PATIENT

Simon Bond

SPECIES

Canine

BREED

Yorkie

SEX

Male, neutered

AGE

2/1/16

WEIGHT

8.7 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

AH of South Carolina

REFERRING VET

Dr. Stone

INVOICE

13585

DATE

5/27/26

PRESENTING CLINICAL SIGNS

Pt has 1 month history of vomiting and weight loss with a distended abdomen. Has recently become lethargic. Low proteins, albumin 1.6, elevated QPL 1500

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is mildly to 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 normal in size (0.56 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal in size (3.69 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 (3.69 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 enlarged (0.63 cm at cranial pole) (1.03 cm at caudal pole) with swollen peripheral contours. 2 hyperechoic nodules are observed at the caudal pole, one measuring 0.89 x 0.53 cm and the other measuring 0.58 x 0.34 cm. The glandular echogenicity and detail at the cranial pole are unremarkable. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is mildly enlarged (0.81 cm at cranial pole) (0.56 cm at caudal pole) with a normal shape. 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 (0.77 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 to mineralized partially dependent debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is moderately 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

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is segmentally dilated with chyme. The small intestinal wall is diffusely thickened (up to 0.50 cm) with retention of the normal layering pattern. There is evidence of mucosal fogging in most segments. Discreet masses are not identified. The ileocecocolic junction is prominent. The colonic wall is normal. The colonic lumen contains granular appearing fecal material. There is no obvious evidence of an obstructive pattern.

Pancreas

A portion of the pancreas is obscured by the gastric distention. In the visualized portion of the right limb, the pancreas appears enlarged with slightly irregular peripheral contours. The parenchyma is mildly hypoechoic relative to surrounding omental fat and mottled in appearance. The pancreatic duct is not overtly dilated.

Lymph nodes

1-2 prominent mesenteric lymph nodes are visualized, one of the nodes measuring 2.08 x 0.50 cm.

Free Abdomen

The mesentery throughout the abdomen is hyperechoic. A moderate amount of anechoic free fluid is observed.

Other

A brief visualization of the thorax reveals moderate pleural effusion. There is no obvious evidence of pericardial effusion or intracardiac masses.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The small intestinal wall changes, in conjunction with the patient's clinical history are most consistent with a protein losing enteropathy. Top considerations include lymphangiectasia, inflammatory bowel disease, infectious/parasitic disease or less likely emerging lymphoma.
- The pancreatic changes are suggestive of chronic +/- active pancreatitis.
- Pleural effusion and ascites, likely secondary to hypoalbuminemia.
- The gallbladder changes are most consistent with a developing mucocele.
- Gastric ileus. Functional ileus is suspected as there is no obvious evidence of a mechanical pyloric outflow tract obstruction.

Secondary Findings:

- 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. However, correlation with the patient's liver values is recommended.
- Bilateral adrenomegaly. The left adrenal nodules could be consistent with focal nodular hyperplasia, adenomas, emerging adenocarcinomas, pheochromocytomas, other.

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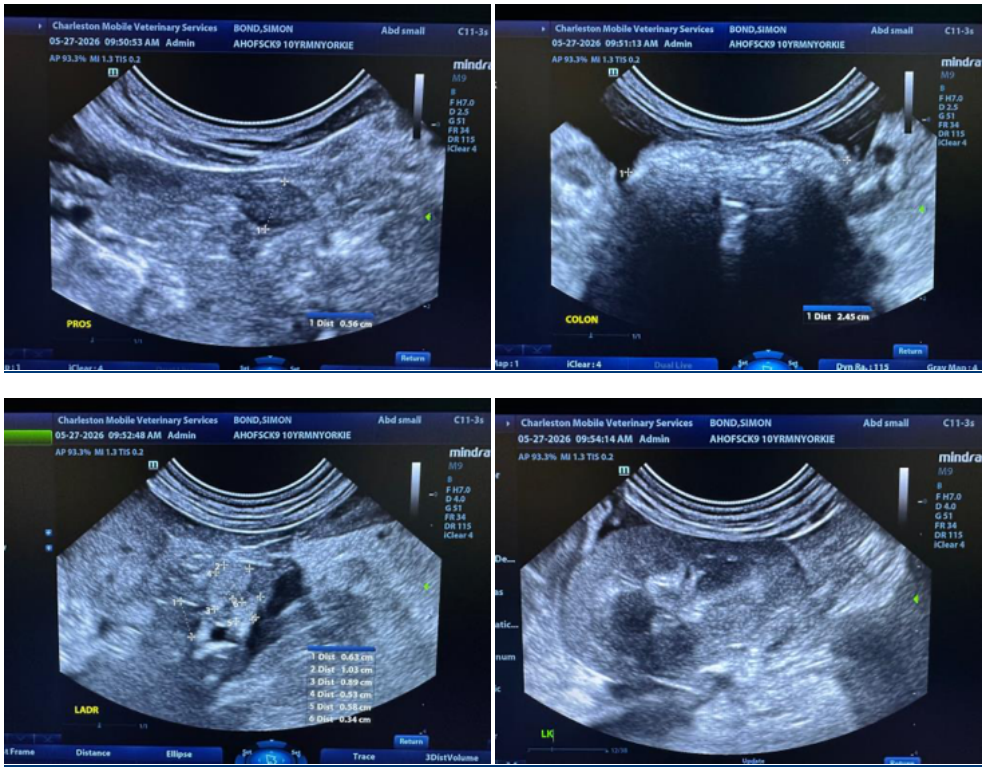
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Further workup for protein losing enteropathy could include the following:
  1. Fecal evaluation for ova and Giardia
  2. GI panel including serum cobalamin, folate, TLI and PLI
  3. Endoscopic or surgical GI biopsies
  4. Transition to a low-fat, limited antigen diet
- Continued symptomatic care for pancreatitis is also recommended.
- Regarding the pleural effusion, therapeutic thoracocentesis may be needed if the patient develops respiratory distress.
- Given the gall bladder changes, Ursodeoxycholic acid (Ursodiol) is recommended. Serial sonographic monitoring (e.g., every 6-8 weeks) of the gall bladder is recommended to assess for progression to a fully formed mucocele. If progression occurs, a cholecystectomy may be warranted.
- Consider testing for hyperadrenocorticism with a low-dose dexamethasone suppression test or ACTH stimulation test if clinical signs (i.e., PU/PD) develop in the future.
- Regarding the left adrenal nodules, consider a recheck ultrasound In 2-3 months to assess for growth of the lesions.



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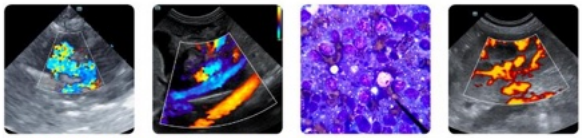

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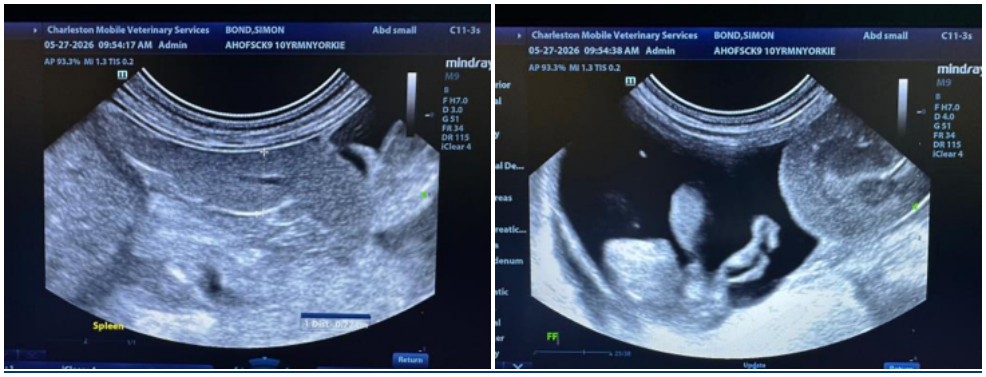

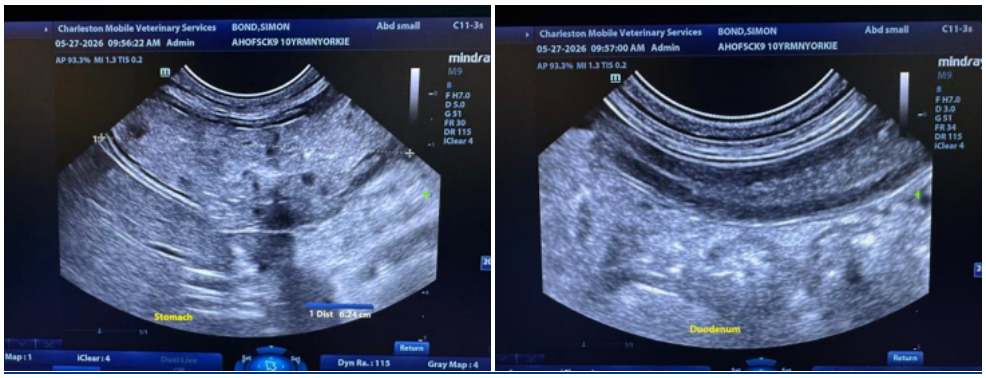

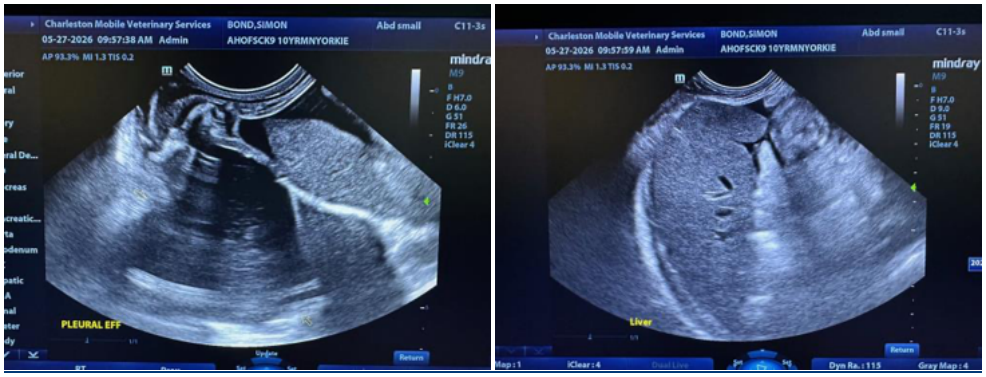

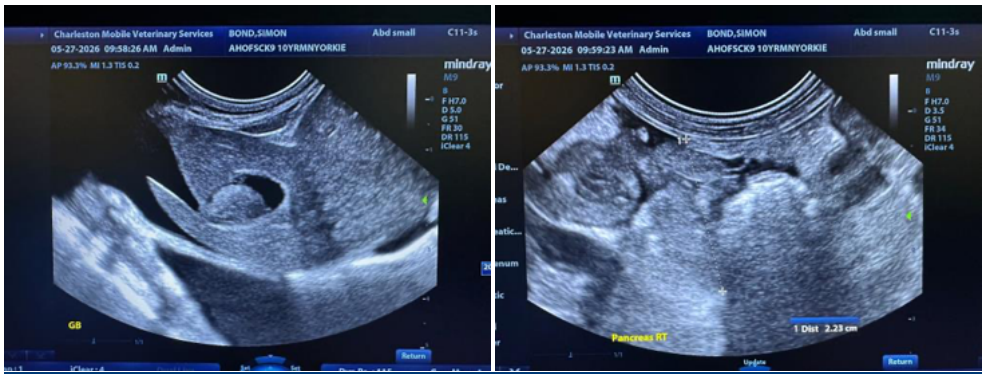

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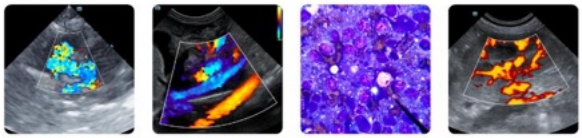

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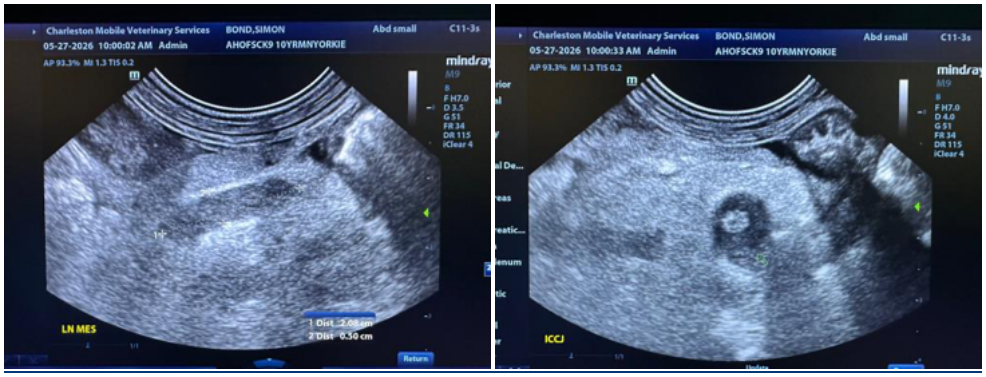

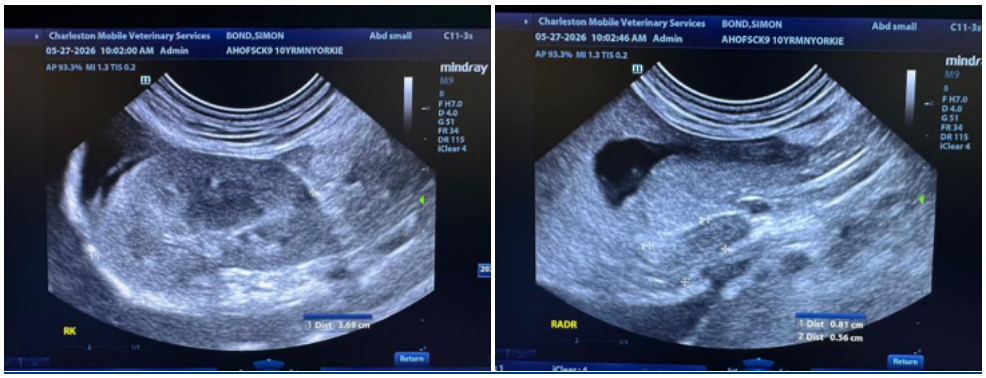

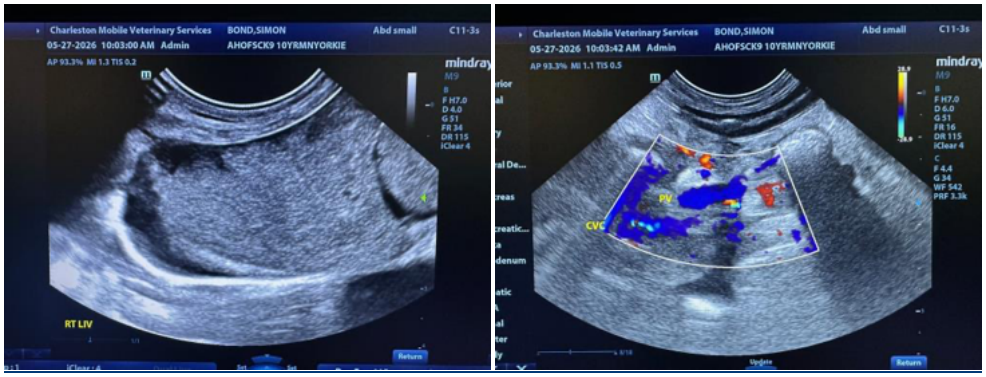

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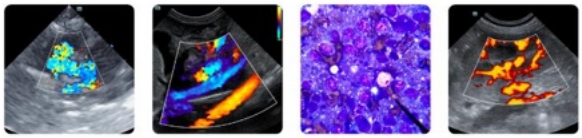

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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