

PATIENT

Gizmo Walker

SPECIES

Canine

BREED

Long hair Chihuahua

SEX

Male, neutered

AGE

7 Yrs.

WEIGHT

8.8 kg.

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Dr. Belan

HOSPITAL NAME

Alpine 24-7 AH

REFERRING VET

Dr. Pinel

INVOICE

15217

DATE

8/22/23

PRESENTING CLINICAL SIGNS

History: Abnormal blood work when pre orthopaedic exam and blood work done. Patient body score 4/5 non clinical but scheduled for a TPO

Abnormal PE/Chem/CBC/UA Results: Mild elevation of ALP and mild anemia

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended. The wall is normal in thickness with a smooth mucosal surface. A few small cystic calculi are visualized, the largest measuring 0.47 cm in diameter. The region of the trigone and the visible portion of the proximal urethra are normal.

The prostate is normal in size (0.54 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal size (4.45 cm in length); normal shape and architecture with 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.

The right kidney is normal size (3.92 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is hyperechoic relative to the spleen with several small cortical cysts visualized. A few small cortical cysts are seen. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.39 cm at cranial pole) (0.56 cm at caudal pole) with a slightly prominent caudal pole. 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 normal size (0.35 cm at cranial pole) (0.49 cm at caudal pole); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

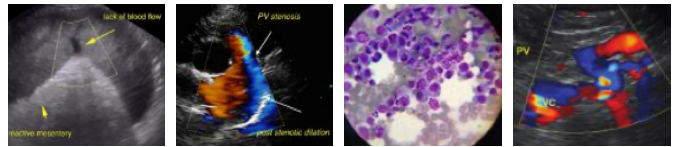
Spleen

The spleen is normal to slightly prominent in size (0.85 cm in width at the level of the hilus) with a mildly swollen medial contour. The parenchyma is subtly mottled in appearance with a few small ill-defined hypoechoic nodules/areas. Splenic vasculature is normal with no evidence of thrombosis.

Liver

The liver is subjectively prominent in size with slightly rounded peripheral contours. The parenchyma is isoechoic relative to the spleen and subtly heterogeneous in appearance. A 0.59 x 0.54 cm hyperechoic nodule is observed on the left side. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gall bladder lumen is moderately distended. The wall is thin and smooth. A moderate amount of consolidated hyperechoic partially dependent sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal



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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 thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. No obstructive disease is noted.

Pancreas

The base/right limb of the pancreas are 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.

Free Abdomen

There is no obvious evidence of free fluid. A few prominent slightly rounded hypoechoic mesenteric lymph nodes are visualized, the largest measuring 0.91 x 0.40 cm. Surrounding mesentery is hyperechoic.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

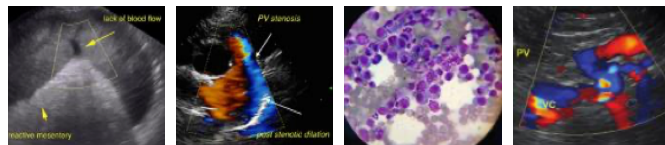
- Gallbladder changes consistent with an emerging mucocele.
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory and infiltrative disease are considered less likely.
- Cystic calculi.

Secondary Findings:

- Mild bilateral chronic renal changes with cortical cysts.
- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or antigenic stimulation with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Mild left adrenomegaly.
- The prominent mesenteric lymph nodes could be consistent with lymphoid hyperplasia, reactive lymphadenitis or emerging neoplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the gall bladder changes, Ursodeoxycholic acid (Ursodiol) is recommended. Serial sonographic monitoring (e.g., every 6-8 weeks) of the gall bladder is recommended to assess for progression to a fully formed mucocele. If progression occurs, a cholecystectomy may be warranted.



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- A cystotomy with stone removal analysis and culture is recommended. Alternatively, medical dissolution of the stones can be considered with a prescription urinary diet and broad-spectrum antibiotic therapy. If there is no improvement in stone size after 4 weeks of therapy, a cystotomy should be reconsidered. If the stone size is reduced, continue therapy until complete dissolution has been achieved.
- Serial monitoring (i.e., every 3-4 months) of the patient's liver values is recommended. If liver values continue to increase, a repeat abdominal ultrasound +/- hepatic tissue sampling may be warranted.
- 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.
- Regarding the mild anemia, consider the following:
 1. Reticulocyte count to determine if the anemia is regenerative.
 2. Three-view thoracic radiographs to assess for occult disease in the chest.
 3. T4/free T4 by equilibrium dialysis if not already performed, as hypothyroidism can occasionally cause mild anemia.
 4. +/- testing for vector borne disease.
 5. Serial monitoring of the patient's hematocrit to assess for worsening anemia. If anemia worsens and the above diagnostics are inconclusive, a bone marrow aspirate may be warranted.

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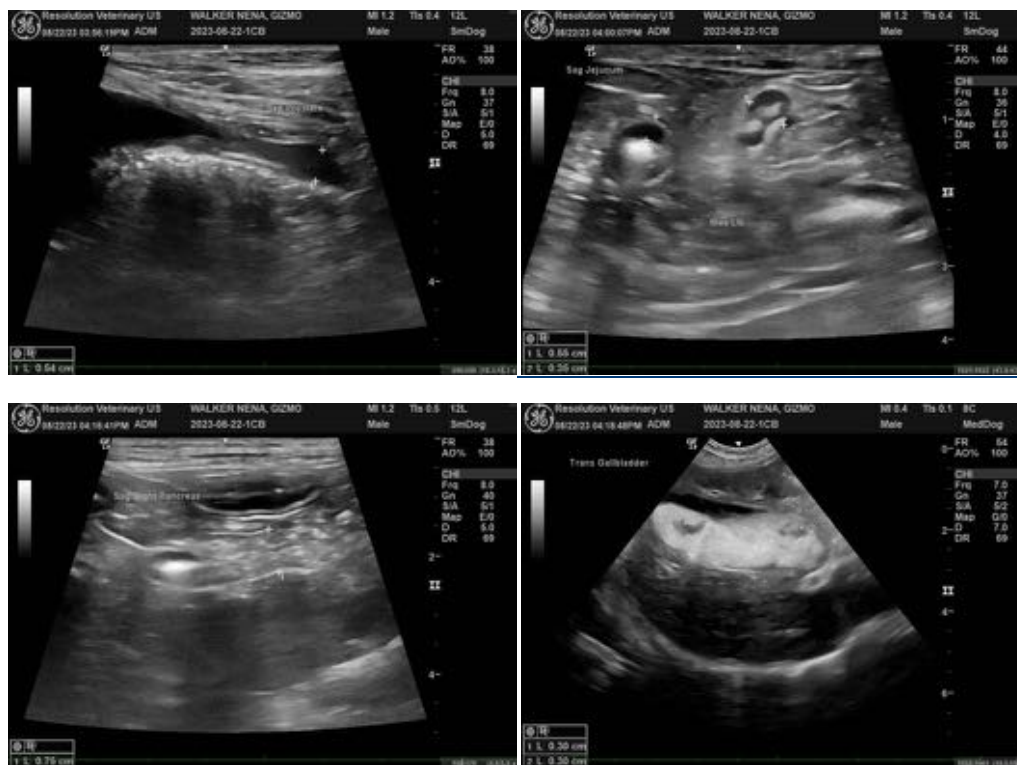
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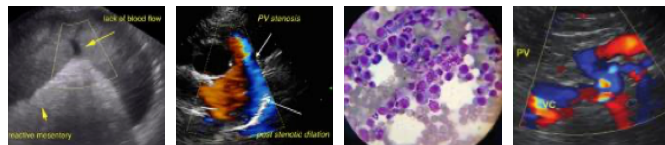
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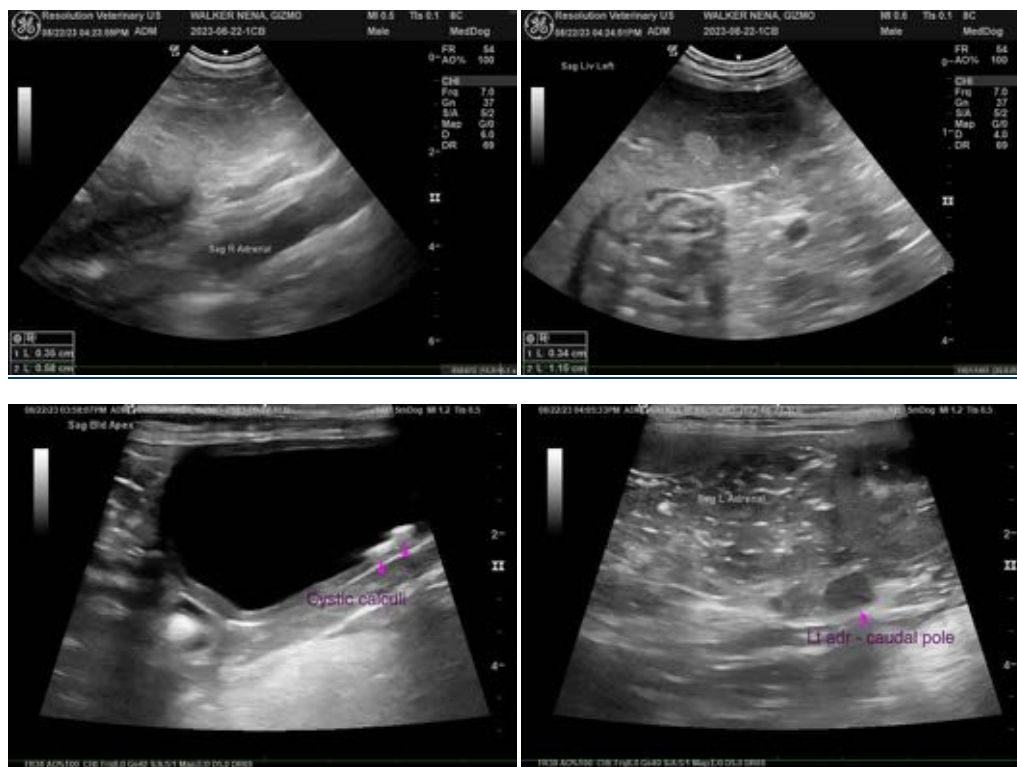
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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