

PATIENT

Hercules Putney

SPECIES

Canine

BREED

Boston Terrier

SEX

Male, neutered

AGE

13 Yrs.

WEIGHT

INTERPRETED BY

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

IMAGING PERFORMED BY

Sara Hansen

HOSPITAL NAME

Companion Pet Clinic

REFERRING VET

Companion Pet Clinic

DATE

7/26/22

INVOICE

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PRESENTING CLINICAL SIGNS

History: P having diarrhea for 7+ days decreased appetite decreased activity
Abnormal PE/Chem/CBC/UA Results: PLT 598, ALT 193, ALP 339, GGT 25, CHOL 431, TRIGLYC 826, LIPASE 277, SPEC CPL 307. Primary Question/Differential to Be Answered in This Exam CONCERNED ABOUT LIVER

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 prostate is normal in size (0.74 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 (5.29 cm in length); normal shape and architecture with smooth peripheral margins. The cortex is mildly hyperechoic. 1-2 small cortical cysts are seen. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal size (6.93 cm in length) with a slightly irregular shape. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. A 3.86 cm cortical cyst is observed at the caudal aspect. The cyst causes distortion of a portion of the renal architecture. In the remainder of the kidney there is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

One still image of the left adrenal gland is available for interpretation. The left adrenal gland is mildly enlarged (0.89 cm at cranial pole) (0.67 cm at caudal pole) (2.14 cm in length) with a slightly irregular shape. The parenchyma appears slightly heterogeneous with some loss of glandular detail.

The right adrenal gland is enlarged (1.62 cm at cranial pole) (1.68 cm at caudal pole) (4.15 cm in length) with an irregular shape. The parenchyma is diffusely heterogeneous with loss of glandular detail.

Spleen

The spleen is normal in size (1.15 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A few small, ill-defined myelolipomas are observed in the region of the hilus. Splenic vasculature is normal.

Liver

The liver is subjectively enlarged with slightly swollen peripheral contours. The parenchyma is isoechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. 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. Luminal contents are mostly



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anechoic. The cystic and common bile ducts are normal/not seen.

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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.

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Pancreas

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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.

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Free Abdomen

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

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Other

A brief echocardiogram reveals no obvious evidence of pericardial effusion.

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ULTRASONOGRAPHIC FINDINGS

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Primary Findings:

- 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.
- Bilateral adrenomegaly, more pronounced on the right side. The right adrenal changes could be consistent with nodular hyperplasia or potentially, emerging neoplasia.

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Secondary Findings:

- Bilateral, chronic age-related renal changes with a large right cortical cyst.

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*An obvious cause for the patient's diarrhea is not identified in this study. Considerations include microscopic gastrointestinal disease (i.e., food allergy/intolerance, infectious/parasitic disease, inflammatory bowel disease), underlying metabolic issue, mild pancreatitis, other.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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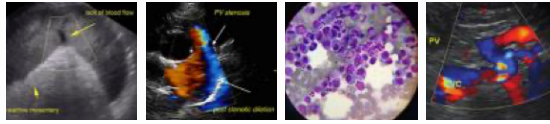
- Consider testing for hyperadrenocorticism with a low-dose dexamethasone suppression test or ACTH stimulation test if clinical signs (i.e., PU/PD) develop. Consider a recheck ultrasound of the adrenal glands (particularly the right adrenal gland) in 1-2 months to assess for changes.

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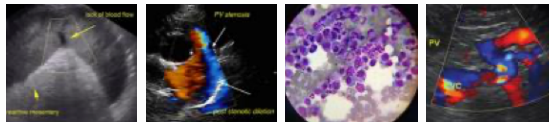
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- Serial monitoring (i.e., every 3-4 months) of the patient's liver values is recommended. If liver values continue to increase, a repeat abdominal ultrasound +/- hepatic tissue sampling may be warranted.
- Regarding the patient's diarrhea, further workup could include the following:
 1. A fecal evaluation for ova/Giardia
 2. Prophylactic deworming with Fenbendazole at 50 mg/kg once a day for 5 days is recommended. Repeat above protocol in 3 weeks.
 3. Malabsorption panel including serum cobalamin, folate, TLI and PLI.
 4. Initiation of a probiotic with a high colony count (i.e., Provable Forte or Visbiome).
 5. Supportive care for gastroenteritis.
 6. If the GI signs persist and the above diagnostics are inconclusive, GI biopsies (i.e., endoscopic or surgical) may be necessary to get a definitive diagnosis.





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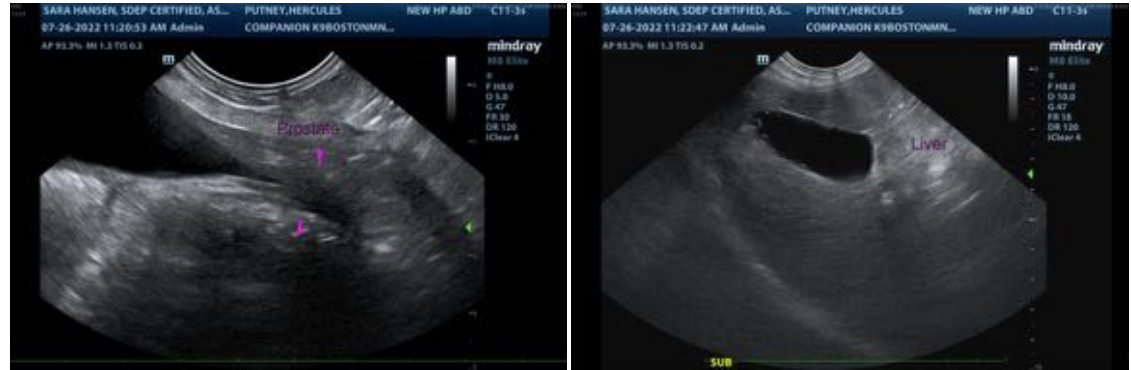
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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