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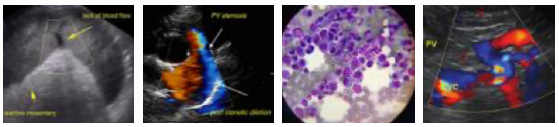


ANIMAL SOUNDS NW
MOBILE VETERINARY ULTRASOUND
IMAGING PERFORMED BY
AnimalSoundsNW.com 541-357-9423

**PATIENT**
Martin Jennings

**SPECIES**
Canine

**BREED**
Boston Terrier

**SEX**
Male, neutered

**AGE**
9 Yrs.

**WEIGHT**
23.2 lbs.

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

**IMAGING PERFORMED BY**
Sara Hansen

**HOSPITAL NAME**
Faithful Friends AC

**REFERRING VET**
Dr. Hiett

**DATE**
3/1/22

**INVOICE**
13074

## PRESENTING CLINICAL SIGNS

History: Dog has had a decreased appetite and lethargy for the past month or two. Has lost ~3 pounds. Used to be very food motivated, and now very decreased appetite. No vomiting nor diarrhea. Abnormal PE/Chem/CBC/UA Results: Reticulocytes 2% on last blood draw, 1.3% in January yet HCT 46% and normal RBCs. BUN decreased at 8, GGT mildly elevated at 14, spec cPL mildly elevated at 260. T4 had been 0.7 and now is at 1.2 with levothyroxine. On UA, trace blood/hemoglobin on USG 1.007 and 2-5 RBC/HPF. Remainder of CBC/Profile WNL Current Medications Ciprofloxacin, Capromorelin, and Maropitant

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder and visible portion of the pelvic urethra are normal for the degree of luminal distension. The urine is anechoic with no evidence of debris. Cystic calculi and discrete masses are not observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The prostate is normal in size (0.79 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 (5.51 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal size (5.57 cm in length); normal shape and architecture with smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

### *Adrenal Glands*

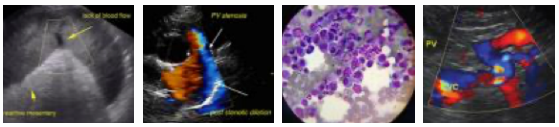
The left adrenal gland is normal size (0.54 cm at cranial pole) (0.69 cm at caudal pole) (1.92 cm in length); normal shape; homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal size (0.93 cm at cranial pole) (0.57 cm at caudal pole) (1.93 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 (1.40 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. Numerous irregular hyperechoic nodules are observed throughout the organ. Splenic vasculature is normal.

### *Liver*





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The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed. The gall bladder 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 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 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.

### *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.

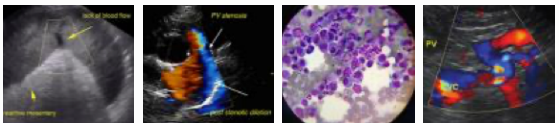
## ULTRASONOGRAPHIC FINDINGS

- The splenic nodules trend toward the benign (i.e., myelolipomas) with a low possibility of emerging neoplasia.
- Minor age-related renal changes.
- Minor age-related pancreatic remodeling +/- fibrosis. Mild pancreatitis may also be present, particularly if the patient exhibits pain on cranial abdominal palpation.

*An obvious cause for the patient's clinical signs is not identified in this study.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Chest X-rays (three-view) are recommended to assess for occult disease (i.e., neoplasia).
- Thorough orthopedic and neurologic examinations are recommended to assess for non-metabolic causes of inappetence.





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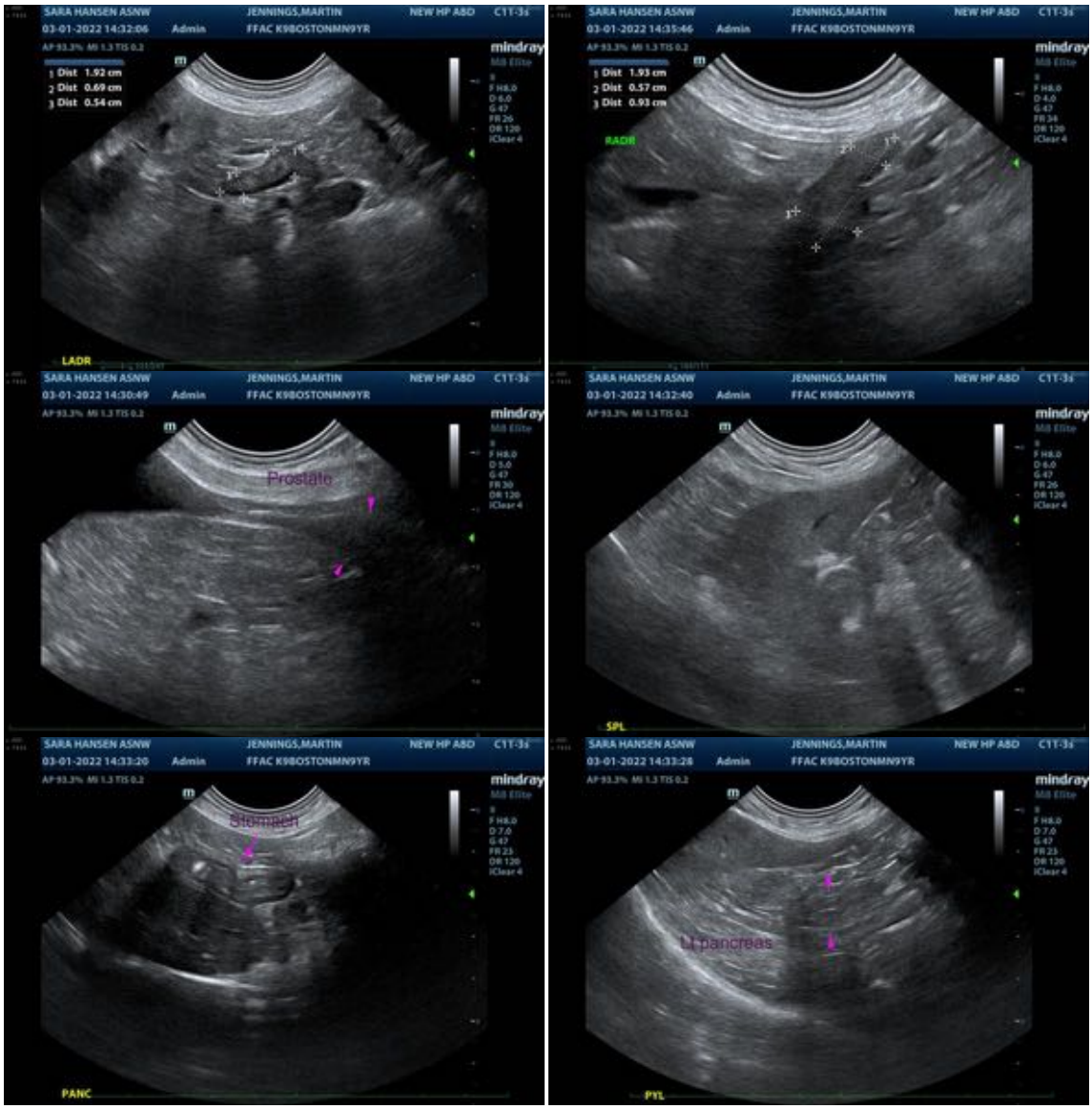
- Consider a GI panel including serum cobalamin, folate, TLI and PLI to assess for maldigestion/malabsorption and pancreatic disease.
- Pre- and post-prandial serum bile acids to assess for occult hepatic dysfunction.
- Also consider a comprehensive tick panel if the above diagnostics are inconclusive.



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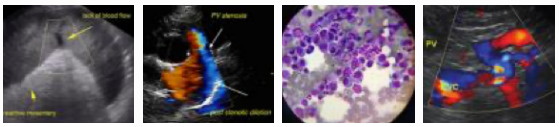

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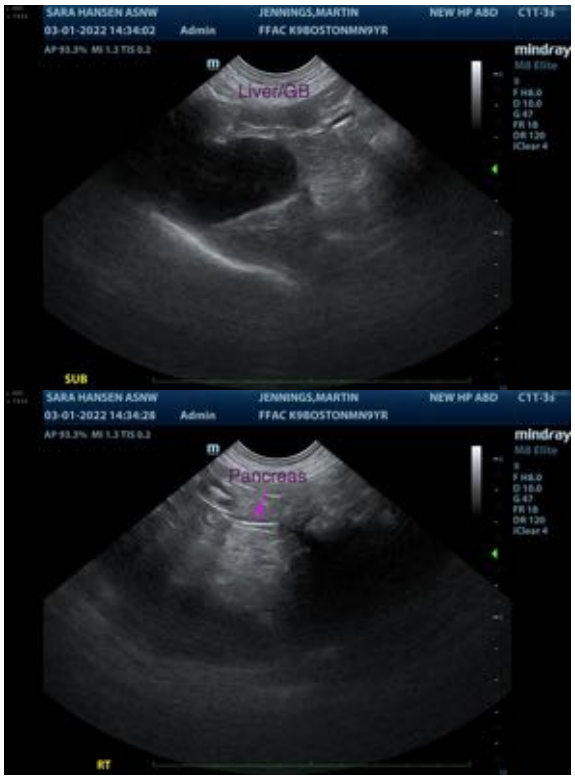


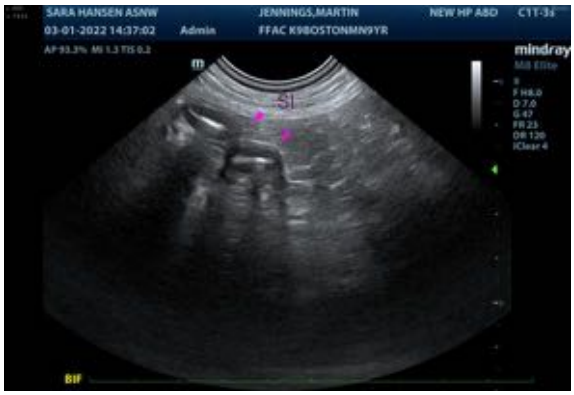


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**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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

andrea.nicastro@sonopath.com