PATIENT

Pennie Robinson

SPECIES

Canine

BREED

Boxer

SEX

Female, spayed

AGE

11 Yrs. 1 month

WEIGHT

68.5 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

Kind Care

REFERRING VET

Dr. Mucci

INVOICE

13603

DATE

3/11/26

PRESENTING CLINICAL SIGNS

Pt not eating or drinking, lethargic, diarrhea, fever 103.3
Small ulcerations at tooth extractions, enlarged spleen palpated.
WBC count 3300 w/ a neutropenia (1640) and lymphopenia (840). ALP 300.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface in the region of the apex is slightly irregular. 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 4 cm, are normal.

The left kidney is normal in size (7.26 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.

The right kidney is normal in size (7.33 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 (0.60 cm at cranial pole) (0.46 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 (1.25 cm at cranial pole) (0.63 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 mildly enlarged (2.39 cm in width at the level of the hilus) with smooth peripheral contour. The parenchyma is subtly mottled in appearance. A 0.61 cm hyperechoic slightly shadowing nodule is observed medially at the mid to caudal aspect. Splenic vasculature is normal.

Liver

The liver is subjectively prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic to slightly hypoechoic 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 small amount of aggregated, echogenic mostly gravity-dependent debris/sludge 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

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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 left limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is mildly hypoechoic relative to surrounding omental fat and slightly heterogeneous in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Lymph nodes

A 1.92 x 0.51 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 splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or antigenic stimulation with a lower possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia). The hyperechoic shadowing nodule likely represents a benign meylolipoma with a lower possibility of more insidious splenic pathology.

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, infiltrative neoplasia and other hepatopathies are considered less likely.
- Gallbladder debris/sludge, non-mucocele
- Minor pancreatic parenchymal remodeling in the left limb.
- The prominent medial iliac lymph node is likely reactive with a low possibility of emerging neoplasia.
- If the patient was fasted for this study, the presence of ingesta within the gastric lumen could suggest delayed gastric emptying.

*An obvious cause for the patient's inappetence, diarrhea and fever are not identified in this study. Considerations include infectious/parasitic disease, other inflammatory issue, occult neoplasia, autoimmune disease, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. A urinalysis +/- culture and sensitivity and a T4 are recommended to complete the minimum database.

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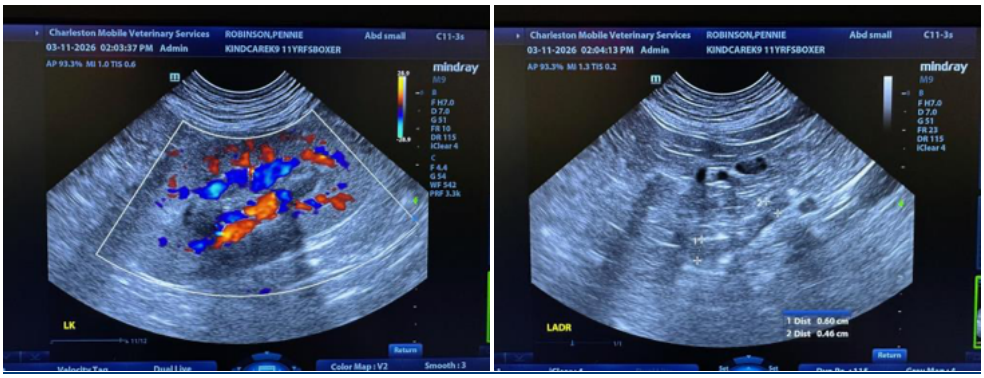
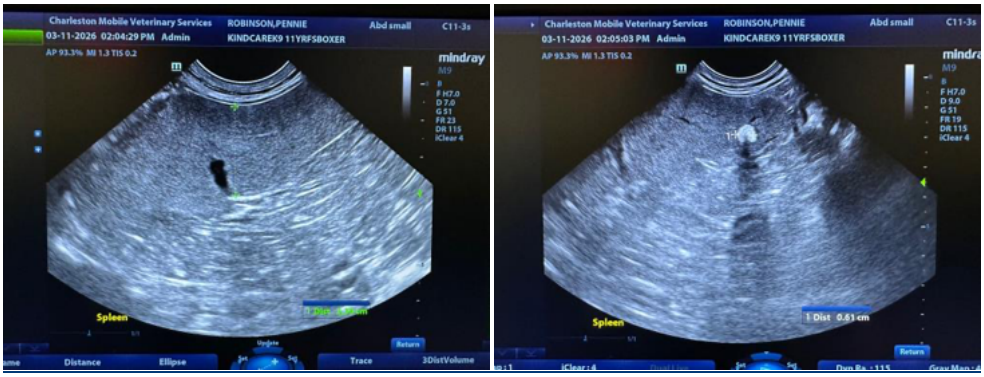
2. A fecal PCR infectious disease panel is also recommended.
3. Also consider prophylactic deworming with Fenbendazole.
4. Consider three-view thoracic radiographs to assess for occult pathology in the chest.
5. Orthopedic and neurologic examinations are also recommended to assess for possible causes of fever of unknown origin.
6. Depending on the results of the above diagnostics, further workup (i.e., full echocardiogram, arthrocentesis, tick panel, bone marrow aspirate +/- CSF tap) may be warranted to further evaluate for causes of fever. In the meantime supportive care is recommended.





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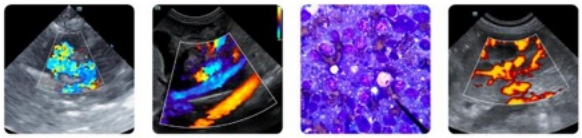

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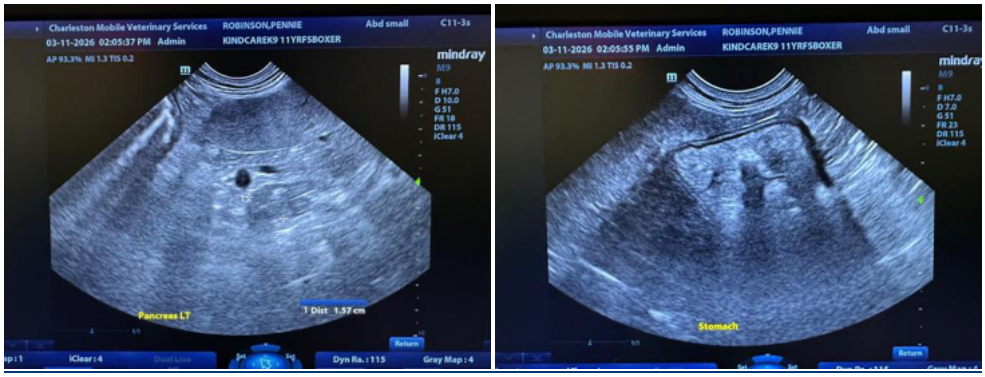

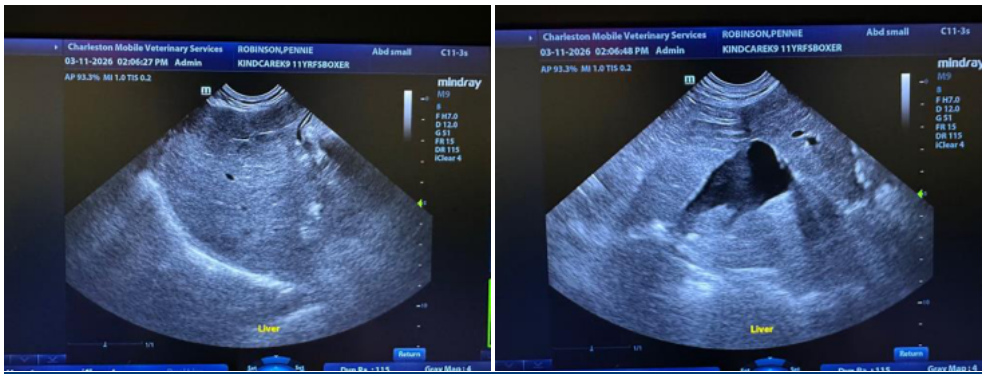

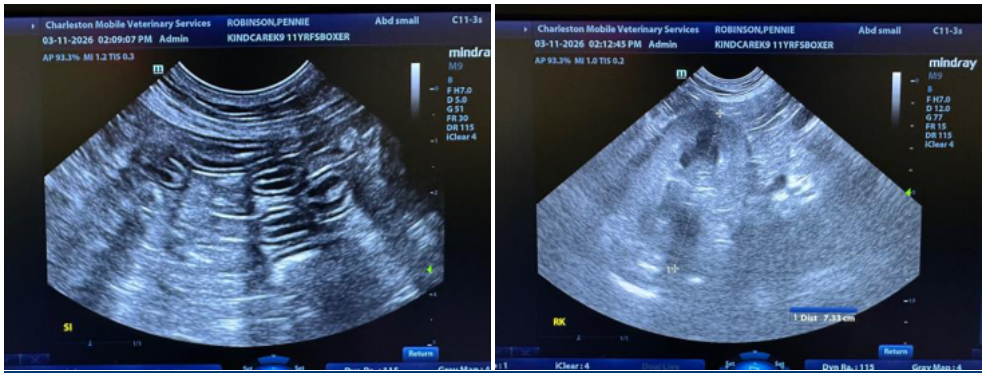

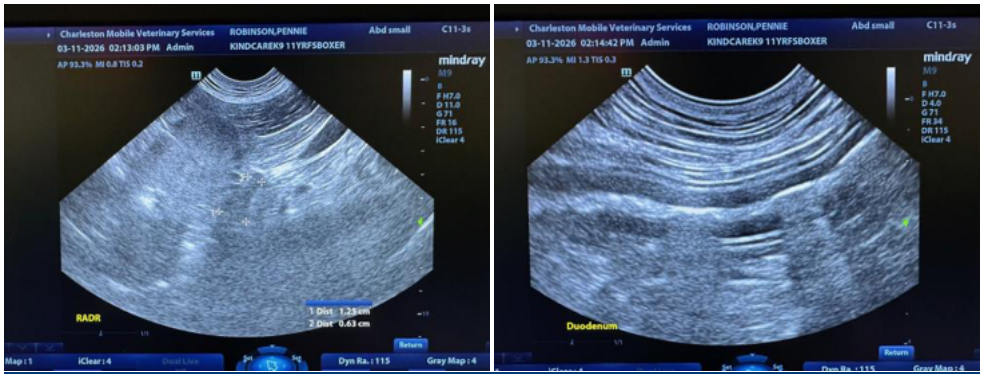

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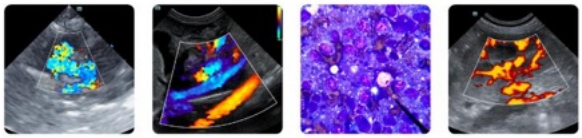

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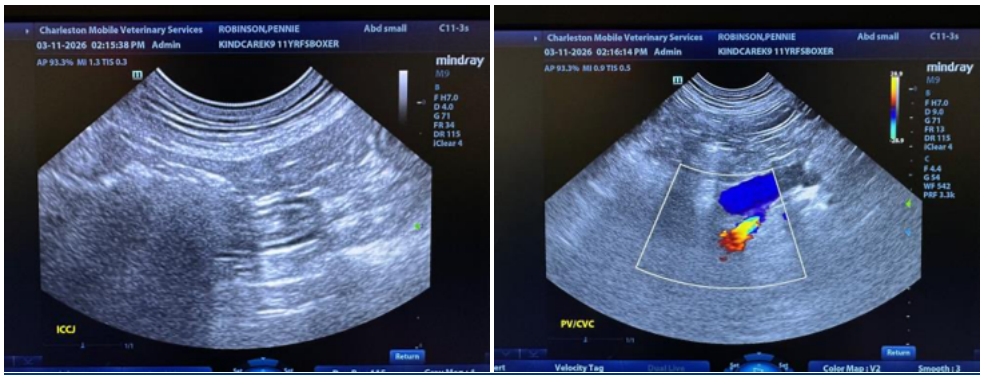

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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