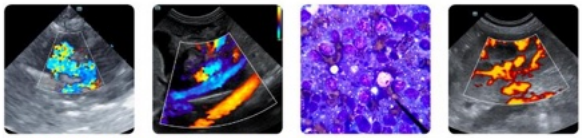



**PATIENT**

Ballian

**SPECIES**

Canine

**BREED**

Lab

**SEX**

Male, neutered

**AGE**

1/14/16

**WEIGHT**

72 lbs.

**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**

Waterway

**REFERRING VET**

Dr. McCalla

**INVOICE**

13429

**DATE**

12/10/25

## PRESENTING CLINICAL SIGNS

Pt has a several week history of vomiting, diarrhea and inappetence. Lab work and radiographs WNL.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is overall normal in size with an irregular shape. A 0.98 cm swelling is observed at the left lateral aspect. The parenchyma is subtly heterogeneous in appearance. The prostatic urethra is not overtly dilated.

The left kidney is normal in size (7.25 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 hydroureter. Renal vasculature is normal.

The right kidney is normal in size (6.93 cm in length) with a normal shape, architecture and 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.

### *Adrenal Glands*

The left adrenal gland is normal in size (0.83 cm at cranial pole) (0.67 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 (0.77 cm at cranial pole) (0.59 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 (1.59 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 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. 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 scant amount of echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

### *Gastrointestinal*

The gastric lumen is not distended. The gastric wall is subjectively thickened although wall thickness Is difficult to determine due to rugal folds. Layering appears intact. The pyloric outflow tract is

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patent. The small intestinal lumen is not dilated. The duodenal wall is normal thickness with a normal layering pattern and appropriate mural detail. One segment of what appears to be jejunum, measuring >4 cm, is thickened (up to 0.64 cm), irregular and hypoechoic with loss of the normal layering pattern. The tissue appears to extend beyond the serosal surface. Surrounding mesentery is hyperechoic. The remaining small intestinal segments are normal in thickness with a normal layering pattern. The ileocolic junction is normal. A focal area of colonic wall at the junction of the transverse and descending colon is thickened (up to 0.64 cm) with a trend toward loss of the normal layering pattern. The remaining colonic wall is normal to borderline thickened with normal layering pattern. The colonic lumen contains some liquid appearing 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***

A 1.50 x 0.98 cm heterogeneous slightly cavitated lymph node is observed in the mid to caudal abdomen on the left side. 2-3 prominent mesenteric lymph nodes are visualized, one of the nodes measuring 0.84 x 0.62 cm.

***Free Abdomen***

There is no obvious evidence of free fluid.

***Other***

A brief echocardiogram reveals no obvious evidence of pericardial or pleural effusion in the visible window.

## ULTRASONOGRAPHIC FINDINGS

**Primary Findings:**

- Bowel wall thickening with loss of layering, suspected to be jejunum. Infiltrative neoplasia (i.e., adenocarcinoma, lymphoma) is suspected with a lower possibility of a focal inflammatory process. Adjacent peritonitis is present.
- The regional lymphadenopathy could be consistent with reactive change or metastatic disease.
- The focal colonic wall thickening could be consistent with infiltrative neoplasia or inflammatory disease.
- Suspected gastric wall thickening most consistent with gastritis.
- The prostatic changes are concerning for emerging neoplasia (i.e., carcinoma). However, a benign process (i.e., parenchymal remodeling, prostatitis, hyperplasia) cannot be excluded.
- The enlarged lymph node seen in the mid to caudal abdomen could be consistent with infiltrative neoplasia, lymphadenitis or lymphoid hyperplasia.

**Secondary Findings:**

- Minor bilateral nonspecific, age-related renal changes

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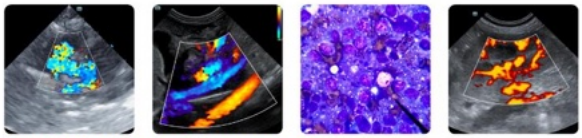

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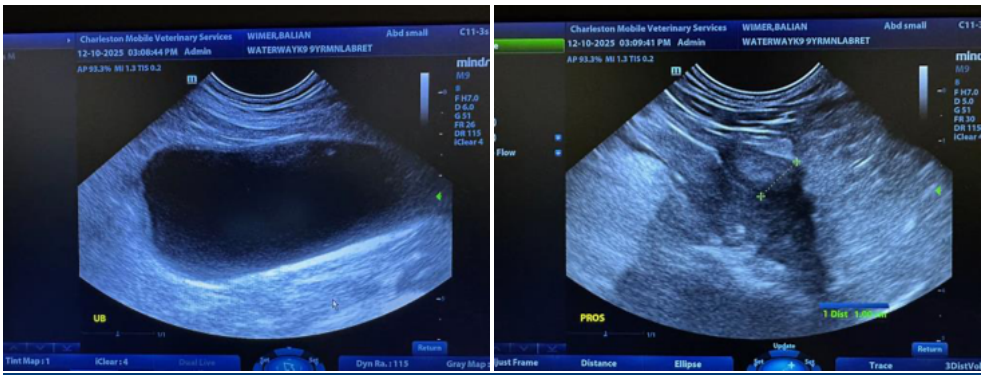
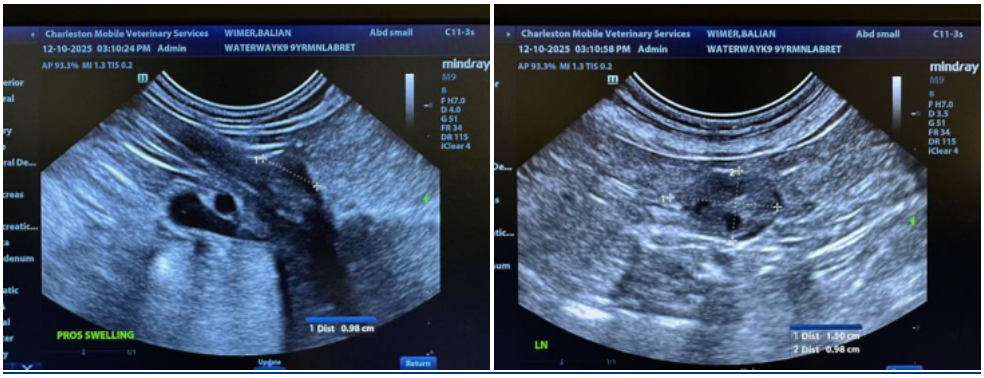
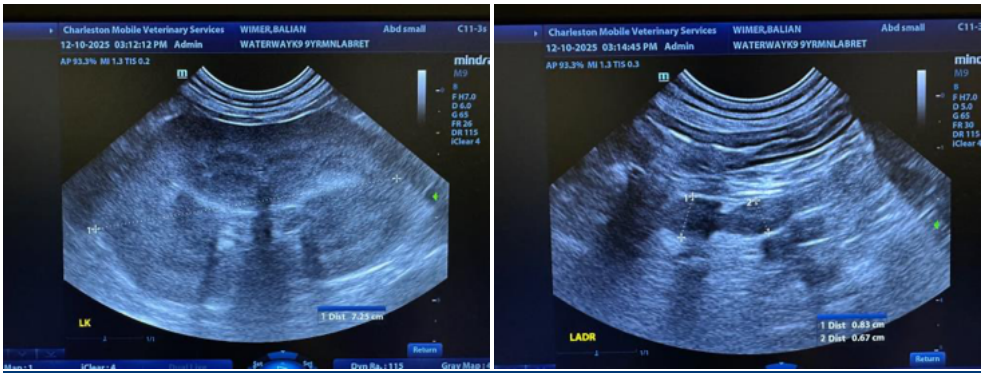
## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Three-view thoracic radiographs are recommended to assess for pulmonary metastases. If there is no evidence of pulmonary metastatic disease and an aggressive approach is desired, consider an abdominal exploratory with biopsies +/- resection of the thickened jejunal segment along with biopsies of the thickened colon and stomach. Prominent lymph nodes should also be biopsied. If further diagnostics are not pursued, palliative care is recommended.



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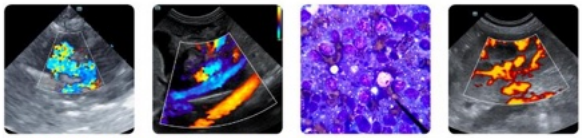

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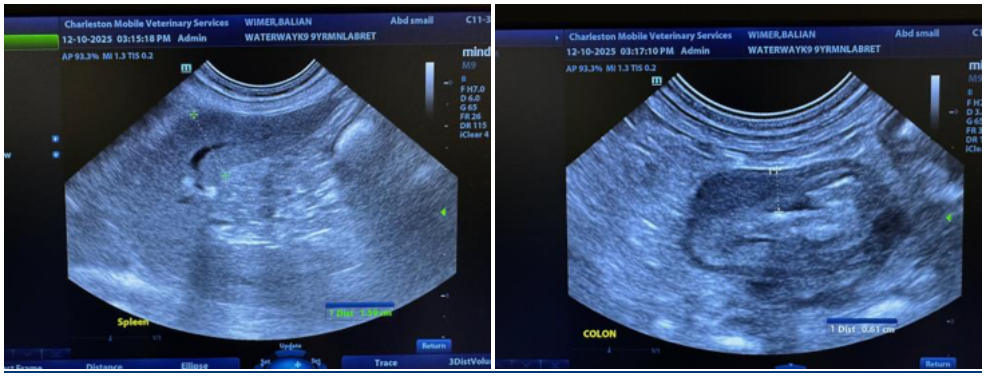


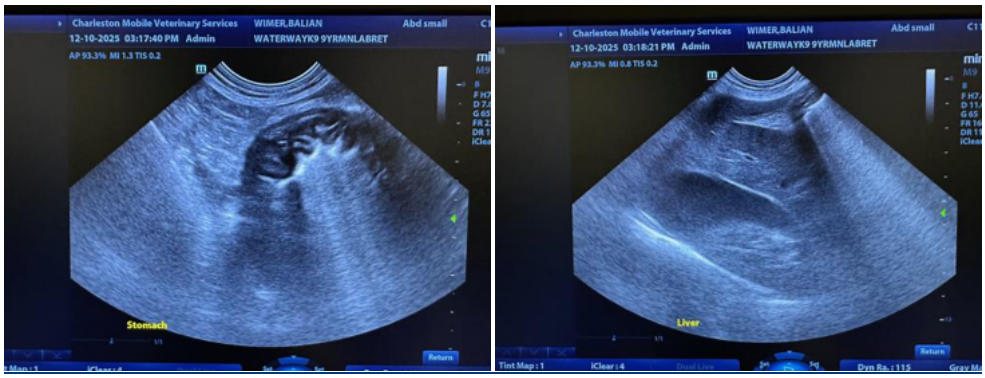


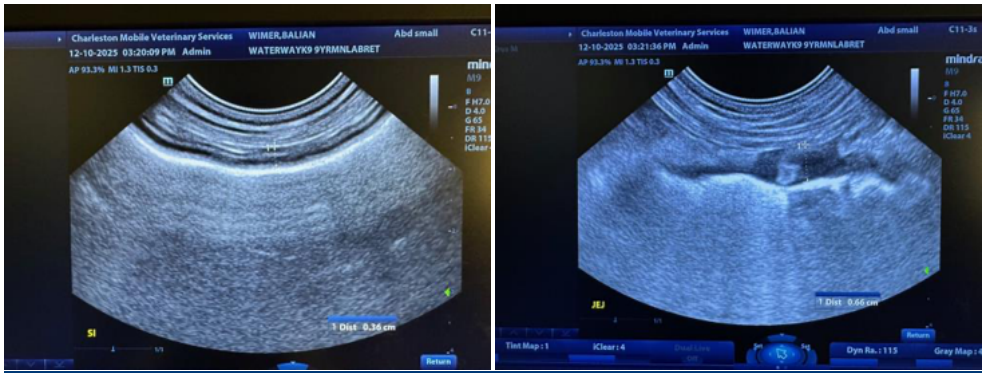


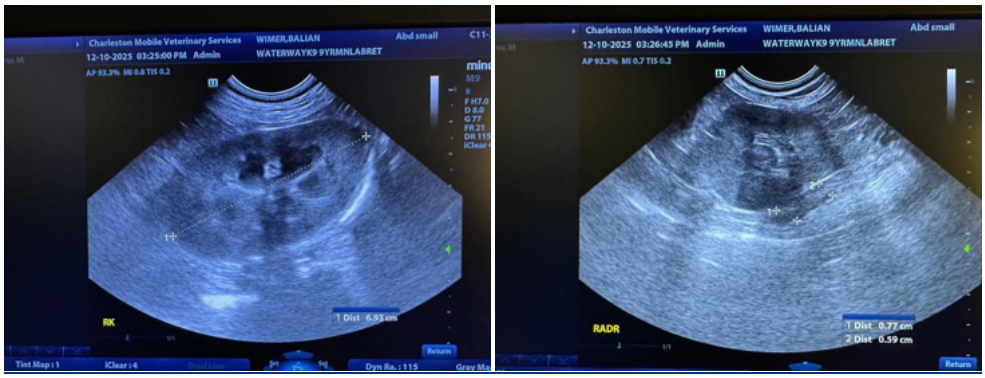

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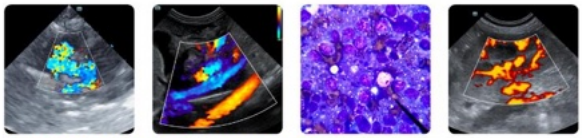

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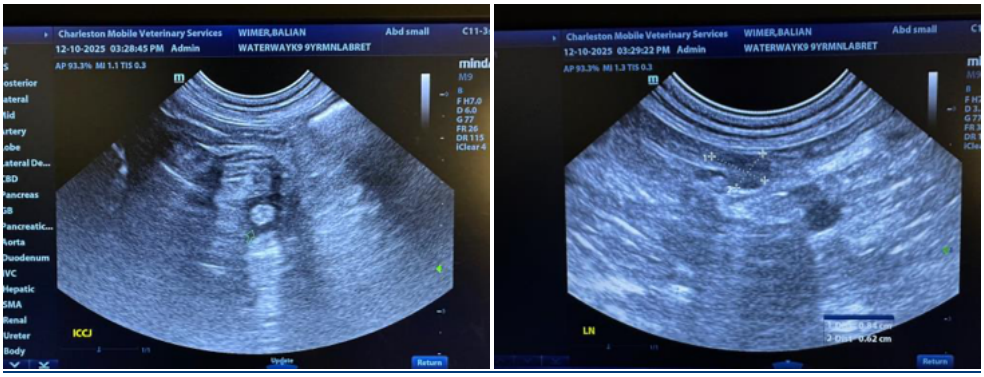


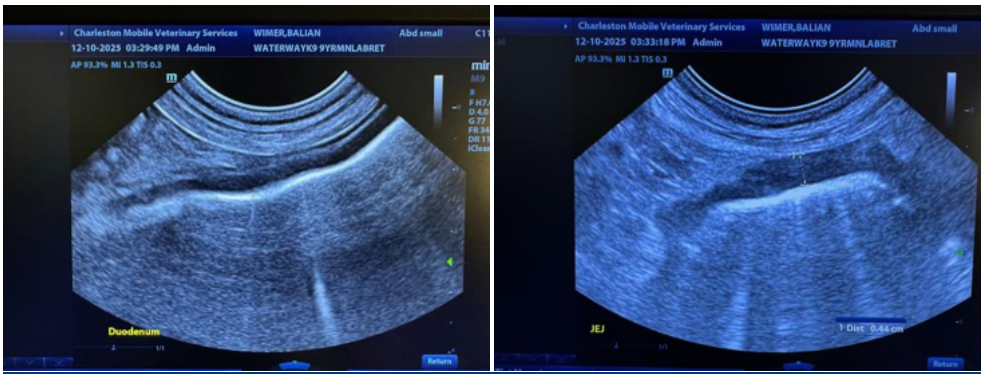


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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