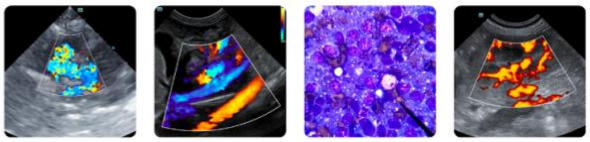


PATIENT

Ella Schuster

SPECIES

Canine

BREED

Pomeranian Mix

SEX

Female Spayed

AGE

16

WEIGHT

13 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Magguilli

HOSPITAL NAME

Willamette VH

REFERRING VET

Tessa Magguilli

INVOICE

23131

DATE

6-5-26

PRESENTING CLINICAL SIGNS

History: Presents for 2 week history of hyporexia, 2 episodes of vomiting during this period of time, started on omeprazole on 6/1, started mirtazapine and Entyce, medium efficacy, bloodwork 2 weeks prior (sr screen) demonstrated mild azotemia, USG 1.020, ALT elevation at 208 (chronic for over 1 year), currently being managed on (stopped NSAID Carprofen) ondansetron, keppra, gabapentin PRN, and holistic veterinarian prescribed-herbs for pancreatitis, pain, and cardiac, recently added an appetite stimulant.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly distended with anechoic urine. The wall is variably thickened (up to 0.44 cm) with an irregular mucosal surface. No cystic calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The left 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 mild loss of corticomedullary distinction. Pinpoint mineralized foci are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (3.85 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 1.6 x 1.4 cm cystic, heterogenous lesion is observed within the parenchyma. Pinpoint mineralized foci are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The region of the adrenal glands is evaluated. No obvious pathology is observed in this region.

Spleen

The spleen is normal in size (1.35 cm in width at the level of the hilus) with a normal capsular contour. The parenchyma is slightly 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 to slightly hypoechoic relative to the spleen, and diffusely mottled and heterogenous in appearance. No distinct focal lesions are observed. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

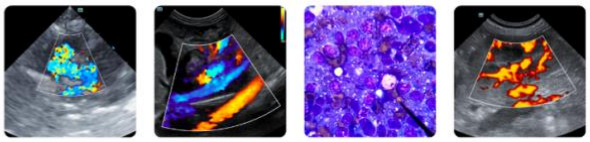
The gallbladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. The cystic and common bile ducts are normal/not seen.

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 and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

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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Lymph Nodes
The abdominal lymph nodes are normal/not visible.

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

ULTRASONOGRAPHIC FINDINGS

- The hepatic changes are nonspecific and could be secondary to inflammatory disease (i.e., cholangiohepatitis, chronic hepatitis), hepatotoxicosis, infiltrative neoplasia (i.e., lymphoma), vacuolar hepatopathy, regenerative nodular hyperplasia, other hepatopathy, or some combination thereof.

- The right cystic renal lesion could be consistent with a complex cyst or an emerging tumor (i.e., hemangiosarcoma, adenocarcinoma, other). Mild bilateral nonspecific age-related renal changes

- 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).

- The urinary bladder wall changes may be artifactual due to lack of full repletion or could be secondary to cystitis. Correlation with the patient's clinical history is recommended.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the azotemia, consider the following:

  1. Urinalysis with culture and sensitivity
  2. UPC if proteinuria is present in the absence of infection
  3. Baseline blood pressure measurement
  4. Transition to a prescription renal diet (if the patient will tolerate it)
  5. Serial monitoring of the patient's renal values to assess progression of the azotemia

- Regarding the hepatic parenchymal changes, tissue sampling (i.e., aspirates or biopsies) would be necessary to get a definitive diagnosis. Laparoscopic or surgical liver biopsies would be ideal. Clotting times and thoracic radiographs should be performed prior to anesthesia. If a conservative approach is desired, consider empirical treatment for bacterial cholangiohepatitis (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.

- Regarding the right renal lesion, if an aggressive approach is desired, consider an abdominal CT scan for further evaluation. Alternatively, bx of the lesion can be considered. If a more conservative approach is desired, consider a recheck ultrasound in 4-6 weeks to assess for growth of the lesion.

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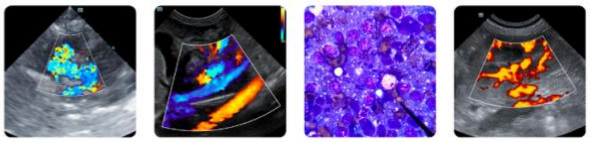

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Educational Teleconsultation Services™

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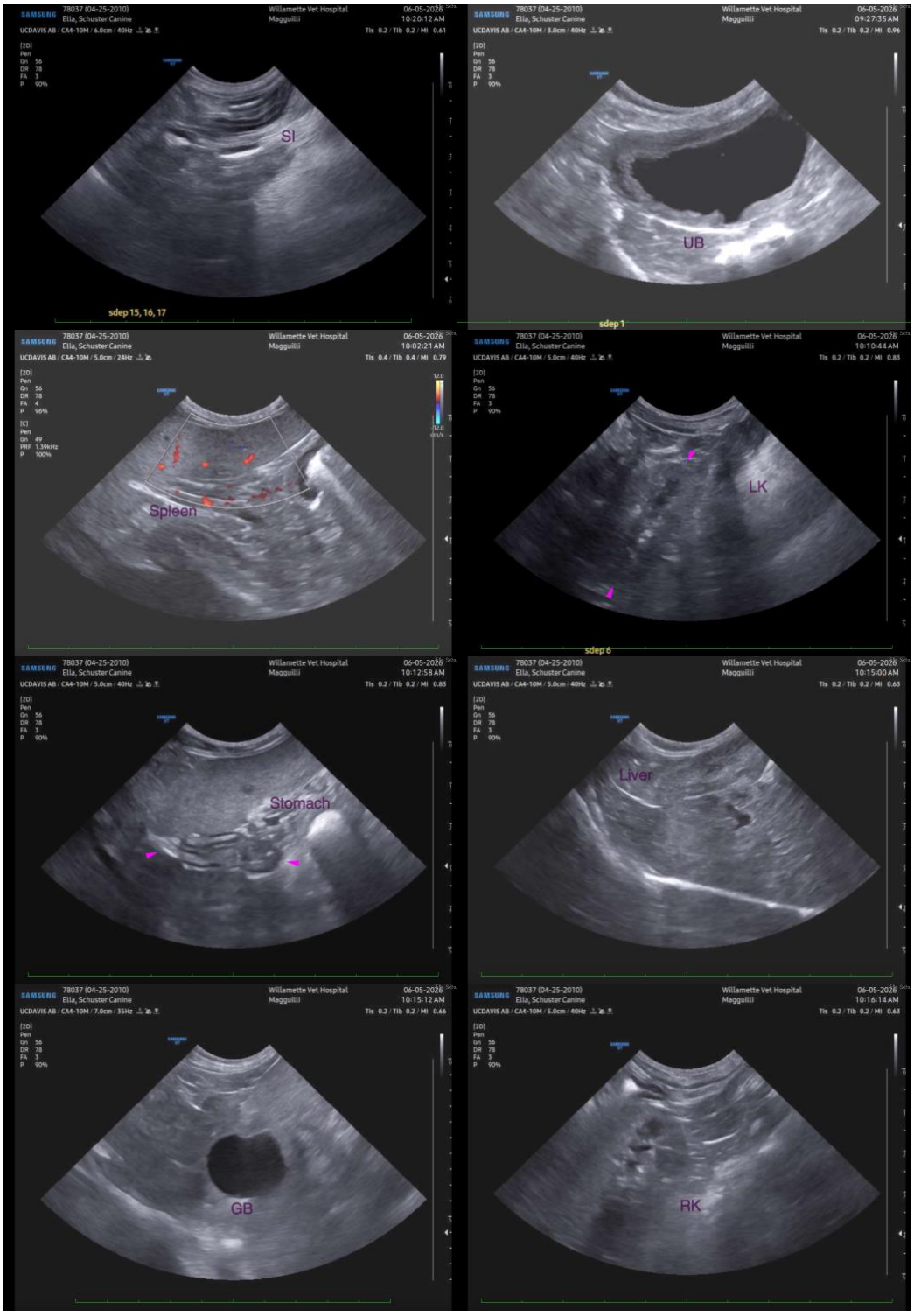

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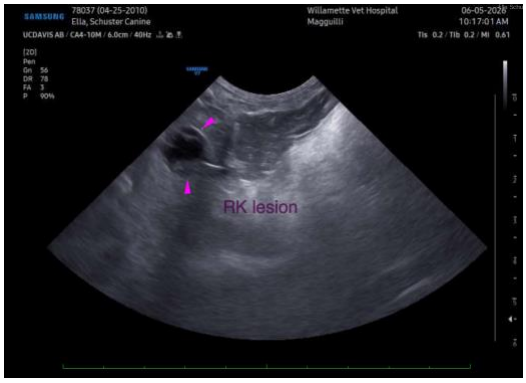

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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