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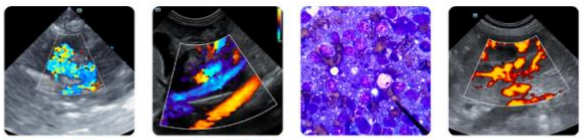

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Oliver Mattila

SPECIES

Canine

BREED

Toy Poodle

SEX

Male Neutered

AGE

10/4/2013

WEIGHT

5.7 lbs

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

Palmetto VH

REFERRING VET

Dr. Alla Sivakoff

INVOICE

23136

DATE

6-8-26

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Sudden onset of enlarged abdomen & suspected constipation
Abnormal lab-work values: Mild elevation in ALT (386). CBC unremarkable. T4 1.6. USG 1.020 with trace proteinuria and an inactive sediment. 4dx negative.
Current Medications: Cerenia for collapsing trachea, Simparica TRIO
Radiographic Findings: Enlarged spleen & liver. Will email rads.

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 3.0 cm, are normal.

The prostate is normal in size (0.42 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 (2.76 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. A few, small, nonobstructive mineralized foci are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (2.96 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. A few, small, nonobstructive mineralized foci are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.45 cm at cranial pole) (0.35 cm at caudal pole) with a normal shape. A 0.25 x 0.19 cm hyperechoic- to heterogenous nodule is observed at the cranial pole. The remaining glandular echogenicity and detail are are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is overall normal in size (0.70 cm at cranial pole) (0.31 cm at caudal pole) with a normal shape. A 0.60 x 0.36 cm hyperechoic- to heterogenous nodule is observed the cranial pole. Glandular echogenicity and detail at the caudal pole are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal- to prominent-in-size (1.05 cm in width at the level of the hilus) with smooth peripheral contour. There is appropriate echogenicity and echotexture. A 1.6 x 1.28 cm isoechoic- to heterogenous nodule is observed just proximal to the hilus. Splenic vasculature is normal.

Liver

The liver is subjectively normal- to small-in-size on the left side, with a prominent right lateral lobe, with rounding of the peripheral margins on the right side. The parenchyma is hypoechoic relative to the spleen and homogenous in appearance. 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. A small amount of aggregated, echogenic- to mineralized sludge/sand is observed within the lumen. The cystic and common bile ducts are normal/not seen.

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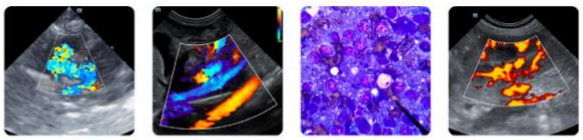

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Gastrointestinal
The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas
The right limb of the pancreas is 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
The abdominal lymph nodes are normal/not visible.

Free Abdomen
There is no obvious evidence of free fluid.

Other
A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Splenic nodule just proximal to the hilus. This lesion may represent a benign focus (i.e., lymphoid hyperplasia or similar). Alternatively, an emerging tumor is possible. There is equivocal splenomegaly.
- Rounding/swelling of the right lateral lobe of the liver, the significance of which is unclear. It may be secondary vacuolar hepatopathy, inflammatory disease, hepatotoxicosis (i.e., copper), infiltrative neoplasia (less likely), and/or other hepatopathy.
- Gall bladder sludge/sand, non-mucocele
- Bilateral adrenal nodules, both at the cranial poles. These lesions may represent focal nodular hyperplasia, adenomas, emerging adenocarcinomas, pheochromocytomas, other.

Secondary Findings

- Mild bilateral nonspecific age-related renal changes with nonobstructive nephrocalcinosis \
- Minor pancreatic parenchymal remodeling in the right limb

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the splenic nodule, consider the following:

    1. Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
    2. +/- fine-needle aspiration (assuming normal clotting status). A 25-gauge needle should be used. The lesion may be difficult to reach due to its depth within the abdomen. If aspiration is not

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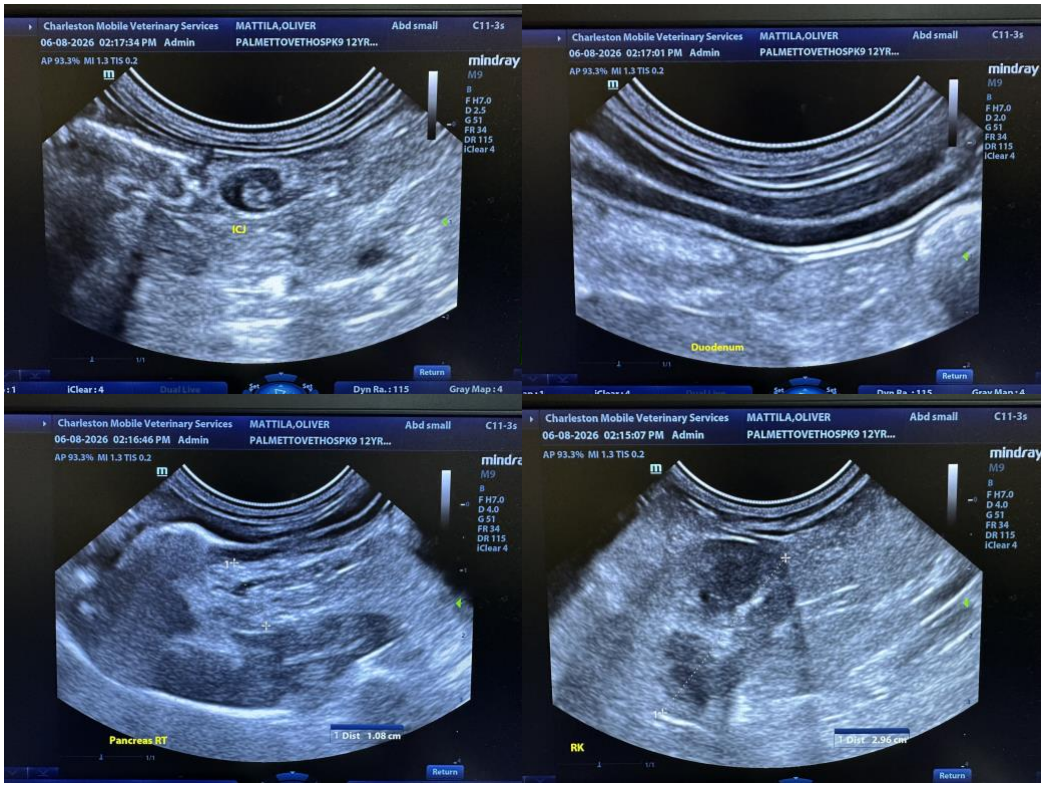
pursued, consider either a splenectomy with submission of the spleen for histopathology or a recheck ultrasound in 4-6 weeks to assess for growth of the lesion.

- Regarding the elevated ALT, consider the following:

1. Pre- and postprandial serum bile acids
2. Leptospirosis testing (i.e., blood and urine PCR, serology) particularly if the clinical suspicion for disease is high
3. Hepatic tissue sampling (i.e., aspirates or biopsies). Liver biopsies are preferred, as some liver diseases (i.e., chronic hepatitis, copper hepatotoxicosis) require larger tissue samples to get a definitive diagnosis. If liver biopsies are pursued, aerobic and anaerobic bile cultures and hepatic copper quantitation should also be performed.
4. 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.

- Consider testing for hyperadrenocorticism with a low-dose dexamethasone suppression test or ACTH stimulation test if clinical signs (i.e., PU/PD) develop in the future.



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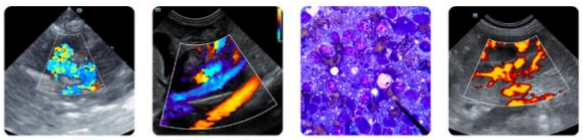

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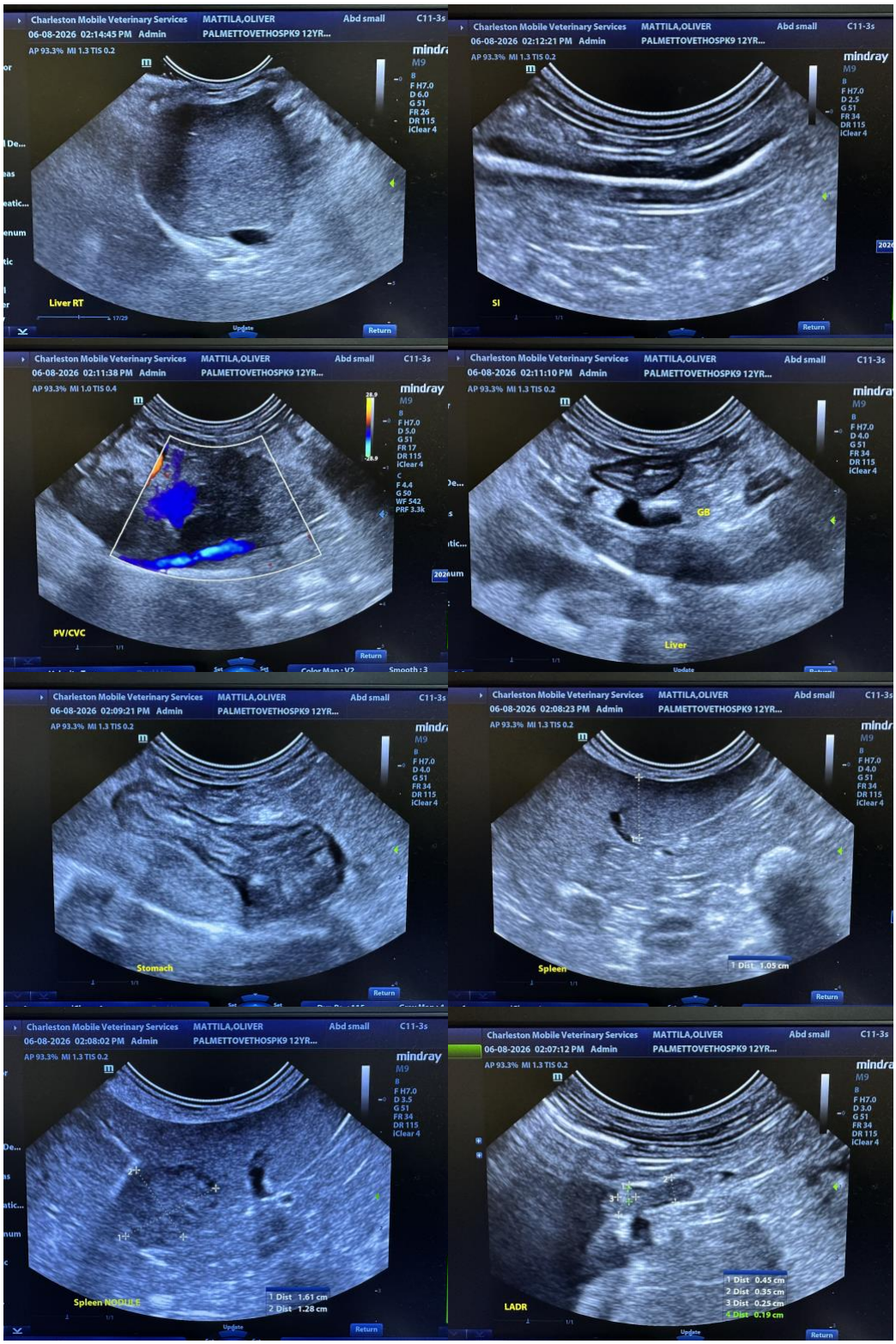

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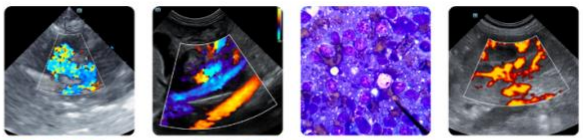

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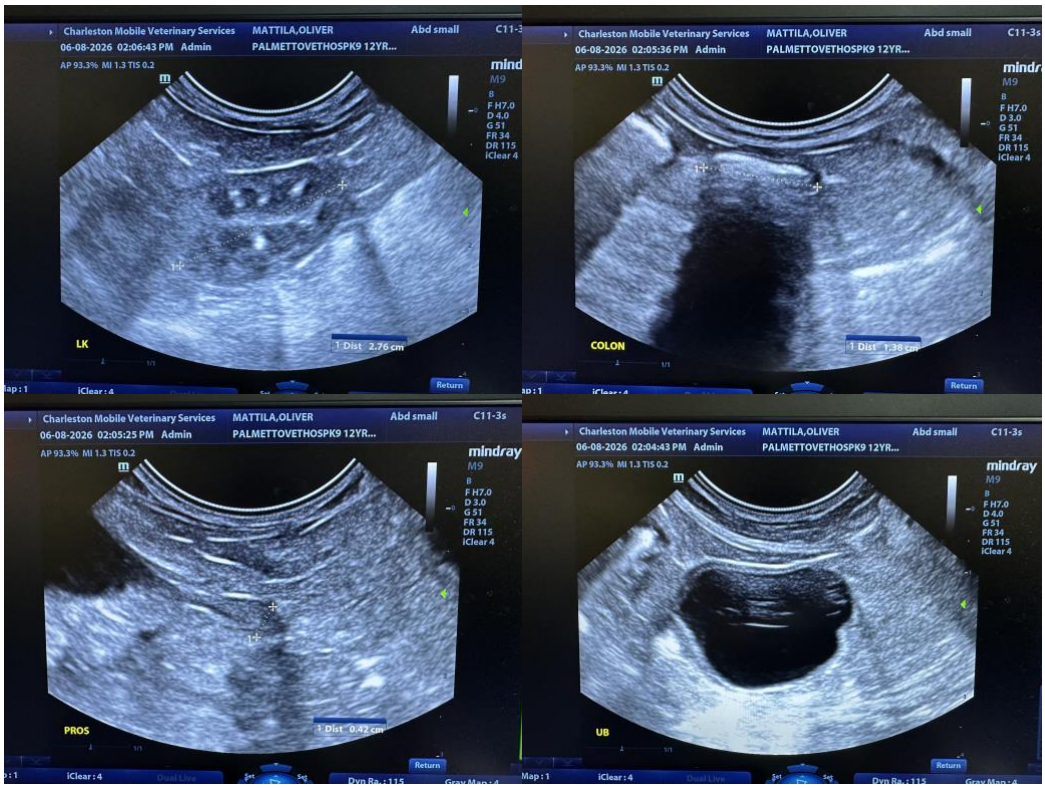

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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