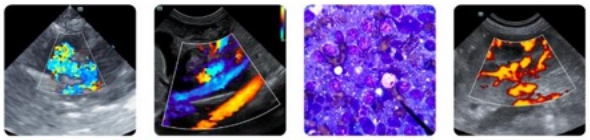

PATIENT

Tito Tangelo

SPECIES

Canine

BREED

Cocker Spaniel

SEX

Male, intact

AGE

5/5/2016

WEIGHT

39 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Hardee

HOSPITAL NAME

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INVOICE

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PRESENTING CLINICAL SIGNS

- Perform an in-house cPL (canine pancreas-specific lipase) test to check for pancreatitis. (If the cPL test is normal but clinical signs continue, an abdominal ultrasound with a traveling specialist will be recommended to evaluate all abdominal organs further.)
- - Vomiting and abdominal tenderness, a potential flare-up of chronic pancreatitis is suspected.
- Patient is presented for vomiting bile and some food. The patient has a history of pancreatitis diagnosed in November, with a recheck of lab values around Christmas that were within normal limits. Abdominal radiographs were performed at another clinic around Thanksgiving and were reportedly unremarkable. He currently eats a low-fat prescription diet. The patient has also been exhibiting episodes of what appear to be abdominal cramps, during which he acts anxious, uncomfortable, and avoids his usual resting positions. Despite the clinical signs, his overall demeanor is described as feeling okay. Chronic intermittent vomiting and diarrhea is currently receiving Purina EN and Omeprazole. Has been on Metoclopramide. Lab work from May 2025 revealed USG 1.044, 1+ proteinuria, inactive sediment, some struvite crystals, CBC chem from Nov 2024 WNL. T4 and 4DX normal/negative at that time.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly distended with mostly anechoic urine. The wall in the region of the apex is moderately thickened (up to 0.71 cm) with a slightly irregular mucosal surface. The wall tapers to a normal thickness as it extends toward the cystourethral junction. The region of the trigone and the proximal urethra, visible to a depth of 3-4 cm, are normal.

The prostate is enlarged (3.19 cm in width) with relatively smooth peripheral contours. The parenchyma is hyperechoic relative to surrounding omental fat and slightly heterogeneous in appearance. No distinct focal lesions are observed. The prostatic urethra is not overtly dilated.

The left kidney is normal in size (6.18 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 hydroureter. Renal vasculature is normal.

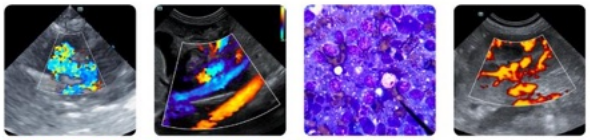
The right kidney is normal in size (6.24 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.44 cm at cranial pole) (0.48 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 (0.42 cm at cranial pole) (0.43 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



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A 2.9 x 2.0 cm hypoechoic to heterogeneous expansile mass is observed approximately mid-body. At least 2 smaller hypoechoic nodules/masses are also seen. In the remainder of the spleen, the parenchyma is homogenous. Splenic vasculature appears normal with no evidence of thrombosis.

Liver

The liver is subjectively prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits mild heterogeneity. No distinct focal lesions are observed. Hepatic vasculature 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 moderate amount of aggregated, echogenic partially dependent debris/sludge is observed within the lumen. Some echogenic debris is also adhered to the mucosal surface. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

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 is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocolic junction and colonic wall are normal. There is no 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

A 1.80 x 0.51 cm periportal lymph node is visualized. A 4.02 x 0.44 cm mesenteric lymph node is also seen.

Free Abdomen

There is no obvious evidence of free fluid.

Other

The testicles are subjectively normal in size (left 2.6 x 1.5 cm; right 2.7 x 1.7 cm) and symmetrical with homogeneous parenchyma.

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Multiple splenic masses. Neoplasia (i.e., round cell tumor, sarcoma) is suspected with a lower possibility of a benign process (i.e., multifocal inflammatory disease, lymphoid hyperplasia, other).

Secondary Findings:

- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory disease,

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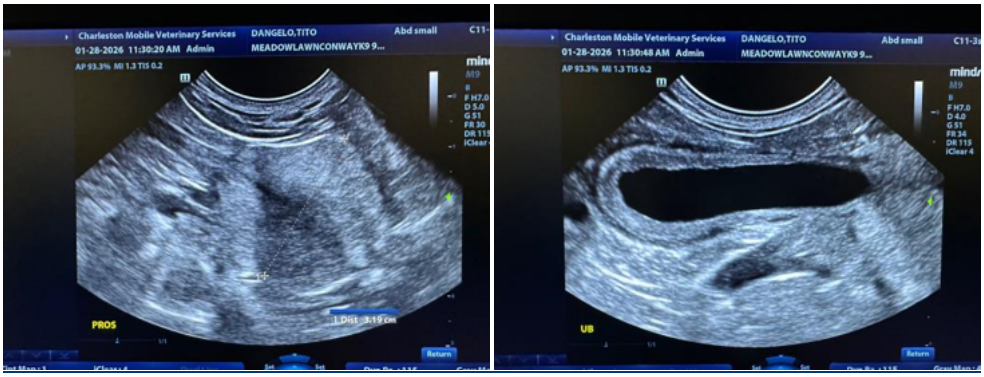
infiltrative neoplasia and other hepatopathies are considered less likely. However, correlation with the patient's liver values is recommended.

- The gallbladder changes could be consistent with cholestasis, fasting or emerging mucocele.
- Bilateral nonspecific, age-related renal changes
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The urinary bladder wall changes could be consistent with cystitis or may be artifactual due to lack of full repletion.
- The prostate changes are most consistent with benign prostatic hyperplasia. Bacterial prostatitis is also a differential but considered unlikely in the absence of lower urinary tract signs.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A minimum database including a CBC chemistry panel, urinalysis and T4 is recommended to assess overall metabolic function.
- Given the splenic lesions, consider the following:
  1. Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
  2. Fine needle aspiration (if clotting status is appropriate). A 25-gauge needle should be used. Depending on results, consultation with a board-certified oncologist and/or surgeon may be warranted. If surgery is pursued, GI biopsies should also be obtained at the time of surgery.
- Given the GI signs, other diagnostic/therapeutics to consider include the following:
  1. GI panel including serum cobalamin, folate, TLI, PLI and resting cortisol level
  2. Fecal evaluation for ova and Giardia
  3. Prophylactic deworming with Fenbendazole
  4. 3-4 week limited antigen or hydrolyzed protein
  5. A probiotic +/- fiber supplement (i.e., psyllium)
  6. +/- endoscopic or surgical GI biopsies (as stated above)



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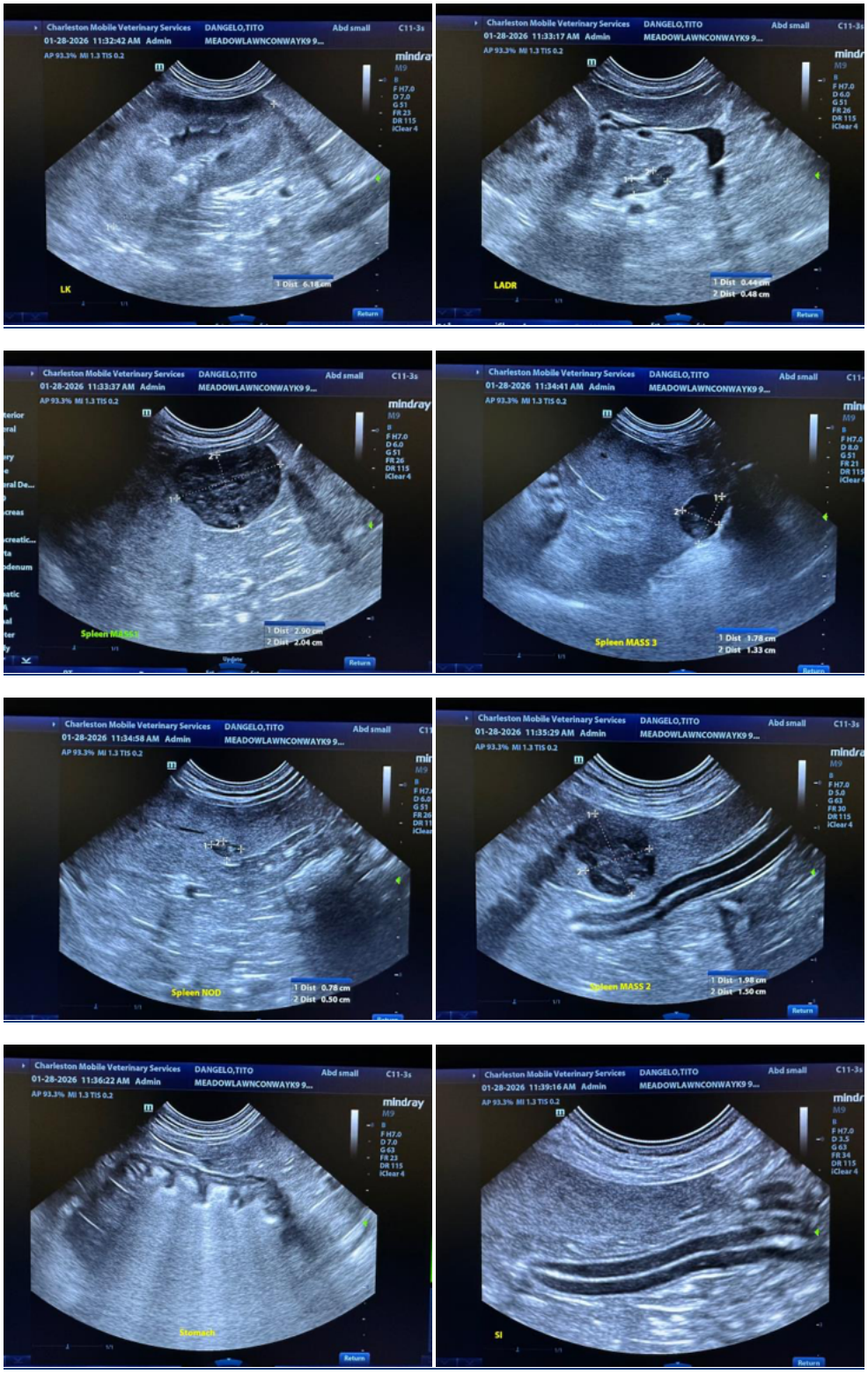

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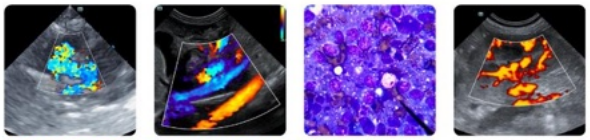

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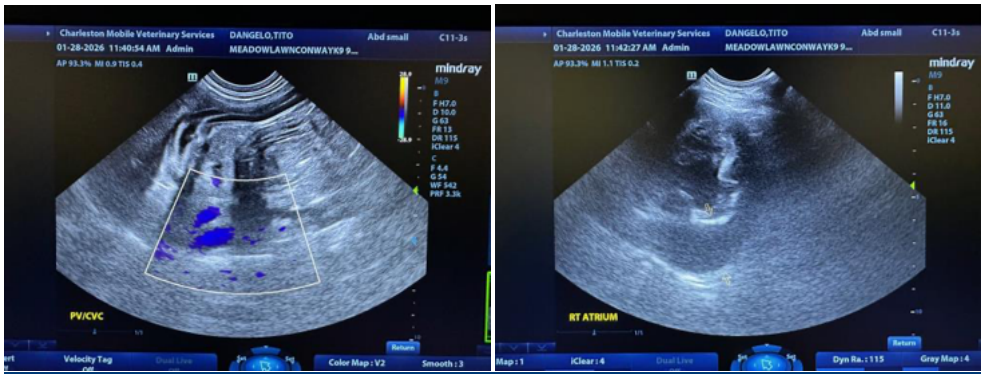

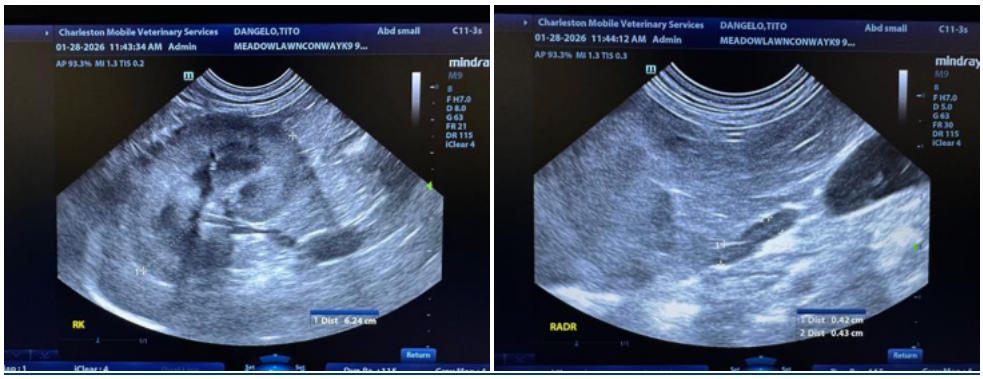

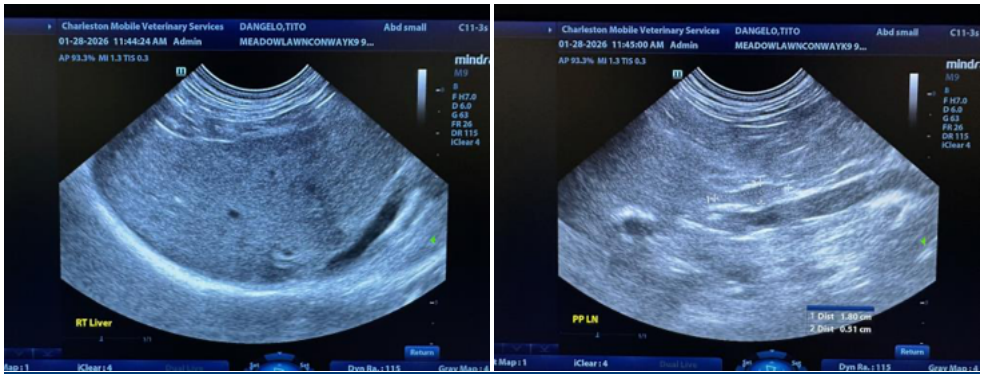

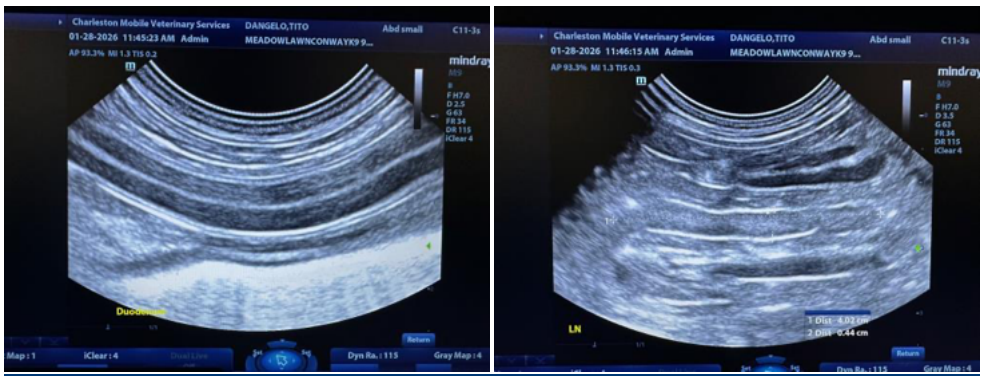

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com