weeks and 1 week beyond normalization of the liver values.
- Given the patient's age, three-view thoracic radiographs are recommended to address cardiopulmonary status (if not already performed).
- While awaiting test results, supportive care for diabetic ketoacidosis is recommended.
- Regarding the splenic nodule, consider fine-needle aspiration (assuming normal clotting status). A 25-gauge needle should be used. Depending on the results, a splenectomy may be warranted.
- Regarding the region of the trigone, consider a recheck ultrasound in 4-6 weeks to assess for changes. Ultimately, a urine BRAF test may be recommended to further evaluate for lower urinary tract neoplasia.



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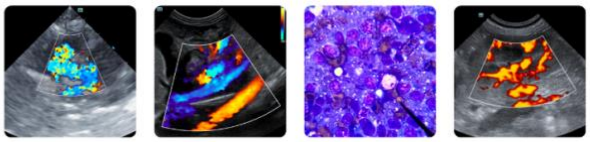

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Educational Teleconsultation Services™

SonoPath.com info@sonopath.com 1.800.838.4268

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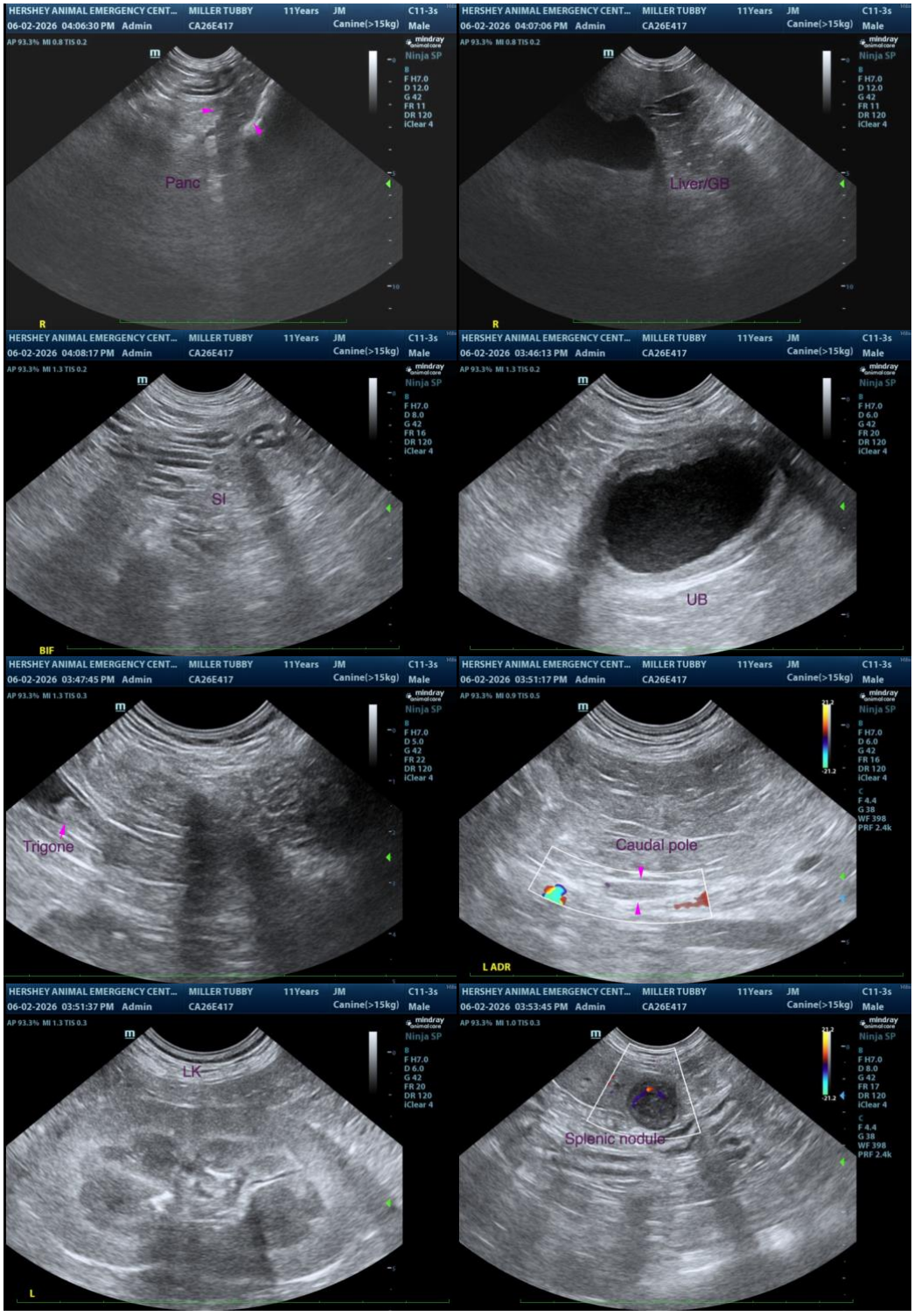

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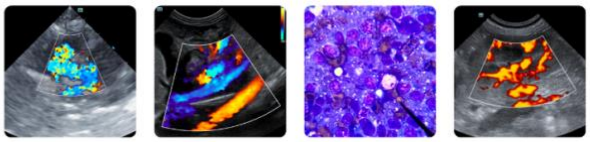

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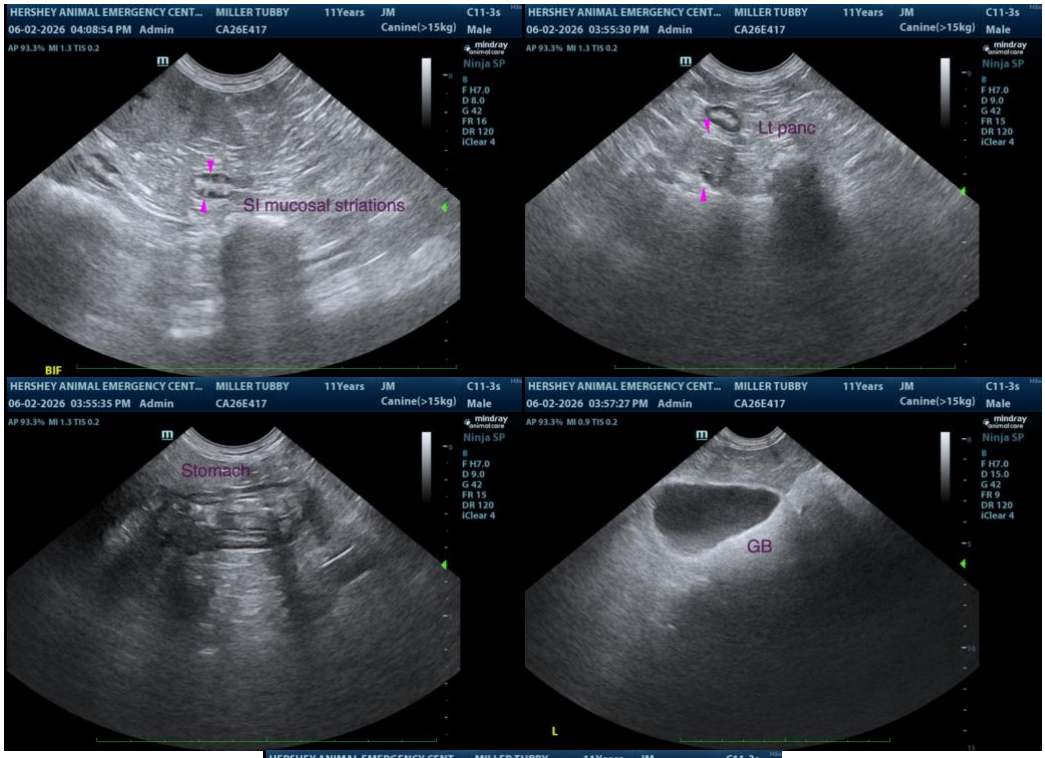

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com