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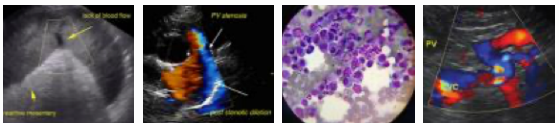

ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

PATIENT
Bella Viramontes

SPECIES
Canine

BREED
Yorkshire terrier

SEX
Female, spayed

AGE
10 Yrs.

WEIGHT
9.56 lbs.

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

IMAGING PERFORMED BY
Jenna Walsh

HOSPITAL NAME
Reid VH

REFERRING VET
Dr. Heider

DATE
12/19/22

INVOICE
14375

PRESENTING CLINICAL SIGNS

History: - Hyporexic since Saturday (12-10-22), not drinking much water either - Hx of pancreatitis - Extremely tense abdomen Current Medications Gabapentin, Meloxidyl Radiographic Findings Lat/VD Spine/Abdom rads findings: - possible IVDD with narrowing at T10-12 - grossly enlarged liver/spleen seen on R & L lateral views - stool distended colon, large bladder Will send radiographs via email Primary Question/Differential to Be Answered in This Exam R/O back vs abdominal pain

ALP 684, ALT 125, USG 1.048, 2+ proteinuria, inactive sediment. T4 normal.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended with anechoic urine. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal in size (4.26 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is mild to moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal size (4.36 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is mild to moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.42 cm at cranial pole) (0.58 cm at caudal pole) (1.51 cm in length); 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.

The right adrenal gland is mildly enlarged (0.81 cm at cranial pole) (0.65 cm at caudal pole) (1.60 cm in length); 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 in size (0.88 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A 0.64 cm ill-defined hypoechoic nodule is observed at the cranial aspect. In addition, several myelolipomas are observed in the region of the hilus. Splenic vasculature is normal.

Liver

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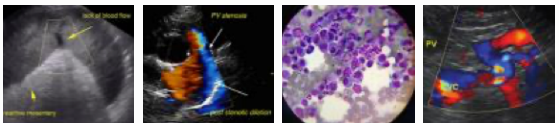

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The liver is subjectively enlarged with swollen peripheral contours. The parenchyma is hyperechoic relative to the spleen and diffusely mottled in appearance. A 2.96 cm irregular hypoechoic mass/lesion is observed deep on the right side, adjacent to the diaphragm. 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 small amount of aggregated echogenic partially dependent debris/sludge 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 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 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.

ULTRASONOGRAPHIC FINDINGS

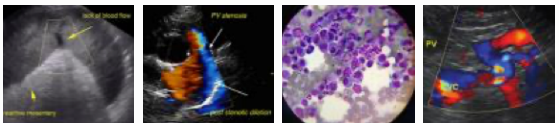
Primary Findings:

- The right hepatic mass/lesion could be consistent with an emerging tumor or a benign process (i.e., regenerative nodule or inflammatory focus). The diffuse hepatic parenchymal changes are most consistent with a benign process (i.e., vacuolar hepatopathy and/or regenerative nodular hyperplasia) with a lower possibility of emerging neoplasia.

Secondary Findings:

- Mild bilateral adrenomegaly.
- Bilateral chronic age-related renal changes with dystrophic mineralization.
- The hypoechoic splenic nodule trends toward the benign (i.e., focus of lymphoid hyperplasia or similar) with a lower possibility of an emerging neoplasia.

*An obvious cause for the patient's discomfort is not definitively identified in this study. Considerations include low-grade pancreatitis, occult pyelonephritis, orthopedic or neurologic disease, other.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the patient's discomfort, consider a cPLI, urine culture and sensitivity and thorough orthopedic and neurologic evaluations.
- Regarding the hepatic parenchymal changes, a fine needle aspirate can be considered with particular attention to the mass/lesion on the right side (if accessible). Clotting status should be assessed prior to any hepatic tissue sampling. If cytology results are inconclusive, surgical biopsies may be necessary to get a definitive diagnosis.
- If a more conservative approach is desired, consider a repeat ultrasound in 2-3 months to assess for progression of the hepatic lesion.
- Consider testing for hyperadrenocorticism with a low-dose dexamethasone suppression test or ACTH stimulation test if clinical signs (i.e., PU/PD) develop.

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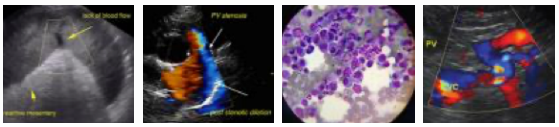

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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