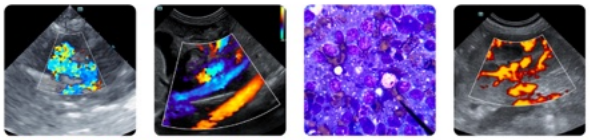


PATIENT

Paisley Dionne

SPECIES

Canine

BREED

Chihuahua

SEX

Spayed female

AGE

12 years

WEIGHT

4.3 kg

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Michelle DeMelo, RVT

HOSPITAL NAME

Woodstock VH

REFERRING VET

Dr. Duschinsky

INVOICE

74707

DATE

4/21/26

PRESENTING CLINICAL SIGNS

History: Presented for her annual exam, O reports PU/PD and showed a video with some muscle twitching of L fore leg which was suspicious for some possible focal seizure activity (?).
Good condition on exam for a 12 yo Chihuahua.
Senior blood and urine showed high total calcium =3.0 (2.2-2.8), moderately elevated urea = 14.2 (3.2-11.0), mildly elevated ALP =197 (5-160) and elevated Lipase = 477 (0-250) with vomiting in the history.
U/A was a dilute midday sample with USG =1.015, O is also reporting waking up at night to urinate.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended, and the wall appears thin and smooth. The urine is anechoic. The bladder neck and proximal urethra have a normal appearance. No calculi or evidence of inflammatory or neoplastic changes are identified.

The left kidney measures 2.72×1.84 cm, with a cortical thickness of 0.30 cm in the sagittal plane. The right kidney measures 2.84×1.91 cm, with a cortical thickness of 0.35 cm. The cortex is isoechoic relative to the hepatic parenchyma. The corticomedullary ratio is normal, and corticomedullary definition is preserved.

Within the renal medulla of both kidneys, multiple hyperechoic foci are identified in a multifocal to clustered distribution. These foci do not form discrete calculi and do not consistently produce clean distal acoustic shadowing. This appearance is most consistent with medullary mineralization (nephrocalcinosis) rather than nephrolithiasis.

Adrenal Glands

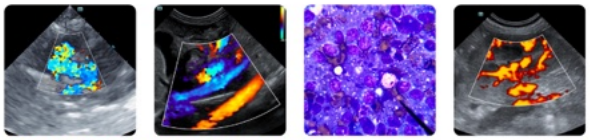
Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.43 cm at the cranial pole and 0.47 cm at the caudal pole. The right adrenal gland measures 0.58 cm at the cranial pole and 0.46 cm at the caudal pole.

Spleen

Splenic thickness is 1.30 cm. The spleen has mildly rounded margins. The parenchyma is mildly heterogeneous, with a few subtle hypoechoic to hyperechoic regions measuring less than 1 cm. A well-defined hypoechoic nodule measuring 0.83×0.99 cm is present, without capsular distortion. The splenic capsule is smooth and regular. Splenic vasculature appears normal.

Liver

The liver is subjectively normal in size, with sharp edges and a regular contour. The parenchyma is mildly hyperechoic relative to the falciform fat, with a homogeneous echotexture. A cystic hepatic lesion measuring approximately 1.71×1.36 cm is identified. No hepatic lymphadenopathy is observed.



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The gallbladder is normally distended. The wall shows changes consistent with mucosal (mucinous gland) hyperplasia, and the lumen contains a moderate amount of biliary sludge. No dilation of the cystic duct or common bile duct is observed.

Gastrointestinal

The stomach is empty and folded, with a mural thickness of 1.71 mm and preserved wall layering. The pylorus measures 4.27 mm. The duodenum measures 2.38 mm, and the jejunum measures 2.85 mm, both within normal limits, with preserved wall layering. No signs of inflammation, ileus, or foreign material are identified. The colon measures 0.84–1.06 mm, with formed feces in the descending segment.

Pancreas

The evaluated pancreatic areas do not show evidence of overt inflammation or neoplastic disease.

Free Abdomen

No sonographic evidence of abdominal effusion, peritonitis, or lymphadenomegaly is identified. The iliac trifurcation is normal.

PRIMARY FINDINGS

- Bilateral renal medullary mineralization (nephrocalcinosis)
- Mild splenic heterogeneity with small hypoechoic nodule.
- Mildly hyperechoic liver with cystic lesion.
- Gallbladder mucosal hyperplasia with moderate biliary sludge

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The presence of bilateral medullary mineralization (nephrocalcinosis) in the context of documented hypercalcemia and PU/PD, is highly supportive of a systemic calcium metabolism disorder, rather than primary renal disease. Hypercalcemia is a well-recognized cause of nephrocalcinosis and can also lead to impaired urinary concentrating ability, consistent with the reported USG.

The adrenal glands are within normal limits in size and appearance, with no evidence of masses. There are no ultrasonographic findings to support adrenal-dependent disease or obvious neoplasia.

The spleen shows mild heterogeneity and a small hypoechoic nodule. In an older dog, these findings are most commonly associated with benign processes such as nodular hyperplasia or extramedullary hematopoiesis, although early infiltrative disease cannot be completely excluded. No features strongly suggest aggressive neoplasia.

The liver demonstrates mild, diffuse hyperechogenicity, which may reflect vacuolar hepatopathy or

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nonspecific metabolic change. The cystic lesion is most consistent with a benign hepatic cyst or biliary structure and is unlikely to be clinically significant.

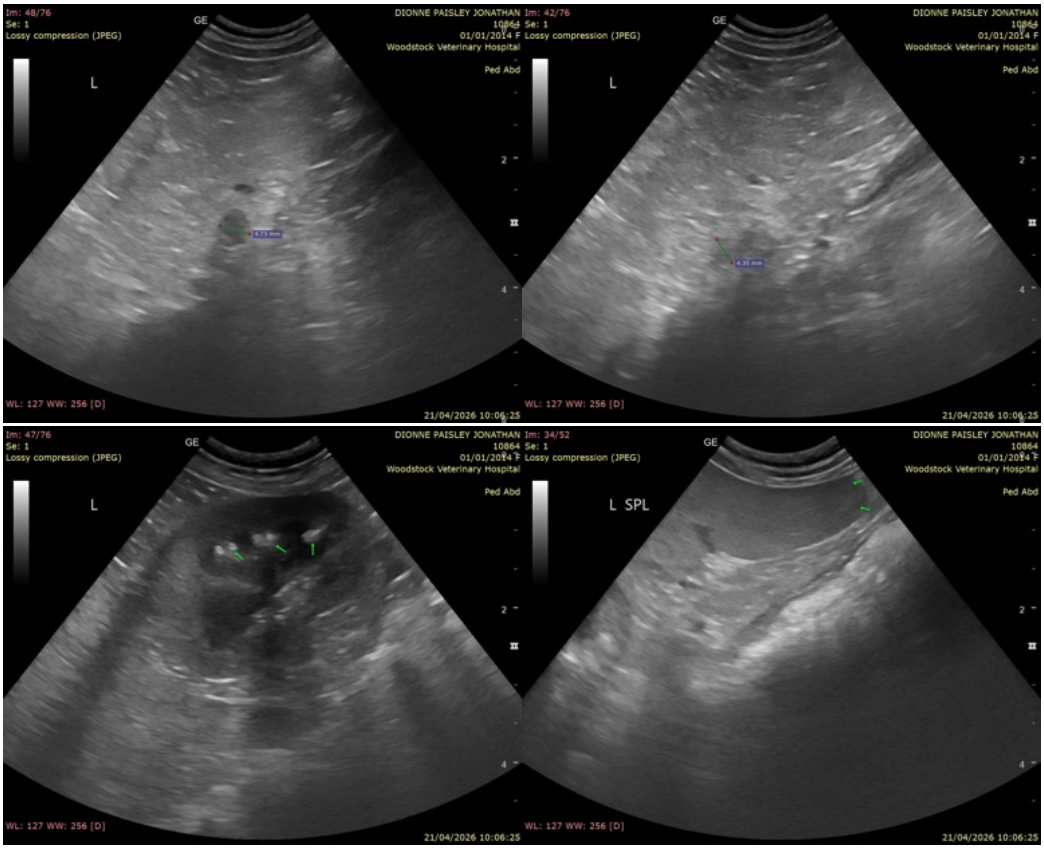
Gallbladder changes are consistent with mucosal hyperplasia and biliary sludge, which are common incidental findings in older dogs and may reflect chronic biliary stasis.

Importantly, no definitive ultrasonographic evidence of neoplasia is identified, including no masses in the abdomen or significant lymphadenomegaly.

Recommendations

- Given the mild degree of hypercalcemia, confirmation with ionized calcium is recommended. If persistent, further evaluation with parathyroid hormone (PTH) and PTH-related peptide (PTHrP) may be considered to differentiate primary hyperparathyroidism from other causes. The ultrasonographic findings, including nephrocalcinosis, support a chronic or metabolic process rather than overt neoplasia.
- Blood pressure and renal parameters should be monitored given the presence of nephrocalcinosis and PU/PD.

Final diagnostic and therapeutic decisions should be made by the attending veterinarian, who can best integrate these findings with the patient's clinical status.



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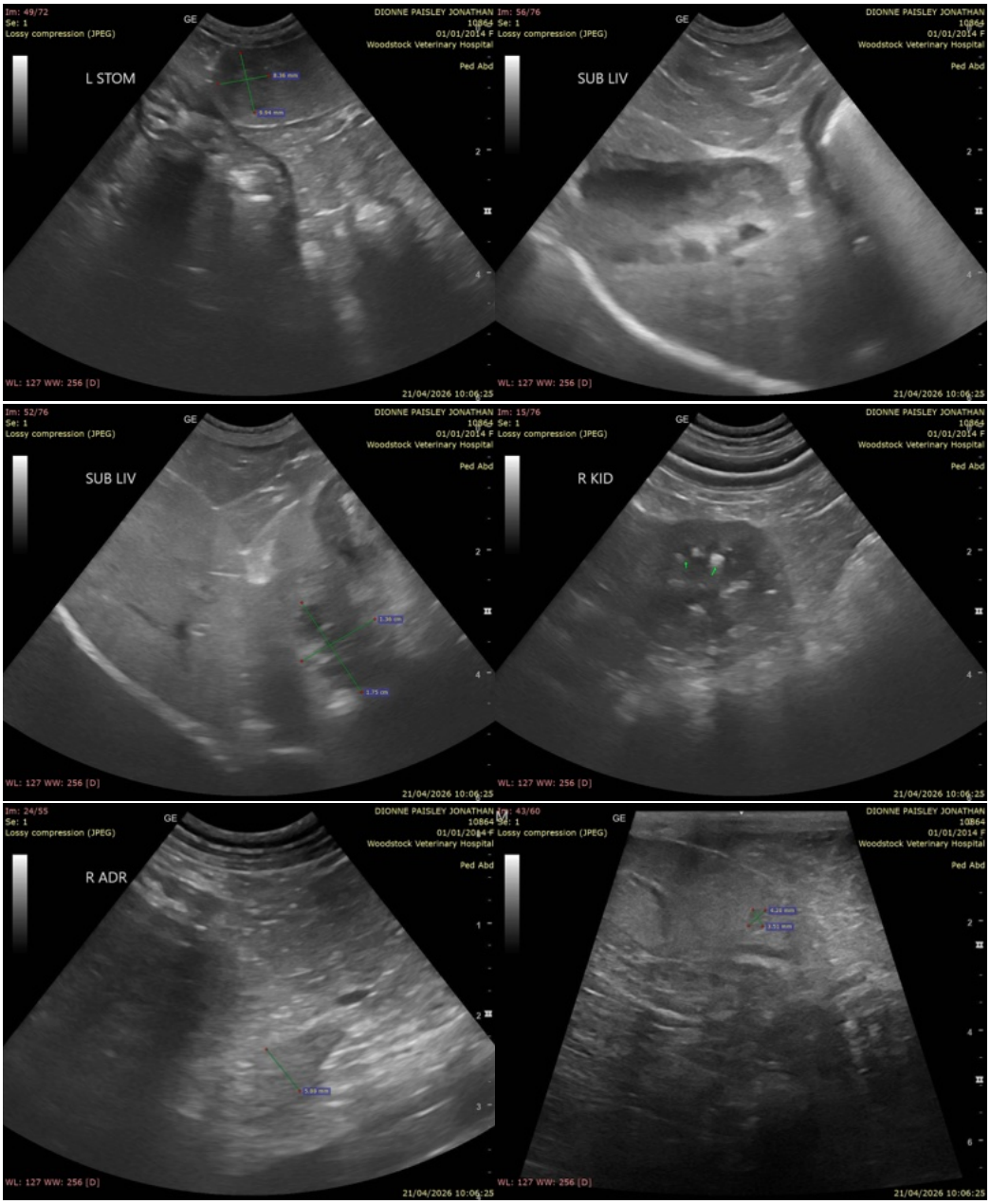

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

info@SonoPath.com