



PATIENT PRESENTING CLINICAL SIGNS

PATIENT
Spiro Posavec
History: Presented at our hospital for bloated abdomen, pacing, panting, whining, retching, started 30 min ago Previous Health Concerns: heart murmur, arthritis Current Medications: 2-week trial of anti-inflammatory Appetite/When did they eat last: good, tonight; owner fed grease from fish fry to dog.

SPECIES

Canine

BREED

Chihuahua X

SEX

Neutered Male

AGE

13 years

WEIGHT

537 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Erin Wicks

HOSPITAL NAME

Shores VEC

REFERRING VET

Dr Miller

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13440

DATE

6.22.23

Abnormal PE/Chem/CBC/UA Results: Cardiovascular: 2/6 murmur Abdominal: stomach large and distended with gas Rads: severely distended stomach with gas with ingesta at the pylorus; gas in the small bowel CBC: nr Chem: bun 33.9 alt 201 alp 195 GGT 15 lipase 271 Epcoc: lactate 4.59 bun 34 glucose 198 ph 7.33

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. Luminal contents are mostly anechoic. No cystic calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The prostate is normal in size (0.57 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 (3.88 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. Moderate pyelectasia is present (0.32 cm in the transverse plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (3.63 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild loss of corticomedullary distinction. Pinpoint mineralized foci are observed within the cortex. Several hyperechoic shadowing diverticular foci are observed. Moderate pyelectasia is present (0.30 cm in the longitudinal plane). There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is enlarged (1.33 cm at cranial pole) (0.77 cm at caudal pole) (2.58 cm in length) with an irregular shape. A 1.30 x 1.13 hyperechoic-to-heterogenous nodule is observed at the cranial pole. Glandular echogenicity and detail at the caudal pole are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.77 cm at cranial pole) (0.43 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 (0.66 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature appears normal.

Liver

The liver is subjectively prominent in size with slightly swollen peripheral contours. The parenchyma is hypoechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are 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, suspended sludge in a partially stellate pattern is observed within the lumen. The cystic and common bile ducts are normal/not seen.

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Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. 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 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.

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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. A 1.31 x 0.40 cm left medial iliac lymph node is visualized. The node is normal in shape and echogenicity.

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ULTRASONOGRAPHIC FINDINGS

Primary Findings

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- The gallbladder changes are consistent with an emerging mucocele.
- The left adrenal nodule could be consistent with an adenoma, adenocarcinoma, pheochromocytoma, macronodular hyperplasia, other.

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Secondary Findings

- Bilateral chronic renal changes with right dystrophic mineralization. The bilateral pyelectasia may be secondary to pyelonephritis, parenchymal remodeling, PU/PD (if applicable) or some combination thereof.
- The prominent medial iliac lymph node likely represents reactive change.
- The prominent liver may be a normal variant for this patient or may represent early vacuolar hepatopathy, inflammatory disease (i.e., bacterial cholangiohepatitis, chronic hepatitis), hepatotoxicosis (i.e., copper), Leptospirosis, infiltrative neoplasia (unlikely), other hepatopathy.

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*An obvious cause for the patient's abdominal distention and discomfort is not definitively identified in this study. Considerations include abdominal pain (i.e., secondary to cholecystitis, pyelonephritis, microscopic gastrointestinal disease, other), orthopedic or neurologic disease, other.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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- Orthopedic and neurologic examinations are recommended to assess for nonmetabolic causes of pain.
- Other considerations include the following:

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1. Urine culture and sensitivity to assess for pyelonephritis



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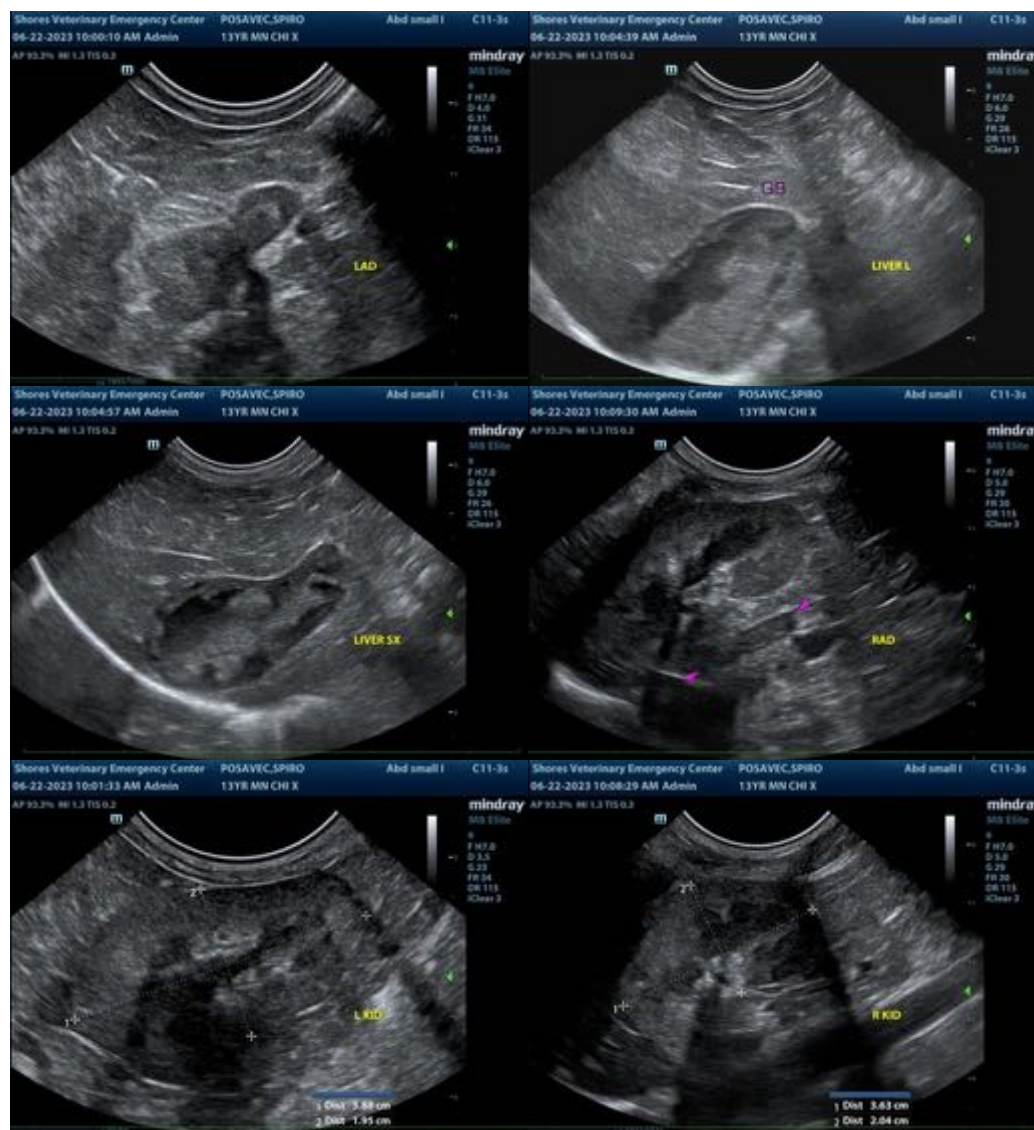
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2. Initiation of broad-spectrum antibiotic therapy as empirical treatment for cholecystitis. In addition, initiation of Ursodiol is recommended with serial sonographic monitoring (i.e., every 4-6 weeks) of the gallbladder to assess for progression to a fully-formed mucocele.
3. A cPLI +/- full GI panel including serum cobalamin and folate, TLI and PLI
4. Three-view thoracic radiographs to assess for occult disease in the chest.
5. While awaiting test results, symptomatic care, including pain management is recommended.



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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.



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