



PATIENT

Lizzie Iannatuono

SPECIES

Canine

BREED

Yorkshire Terrier

SEX

Female, spayed

AGE

12 Yrs. 8 months

WEIGHT

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

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

HOSPITAL NAME

Trinity Island

REFERRING VET

Dr. Oldham

INVOICE

13380

DATE

1/13/26

PRESENTING CLINICAL SIGNS

Pt has a long term history of chronic diarrhea which appears to be mucousy. Blood in the stool is not a consistent finding. Has tried Metronidazole. Pt sedated with Butorphanol for this study.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly distended. A 0.31 nodule is observed along the ventral wall. The remaining wall is of appropriate thickness for the level of repletion. The mucosal surface in the region of the apex is slightly irregular.

The left kidney is normal in size (3.86 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal in size (3.80 cm in length) with a normal shape, architecture and smooth peripheral margins. 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.

Adrenal Glands

The left adrenal gland is normal in size (0.36 cm at cranial pole) (0.40 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 normal in size (0.30 cm at cranial pole) (0.30 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 in size (1.26 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

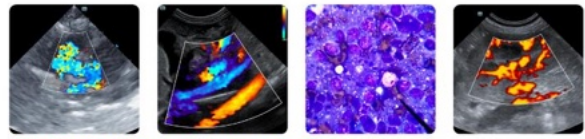
Liver

The liver is subjectively normal in size with normal peripheral contours. The parenchyma is isoechoic to slightly hypoechoic relative to the spleen and subtly heterogeneous in appearance. A few varying sized hyperechoic nodules are observed throughout the organ, the largest measuring 1.8 x 1.6 cm. Vascular and biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1:1.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of gravity-dependent echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is mildly distended with ingesta. 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



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mural detail. Discreet masses are not identified. The colonic wall is normal. The colonic lumen contains some shadowing fecal material. There is no obvious 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.

Lymph nodes

The abdominal lymph nodes are normal/not visible.

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion.

Other

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

ULTRASONOGRAPHIC FINDINGS

- Bilateral nonspecific, age-related renal changes.
- The diffuse hepatic parenchymal changes are most consistent with benign, age-related remodeling. However, other hepatopathies (i.e., inflammation, fibrosis, regenerative nodular hyperplasia) cannot be excluded. Correlation with the patient's liver values is recommended. The hyperechoic hepatic nodules trend toward the benign (i.e., regenerative nodules, meylolipomas) with a lower possibility of more insidious hepatic pathology.
- Gallbladder debris, non-mucocele
- The nodule in the ventral wall of the urinary bladder may represent an inflammatory polyp or emerging neoplasia (i.e., transitional cell carcinoma).

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

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A minimum database including a CBC chemistry panel, urinalysis and T4 is recommended (if not already performed).
- The following diagnostics/treatment recommendations can also be considered to further assess the GI signs:
 1. Texas GI panel including serum cobalamin, folate, PLI, TLI and resting cortisol level
 2. Fecal evaluation for ova/Giardia
 3. Prophylactic deworming with Fenbendazole.
 4. 3-4 week hypoallergenic or hydrolyzed protein diet trial
 5. Initiation of a probiotic with a high colony count +/- fiber supplement (i.e., psyllium).
 6. Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be warranted. Three-view thoracic radiographs should be performed prior to any anesthetic event.



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- Regarding the urinary bladder nodule, consider a urine BRAF test to further evaluate for neoplasia. A positive test confirms neoplasia, however a negative test does not rule out the possibility of cancer and further testing (i.e., bladder wall biopsies) may be necessary to get a definitive diagnosis. If further diagnostics are not pursued at this time, consider a recheck ultrasound in 1-2 months to assess for growth of the lesion.

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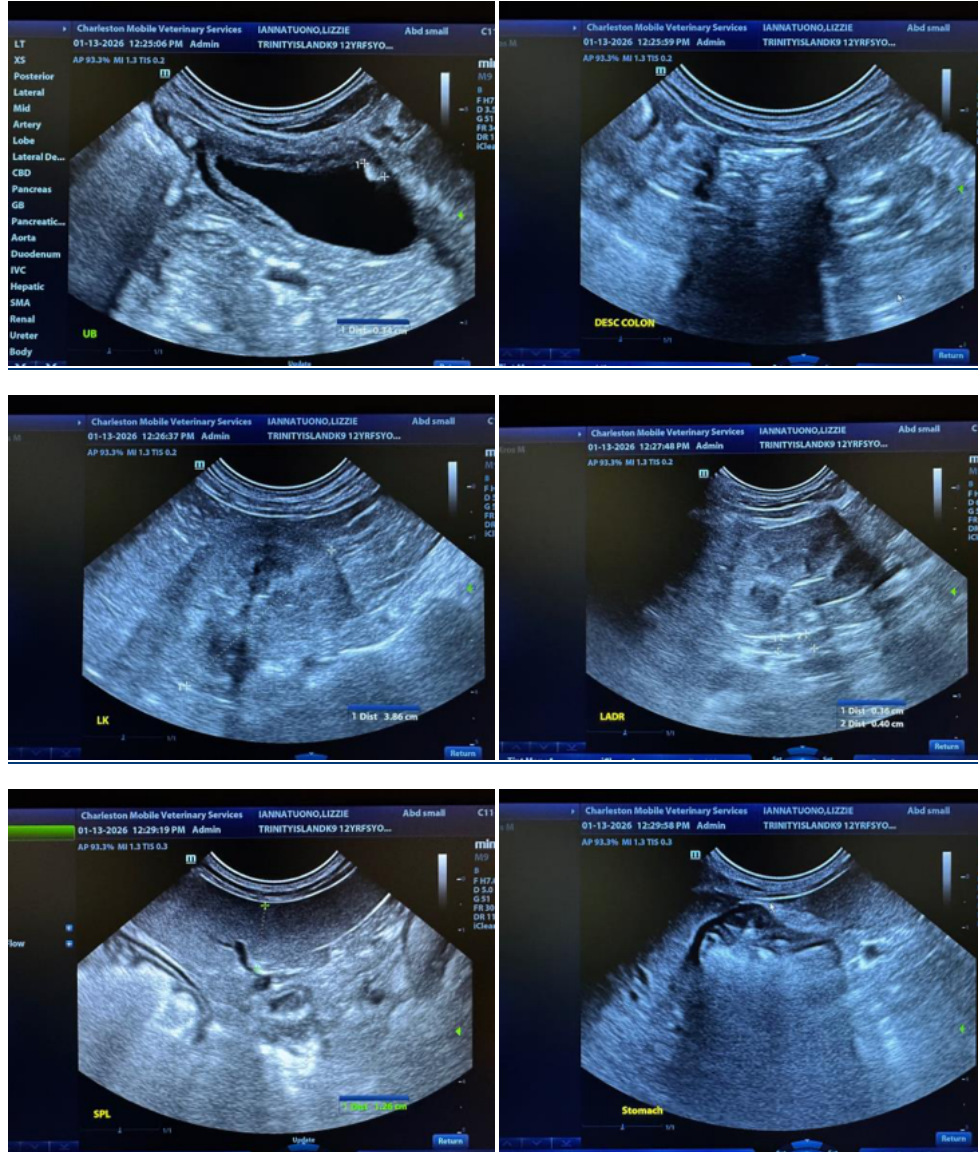
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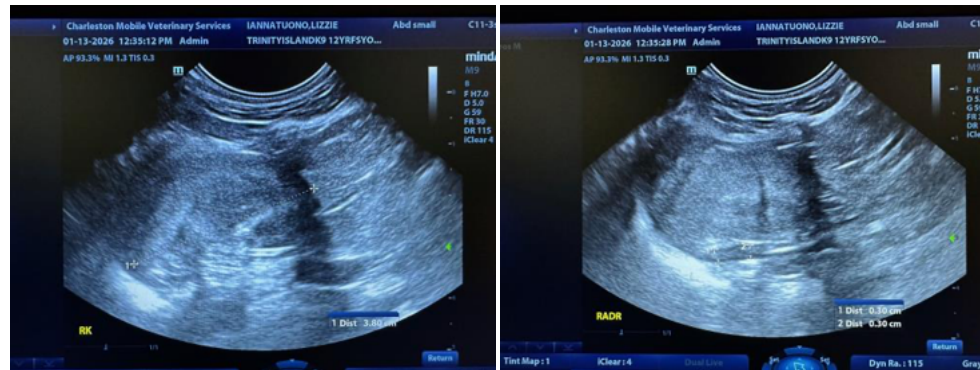
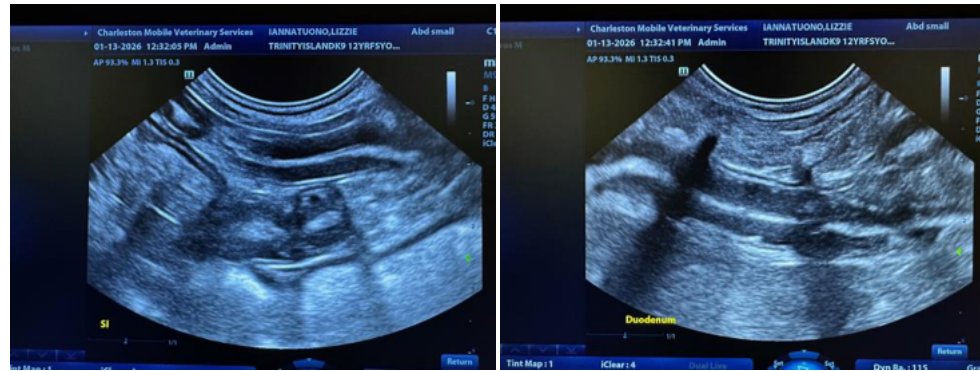
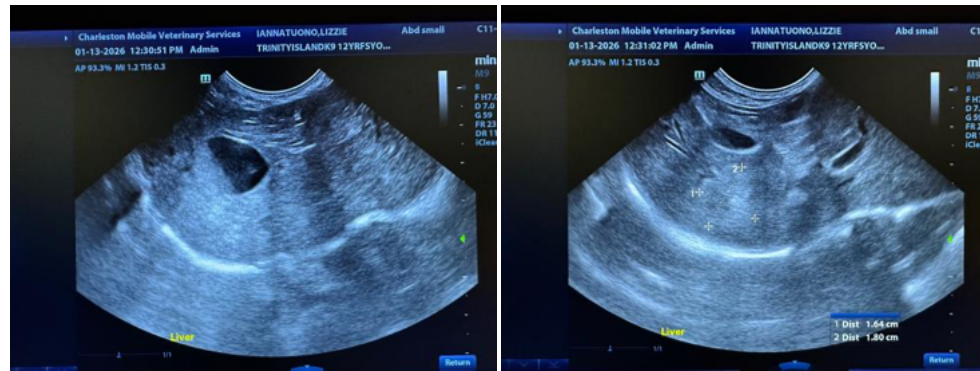
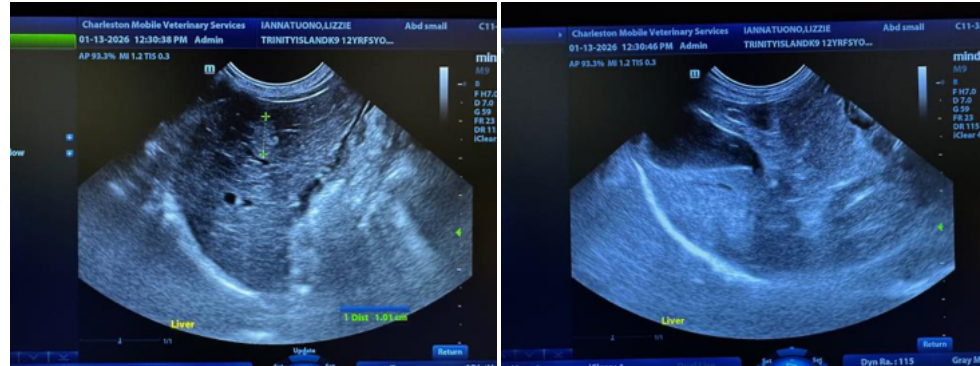
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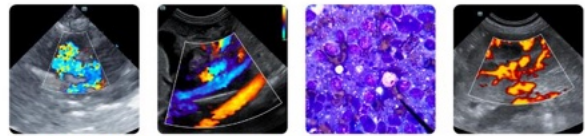
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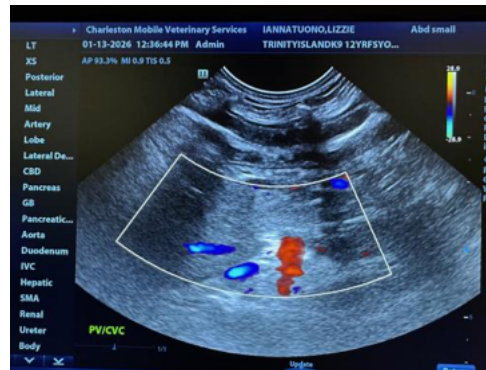
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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