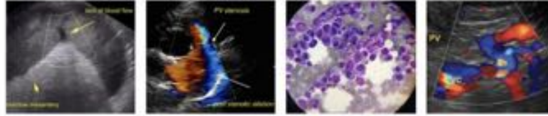


PATIENT

Rose John

SPECIES

Canine

BREED

Pitbull mix

SEX

Female, spayed

AGE

6/15/2008

WEIGHT

51 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

Flowerton AH

REFERRING VET

Dr. Hawk

INVOICE

13223

DATE

4/19/22

PRESENTING CLINICAL SIGNS

Elevated ALT, AST, ALP, GGT- cholangiohep, infectious, bile obstruction, neoplasia, other
Possible linear FB

The patient has been vomiting up everything she eats for the last 4-5 days. Does not vomit immediately after eating, sometimes a couple hours later but only contains undigested food. Still drinking water and keeping that down. No change in appetite. No known dietary indiscretion. Runny stools. Pt is on thyroid medication and anxiety medication.

Abdomen- Painful

Elevated ALT, AST, ALP, GGT- cholangiohep, infectious, bile obstruction, neoplasia, other
Possible linear FB per rad ologist

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are normal in thickness and the mucosal surface is smooth. The bladder lumen is moderately distended with anechoic urine. No masses, inflammatory changes or calculi are observed. Ureteral papillae and visualized portion of the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal size (6.67 cm in length); normal shape and architecture with 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 size (7.32 cm in length); normal shape and architecture with 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.

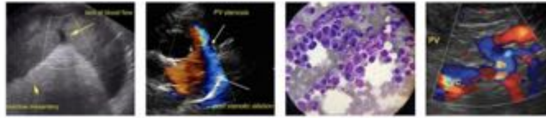
Adrenal Glands

The left adrenal gland is normal size (0.66 cm at cranial pole) (0.74 cm at caudal pole); normal shape; 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 size (0.96 cm at cranial pole) (0.62 cm at caudal pole) (2.52 cm in length); normal shape; 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 (1.61 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A 1.57 cm hypoechoic nodule is observed at the cranial aspect. In addition, a 0.58 cm hypoechoic nodule is also seen. Splenic vasculature is normal.



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Liver

The liver is subjectively normal to slightly prominent in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and diffusely mottled in appearance. A 2.47 cm ill-defined nodule/mass is observed in the region of the right medial lobe. Vascular and biliary tracts are of normal volume with no evidence of congestion. The gallbladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal.

Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. The gastric lumen is mildly distended with gas and a small amount of 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 dilated. The small intestinal wall thickness is normal with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. No obstructive disease is noted.

Pancreas

The region of the left limb of the pancreas is largely isoechoic relative to surrounding omental fat. No obvious pathology is observed in this region. See *Other*.

Free Abdomen

There is no evidence of free fluid.

Lymph Node

See *Other*.

Other

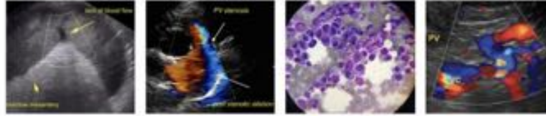
An approximately 3.5-4 cm irregular, hypoechoic to heterogeneous mass is observed adjacent to the pylorus, in the region of the base of the pancreas.

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The origin of the mass in the cranial abdomen is unclear but may be arising from the pancreas, mesentery, lymph node, GI tract, other. A pancreatic origin is favored. Neoplasia (i.e., adenocarcinoma) is suspected. However, a benign process (i.e., inflammatory) cannot be completely excluded.
- The hepatic parenchymal changes, including the nodule, are non-specific and could be secondary to an inflammatory hepatopathy (i.e., bacterial cholangiohepatitis, chronic active hepatitis), infiltrative neoplasia, hepatotoxicosis, Leptospirosis, other hepatopathy.
- The splenic nodule could be consistent with a metastatic lesion, primary tumor or benign pathology (i.e., focus of lymphoid hyperplasia, extramedullary hematopoiesis or splenitis.



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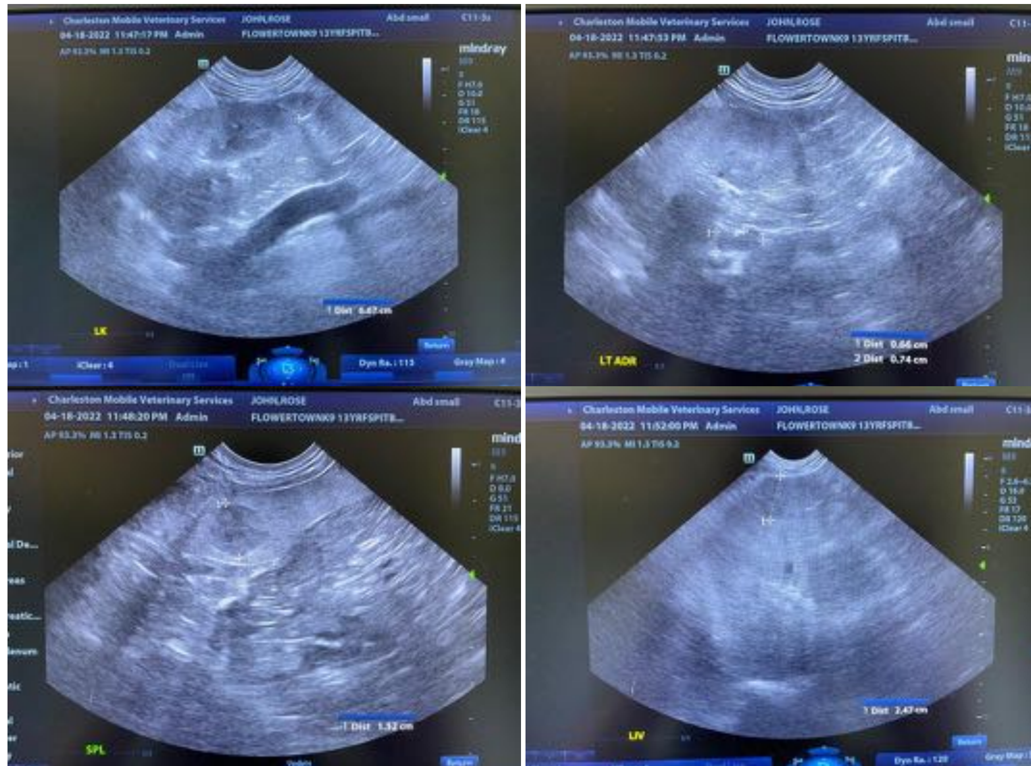
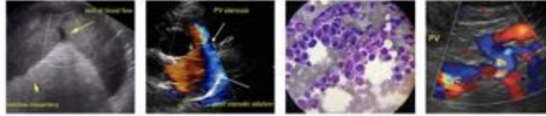
Secondary Findings:

- Bilateral non-specific age-related renal changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider a fine needle aspirate of the splenic nodule, if clotting status is appropriate. A 25-gauge needle should be used.
- Unfortunately, the cranial abdominal mass is not accessible for aspiration. Therefore, an abdominal exploratory with biopsy/removal of the mass as well as liver biopsies, bile cultures (i.e., aerobic and anaerobic) +/- splenectomy with submission of the spleen for histopathology) may be necessary to get a definitive diagnosis.
- While awaiting test results, empirical treatment for bacterial cholangiohepatitis (i.e., fluid therapy, broad spectrum antibiotics, gastric protectants, antiemetics and hepatic antioxidants) is recommended.





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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.

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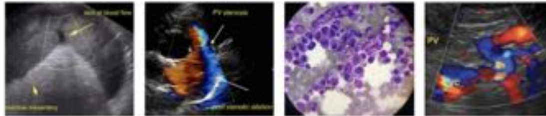

Charleston Mobile Veterinary Services
IMAGING PERFORMED BY
CharlestonMobile.Net 800.403.5408

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

Andrea.Nicastro@CharlestonMobile.net