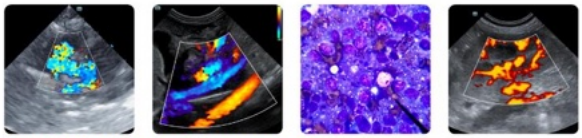

PATIENT

Florence Wagner

SPECIES

Canine

BREED

Beagle

SEX

Female, spayed

AGE

10/11/2010

WEIGHT

25.2 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

VC Myrtle Beach

REFERRING VET

Dr. Rodger

INVOICE

13407

DATE

12/3/25

PRESENTING CLINICAL SIGNS

15 yr FS Beagle presented for lethargy, panting, and bloating of the abdomen after eating. Hx of vomiting x2-3 weeks that resolved after switching to Hills I/D. No diarrhea, normal appetite. Currently on Ursodiol.

Gall Bladder sludge appreciated on u/s
abdominal rads are concerning for abdominal mass in the mid/cranial region

Hx of chronic urinary symptoms (UTIs, malodorous urine, hematuria - bladder inflammation noted on u/s on several occasions)

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 3-4 cm, are normal.

The left kidney is normal in size (5.05 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. Trace pyelectasia is present (0.19 cm in the longitudinal plane). Several small cortical cysts are seen. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (5.06 cm in length) with a normal shape, smooth peripheral margins and normal internal architecture. There is moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. Several cortical cysts are seen. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is borderline enlarged (0.47 cm at cranial pole) (0.70 cm at caudal pole) with a slightly irregular shape. The glandular echogenicity and detail are unremarkable. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.84 cm at cranial pole) (0.65 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 (1.11 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 enlarged with swollen curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and subtly heterogeneous in appearance. A 5.1 x 2.8 cm isoechoic swelling is observed left to mid-liver. 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.

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The gall bladder lumen is moderately distended. The wall is variably thickened (up to 0.36 cm) and hyperechoic. A small to moderate amount of partially dependent debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is moderately to severely fluid distended and hypomotile. Ingesta is also seen within the fluid. 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 ileocecocolic junction and colonic wall are normal. There is no obvious evidence of an obstructive pattern.

Pancreas

The base and limbs of the pancreas are 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.

Lymph nodes

A 1.68 x 0.40 cm medial iliac lymph node is visualized.

Free Abdomen

There is no obvious evidence of free fluid.

Other

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The gastric distention could be consistent with gastric ileus (i.e., secondary to a primary motility disorder, other enteropathy, or underlying metabolic disease), recent water/food ingestion, other. There is no obvious evidence of a mechanical outflow tract obstruction.
- The left to mid hepatic swelling could be consistent with a prominent swollen benign liver lobe, emerging adenoma, adenocarcinoma, other. A benign process is favored at this time. The diffuse hepatic parenchymal changes are non-specific and could be consistent with vacuolar hepatopathy (i.e., idiopathic, endocrine), regenerative nodular hyperplasia or less likely, inflammatory disease, infiltrative neoplasia, hepatotoxicosis or other hepatopathy.
- The gallbladder wall changes are suggestive of cholecystitis. The partially dependent debris may be secondary to cholestasis, fasting or emerging mucocele.

Secondary Findings:

- Borderline left adrenomegaly
- Bilateral non-specific, age-related renal changes with cortical cysts, trace left pyelectasia and right dystrophic mineralization.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

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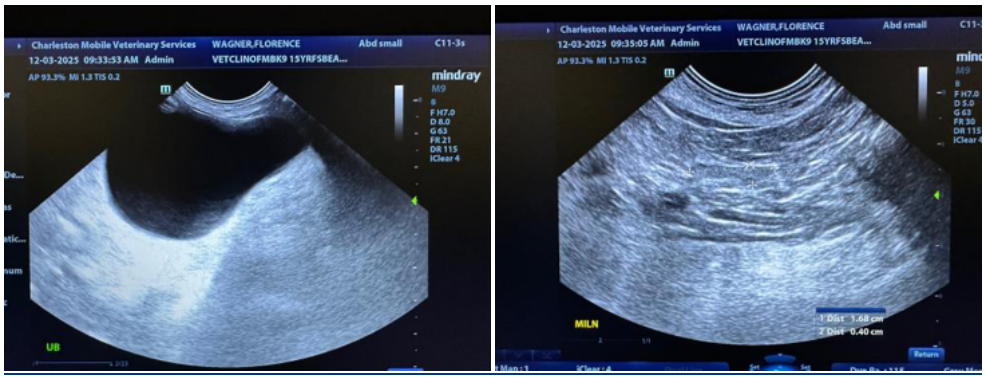
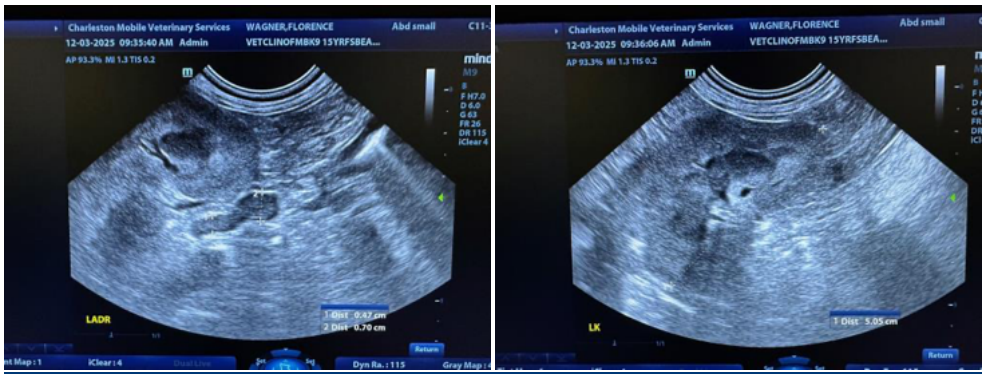
- Prominent medial iliac lymph node is likely reactive with a low possibility of emerging neoplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. If vomiting recurs, consider further workup (i.e., GI panel including serum cobalamin, folate, TLI, PLI, limited antigen diet trial, Metoclopramide trial +/- endoscopic or surgical GI biopsies).
2. Regarding the hepatic changes, consider a recheck ultrasound in 2-3 months to assess for emerging pathology. Serial monitoring (i.e., every 3 months) of the patient's liver values is also recommended.
3. Given the gallbladder changes, continuation of Ursodiol therapy is recommended with serial monitoring (i.e., every 6-8 weeks) of the patient's gall bladder to assess for progression to a fully-formed mucocele.





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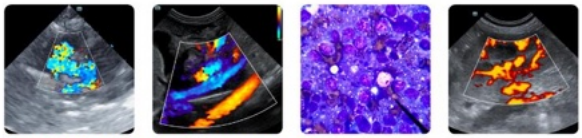

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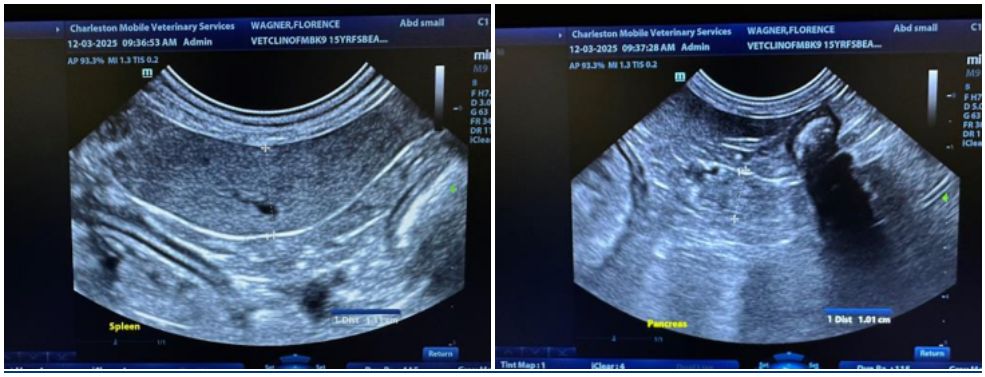

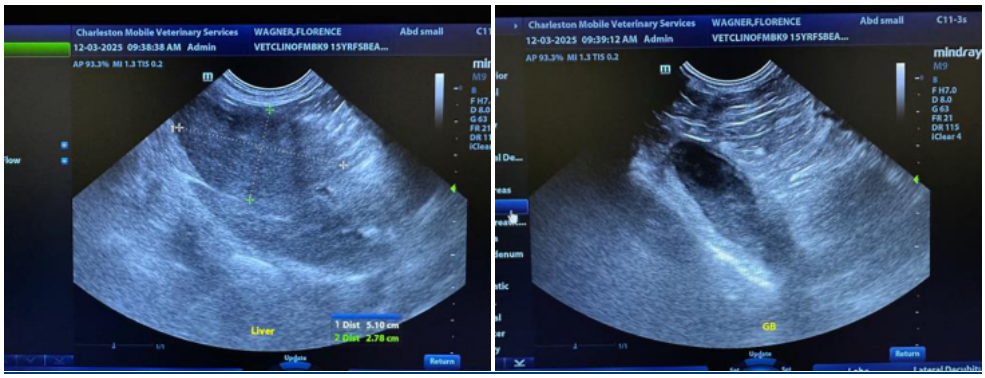

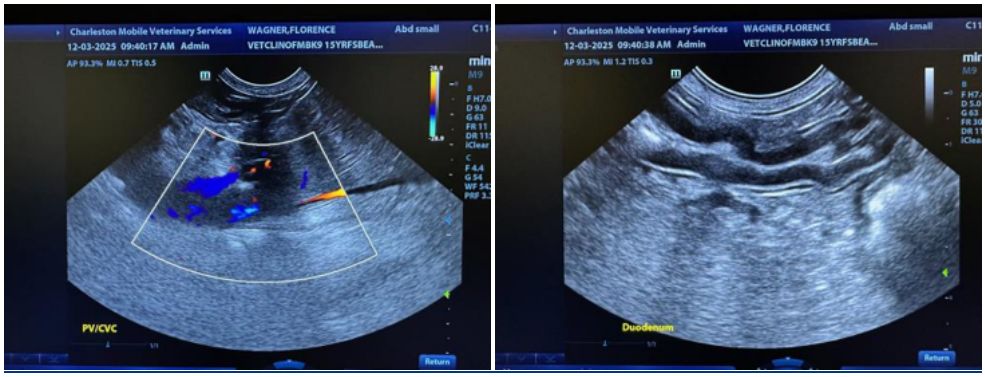

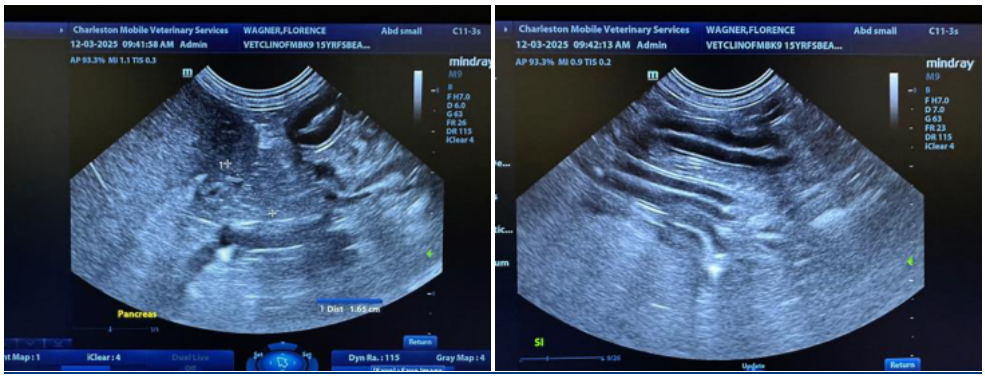

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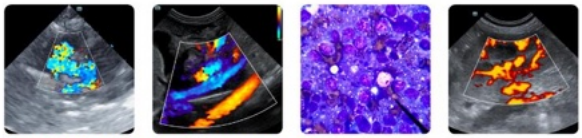

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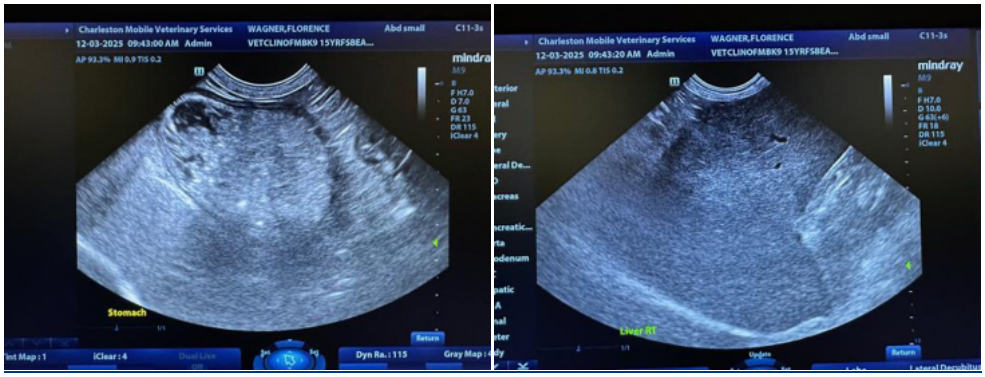

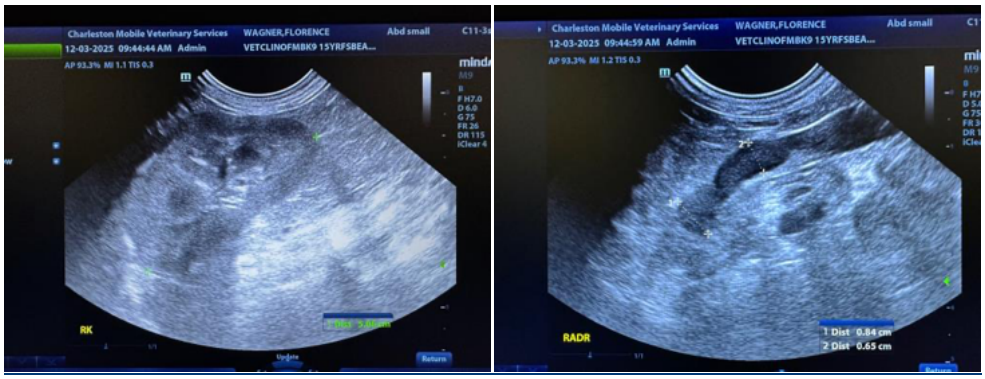

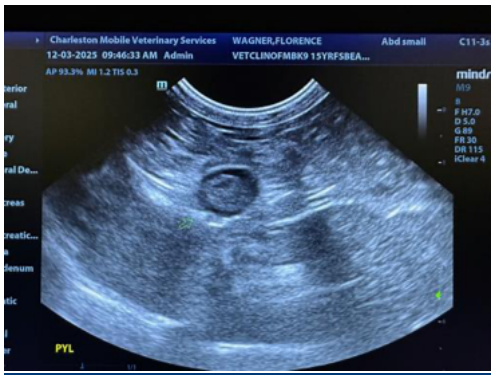

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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