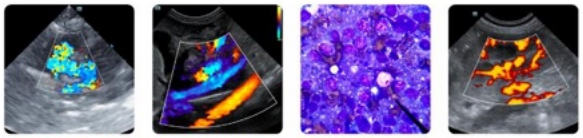

PATIENT

Gunther Nonman

SPECIES

Canine

BREED

Dachshund

SEX

Male, neutered

AGE

8/31/2014

WEIGHT

15.7 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

13497

DATE

2/24/26

PRESENTING CLINICAL SIGNS

- Pt presented 2/23 for continued care from ER for second episode of gastric dilatation
- clinically well at home since previous episode in october 2025 - resolved with short course of metoclopramide
- mildly elevated liver values 2/22
- repeat rads showed moderate gastric distention, approximately half the size of initial rads yesterday
- recommended ultrasound to r/o obstruction, obvious neoplasia, etc.
- hx of HAC - managed on trilostane

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 enlarged (1.41 cm in width) with smooth peripheral contours. The parenchyma is mildly heterogeneous in appearance. The prostatic urethra is not overtly dilated.

The left kidney is normal in size (5.35 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild 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 (4.98 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.

Adrenal Glands

The left adrenal gland is enlarged (0.83 cm at cranial pole) (1.20 cm at caudal pole) with swollen peripheral contours and an irregular shape. The glandular echogenicity and detail are unremarkable. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is enlarged (1.30 cm at cranial pole) (0.85 cm at caudal pole) with swollen peripheral contours. 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 (1.06 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 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 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. The cystic and common bile ducts are normal/not seen.

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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 ileocecocolic junction and colonic wall are normal. The colonic lumen contains shadowing fecal material. 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 hyperechoic relative to surrounding omental fat and heterogeneous in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Lymph nodes

The abdominal lymph nodes are normal/not visible.

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 prostatomegaly could be consistent with late-in-life neutering (if applicable), emerging neoplasia, prostatitis, hyperplasia, other.

Secondary Findings:

- Bilateral adrenomegaly consistent with the previous diagnosis of hyperadrenocorticism.
- The diffuse hepatic changes are most consistent with vacuolar hepatopathy (i.e., endocrine, idiopathic) with a lower possibility of inflammatory disease, infiltrative neoplasia, or other hepatopathy.
- Excessive gallbladder sludge. This may be secondary to cholestasis, fasting or an emerging mucocele.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Bilateral nonspecific, age-related renal changes

*An obvious cause for the episodic bloating is not identified in this study. Considerations include primary gastrointestinal motility disorder, aerophagia (i.e., secondary to primary respiratory disease), other.

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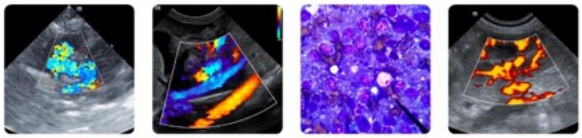

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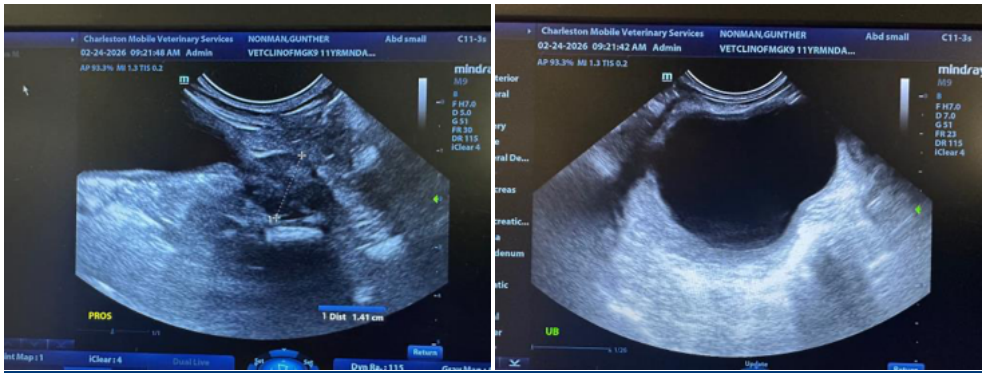
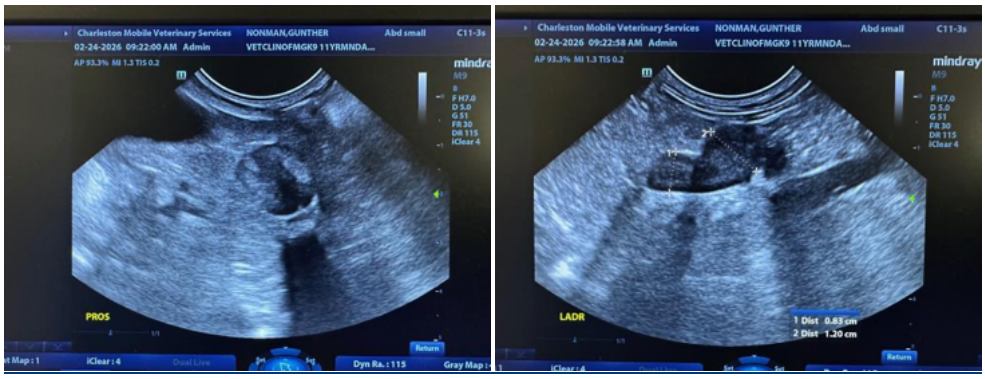
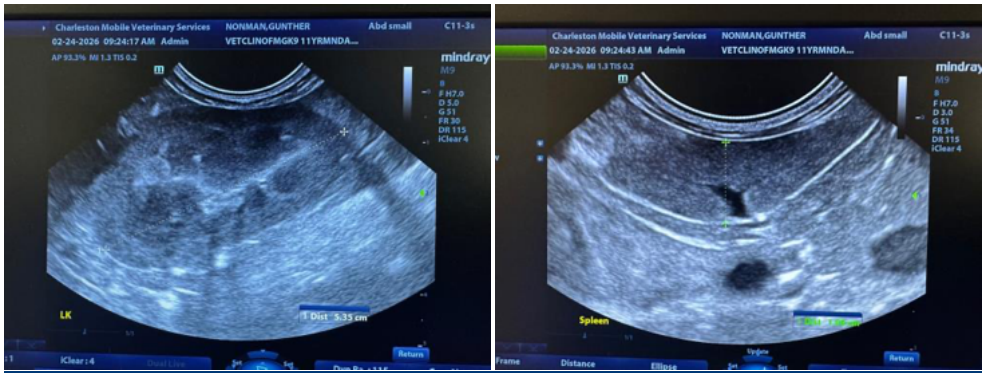
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. A thorough history regarding the patient's respiratory status would be useful in determining if aerophagia is a potential cause for the bloating.
2. Consider empirical treatment for a primary motility disorder (i.e., Metoclopramide).
3. Regarding the prostatomegaly, consider a urine BRAF test to further evaluate for lower urinary tract neoplasia. It should be noted that a positive BRAF test confirms neoplasia. However, a negative test does not rule out the possibility of cancer and further testing (i.e., tissue sampling) may be necessary to get a definitive diagnosis.







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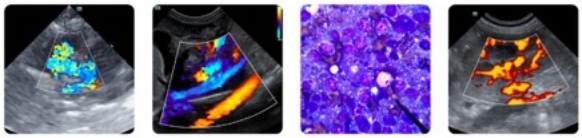

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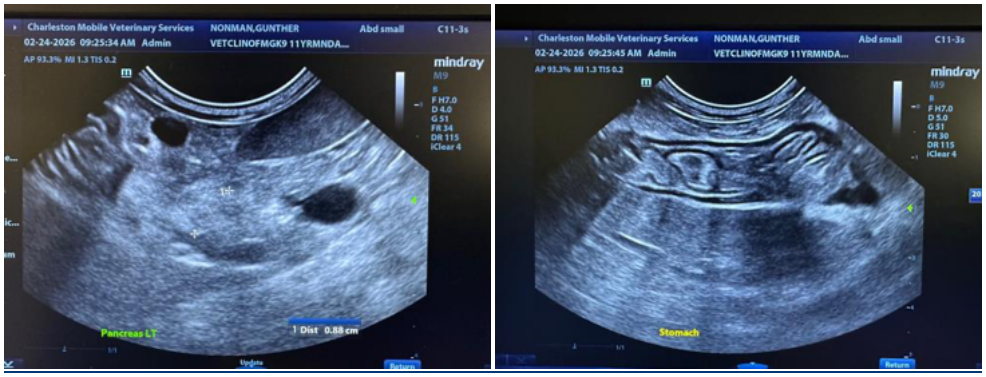

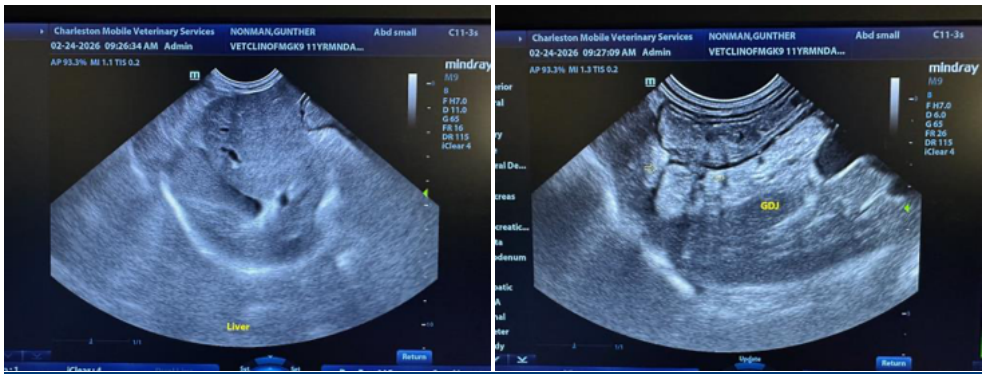

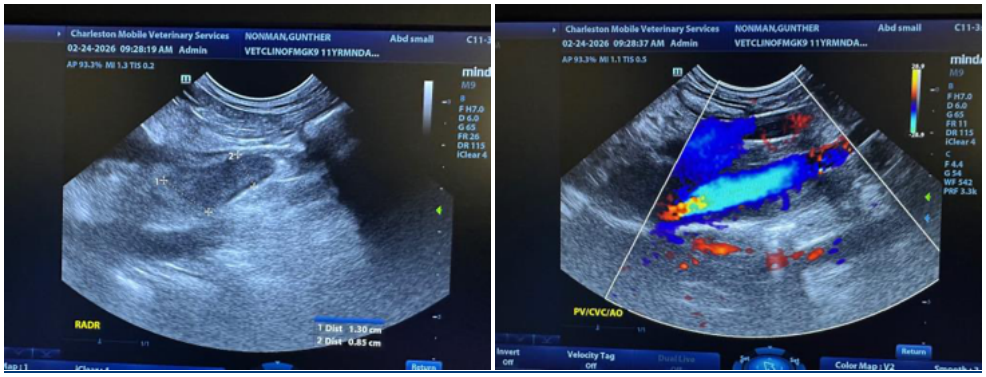

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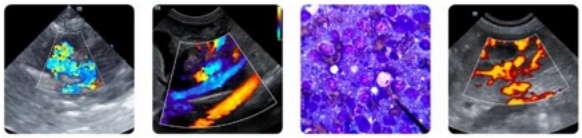

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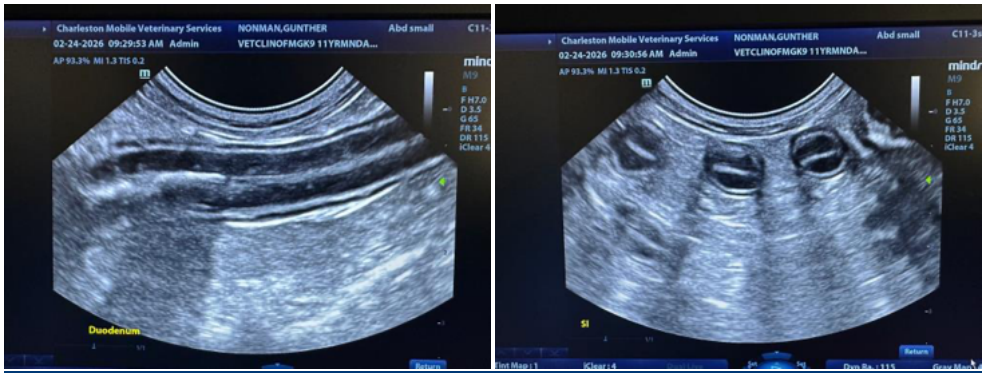

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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