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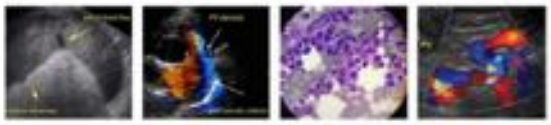


IMAGING PERFORMED BY
pawsonography@gmail.com 530-786-8340

PATIENT

Nala Kee

SPECIES

Canine

BREED

Chihuahua Mix

SEX

Female Spayed

AGE

7.1.12

WEIGHT

6 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

LuxPetVet

REFERRING VET

Dr Kristin Kee

INVOICE

13867

DATE

7.26.23

PRESENTING CLINICAL SIGNS

History: No sedation.
Chronic history of intermittent, random abdominal pain (yelping, hiding, digging, and praying position) and GERD (lip licking and excessive swallowing) that has been managed with frequent small meals of canned Royal Canin GI Low-Fat. Over the last week, patient has been exhibiting PU/PD with a few incidences of inappropriate urination that is very abnormal behavior for patient. Upon exam, patient has moderate dental disease and grade 3 bilateral MPL. BCS 5/9.

Abnormal PE/Chem/CBC/UA Results: ALT 124. USG 1.010. No proteinuria, inactive sediment. Urine culture negative.

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 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 left kidney is normal in size (3.70 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is minimal loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. Several, small, nonobstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter.

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 normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.34 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.

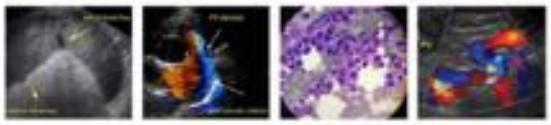
The right adrenal gland is in normal size (0.95 cm at cranial pole) (0.44 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal to slightly prominent in size (1.29 cm in width at the level of the hilus). At the cranial-to mid-aspect, a 1.64 x 1.32 cm irregular, hypoechoic-to-heterogenous nodule is visualized. At the caudal aspect, a 1.55 x 1.09 cm heterogenous, slightly cavitated nodule is seen. Both lesions appear to cause mild capsular expansion. The remaining parenchyma is slightly mottled in appearance. Splenic vasculature appears normal with no evidence of thrombosis.

Liver

The liver is subjectively prominent in size with swollen peripheral contours. The parenchyma is isoechoic relative to the spleen. On the right side, adjacent to the diaphragm, a 2.78 x 2.07 cm hyperechoic, slightly cavitated, ill-defined nodule/mass/area is visualized. The remaining parenchyma is homogenous. Hepatic vasculature and intrahepatic 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 mostly gravity-dependent echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

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

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion. The abdominal lymph nodes are normal/not visible.

Other

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The splenic lesions are concerning for neoplastic processes (i.e., round cell tumor, sarcoma, other). However, benign foci (i.e., lymphoid hyperplasia or similar) cannot be completely excluded. The diffuse splenic parenchymal changes are nonspecific and may be secondary to lymphoid hyperplasia, extramedullary hematopoiesis, splenitis, antigenic stimulation, or infiltrative neoplasia.

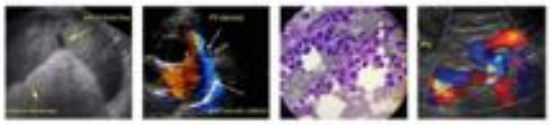
- The hyperechoic, cavitated nodule/mass/area in the right liver may represent a benign lesion (i.e., myelolipoma, regenerative nodule). Alternatively, an emerging tumor (i.e., carcinoma, sarcoma, round cell tumor) is possible. The diffuse hepatic parenchymal changes are most consistent with a benign hepatopathy (i.e., vacuolar). However, inflammatory disease, hepatotoxicosis, neoplasia or other hepatopathies cannot be excluded.

Secondary Findings

- Minor bilateral chronic renal changes with left nonobstructive nephrocalcinosis

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the PU/PD and mildly elevated ALT, pre-and postprandial serum bile acids should be considered to assess hepatic function. If results are inconclusive, consider the following:



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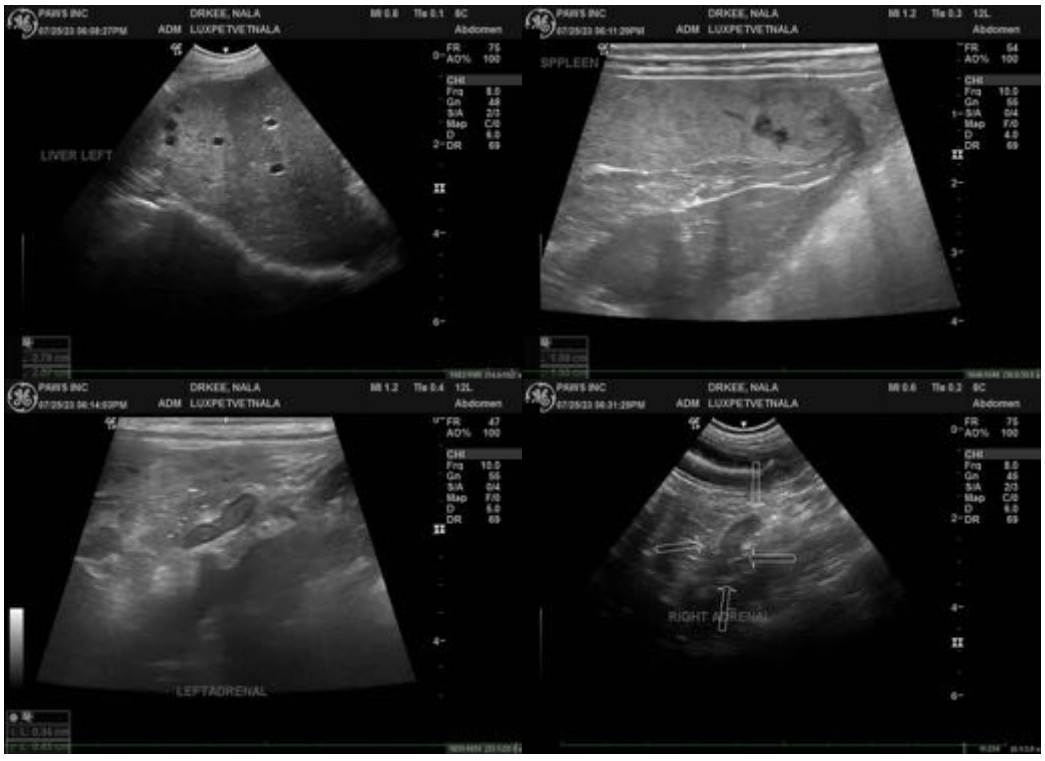
1. Low-dose dexamethasone suppression test or ACTH stimulation test to further evaluate for hypoadrenocorticism. However, it should be noted that Cushing's disease is rare in patients with a normal ALP
2. +/- Leptospirosis testing
3. +/- a DDAVP trial
4. +/- modified water deprivation test

Regarding the splenic lesions, consider the following:

1. Three-view thoracic radiographs are recommended to assess for pulmonary metastatic disease
2. Fine-needle aspirates (if clotting status is appropriate). A 25-gauge needle should be used. If the cytology results are inconclusive, consider a splenectomy with submission of the spleen for histopathology. If pursued, liver biopsies should also be obtained, with particular attention of any abnormal-appearing parenchyma.



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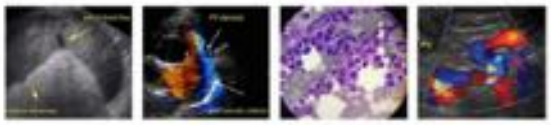

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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