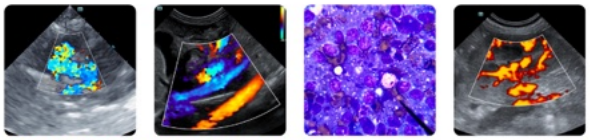


PATIENT

Quinneville Lawry

SPECIES

Canine

BREED

Miniature Schnauzer

SEX

Neutered male

AGE

9 years

WEIGHT

21.1 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Justin Eckenrode, DVM

HOSPITAL NAME

Carlisle Small Animal VC

REFERRING VET

Hillary Morrison, DVM

INVOICE

74940

DATE

4/28/26

PRESENTING CLINICAL SIGNS

History: Major Medical Conditions : History of seasonal atopy, trending elevated ALKP. ALKP continues to elevate, we have been monitoring, no current issues. E/d well, no v/d.
Primary concern or rule out: normal aging changes, Cushing's, mass
Spayed/neutered : yes
ALT 53 (18-121) * was 42* was 27, Alkp 656 (5-160) * was 519 on 9/3/25) * was 276 on 6/11/24

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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

The left kidney measures 5.03×2.24 cm. Cortical thickness is not recorded. The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is within normal limits, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

The right kidney is not visualized. In the right cranial to mid-abdominal region, there is a large cystic structure of uncertain organ origin. The content is markedly echogenic/turbid rather than anechoic, suggesting complex fluid. No clear anatomical continuity with the right kidney can be confidently established on this study.

Adrenal Glands

The left adrenal gland measures 0.47 cm at the cranial pole and 0.57 cm at the caudal pole, within normal limits for a dog of this size (typically ≤0.6–0.7 cm). The right adrenal gland was not confidently visualized.

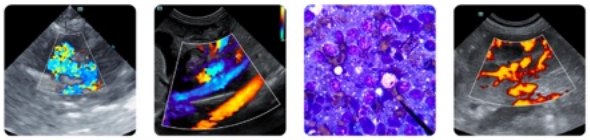
Spleen

Splenic thickness is 1.98 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver

The liver is subjectively normal in size, with sharp edges and a regular contour. The liver parenchyma looks uniform and isoechoic compared to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder lumen is normally distended. The wall is thin and the contents are primarily anechoic with a small amount of biliary sludge. No evident dilation of the cystic duct or common bile duct is observed.



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Gastrointestinal

The stomach is empty and folded, with a wall thickness of 2.90 mm and preserved layering (within normal limits). The duodenum measures 3.15 mm and the jejunum 3.07 mm, both within normal limits, with preserved wall layering. No evidence of inflammation, ileus, or foreign material is identified. The colon contains formed feces; thickness not recorded.

Pancreas

The evaluated pancreatic regions 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

- Large cystic structure in the right abdomen with complex (turbid) content and uncertain origin.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The right kidney is not identified. A large, complex cystic structure is present in the right abdomen, although its organ of origin cannot be determined with confidence on this study.

The inability to demonstrate clear organ continuity is a critical limitation and prevents definitive classification of this structure.

From a pattern recognition standpoint, a purely simple renal cyst would be expected to be anechoic with well-defined margins, which is not the case here. The presence of turbid/echogenic content suggests a complex fluid process, such as hemorrhage, infection, necrosis, or proteinaceous material.
The primary consideration is that this structure may represent a severely altered right kidney, with differentials including:

- Renal abscess
- Marked hydronephrosis with complicated contents (although no clear pelvic dilation pattern is identified)
- Renal cystic or cavitary neoplasm
- Chronic end-stage transformation with cavitation (less typical given size and appearance)

Alternatively, the lesion may be extra-renal, arising from adjacent structures (e.g., mesenteric, retroperitoneal, or less likely adrenal origin), although the anatomical location raises strong suspicion for renal association.

The left kidney appears structurally normal, which is clinically relevant for overall renal function but does not clarify the nature of the right-sided lesion.

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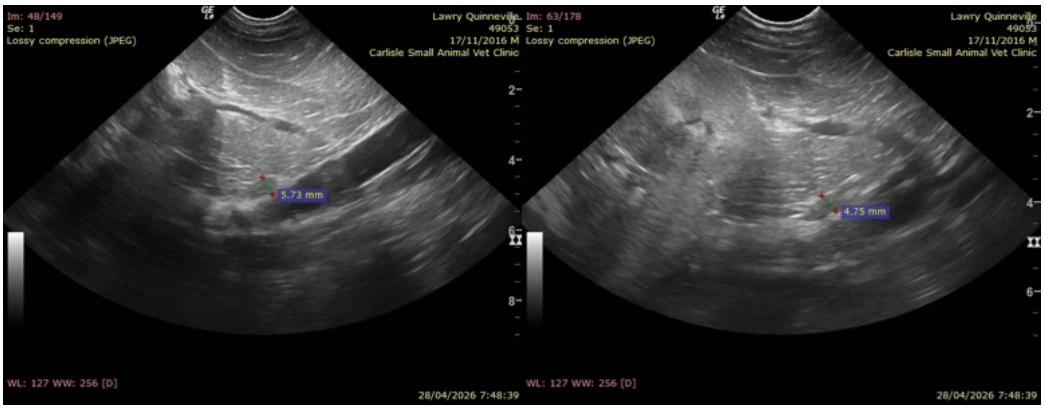
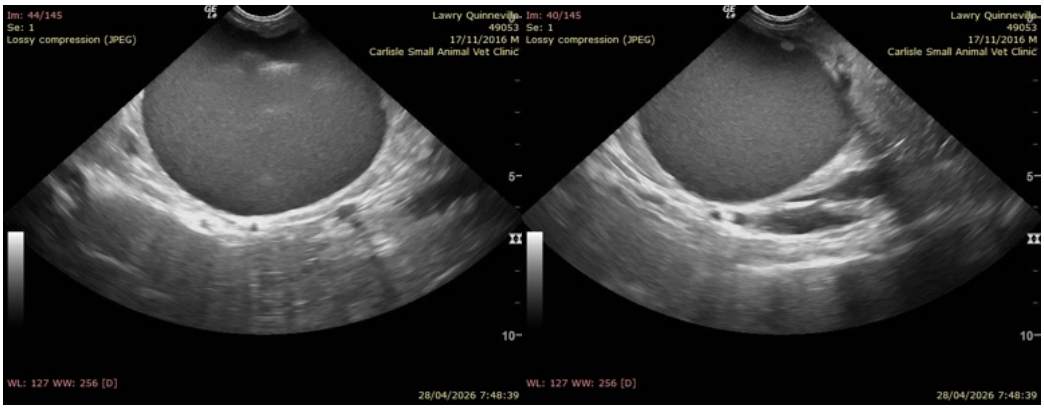
Recommendations

- Further imaging is strongly recommended to better define organ origin, ideally with repeat targeted ultrasound or advanced imaging (CT is preferred if available), as this will significantly improve anatomical characterization.
- Ultrasound-guided sampling (FNA or fluid aspiration) may be considered if safe and clinically appropriate, to differentiate between hemorrhagic, infectious, or neoplastic processes.
- Complete renal function assessment (including chemistry, SDMA, and urinalysis if not current) is recommended to contextualize functional impact.
- If renal origin is confirmed and the lesion is unilateral, surgical exploration (nephrectomy) may be indicated depending on staging and patient status.
- Clinical decision-making should prioritize definitive characterization of the lesion, as management will differ substantially between abscess, neoplasia, and obstructive processes.

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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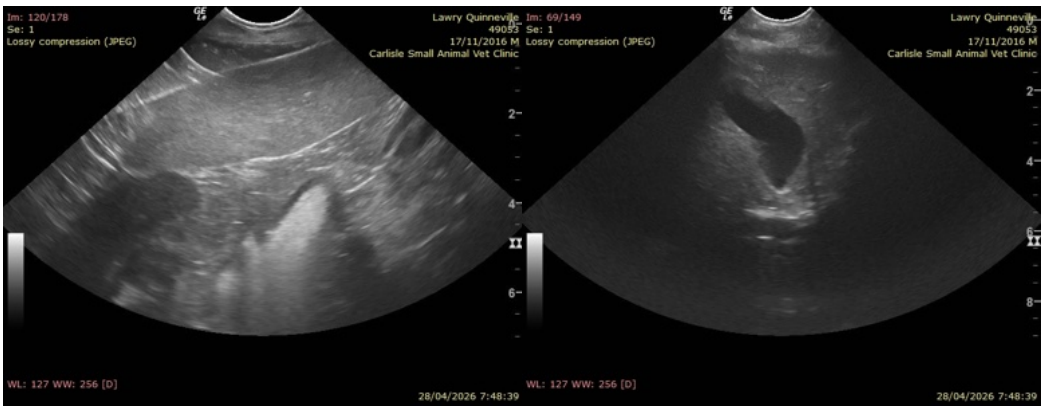

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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