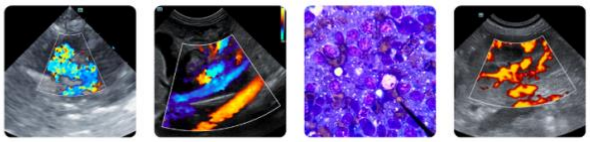


PATIENT

Levi Koski

SPECIES

Canine

BREED

Cockapoo

SEX

Neutered Male

AGE

11

WEIGHT

8.4 kg

INTERPRETED BY

Andrea Nicastro, DVM, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Carlie Koltek, RVT

HOSPITAL NAME

Tuxedo AH

REFERRING VET

Dr. Joselyn Bongiorno

INVOICE

22412

DATE

1-19-26

PRESENTING CLINICAL SIGNS

- Was in two weeks ago and diagnosed with UTI and urolithiasis.
- Cystotomy scheduled but bloodwork showed abnormalities
- Levi is not on any steroids (no oral or topicals)
- Not PU/PD/PP, very energetic, doing very well at home
- Finished Metacam and clavaseptin 5 days prior to bloodwork, no other meds

Abnormal PE/Chem/CBC/UA Results: CBC: Platelets 521 (148 - 484 x10^9/L) Plateletcrit 0.65 0.14 - 0.46 % CHEM: ALT 146 (10 - 125 U/L) ALKP 1,401 (23 - 212 U/L)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly distended. The wall is normal, to moderately thickened (up to 0.76 cm) and irregular. A 1.23 cm cystic calculus is observed within the lumen, along with some mineralized sand. The proximal urethra, visible to a depth of 2 cm, is not overtly dilated.

The prostate is normal in size (0.74 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 (4.13 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild loss of corticomedullary distinction. An ill-defined hyperechoic medullary band is observed at the corticomedullary junction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis.

The right kidney is normal in size (4.37 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 corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.49 cm at cranial pole) (0.60 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 borderline (0.99 cm at cranial pole) (0.56 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.

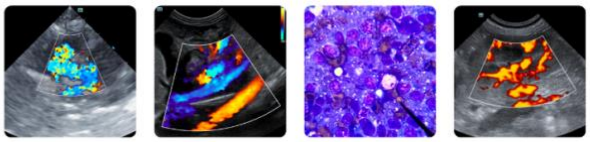
Spleen

The spleen is normal in size (0.91 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 normal- to prominent-in-size with smooth peripheral contours. The parenchyma is isoechoic 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 gallbladder lumen is moderately distended. The wall is thin and smooth. A scant amount of echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.



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Gastrointestinal

The lumen is not distended. The gastric wall is normal in thickness with a normal layering pattern. 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. There is no evidence of an obstructive pattern.

Pancreas

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

Lymph Nodes

The abdominal lymph nodes are normal/not visible.

Free Abdomen

There is no obvious evidence of free fluid.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Cystic calculus/urinary bladder sand, with urinary bladder wall changes consistent with cystitis
- The diffuse hepatic changes are nonspecific 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.
- Borderline bilateral adrenomegaly

Secondary Findings

- Bilateral nonspecific age-related renal changes with left dystrophic mineralization
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the urinary bladder changes, a cystotomy with stone removal, analysis and culture is recommended. Alternatively, an attempt at medical dissolution can be considered. If the patient is to undergo anesthesia, benzodiazepines should be avoided, and opioids used judiciously (in light of the elevated liver values).
- Hepatic tissue sampling (i.e., aspirates or biopsies) can be considered (assuming normal clotting status). If biopsies are pursued, aerobic and anaerobic bile cultures and hepatic copper quantitation should also be performed. If tissue sampling is not pursued at this time, serial monitoring (i.e., every 3-4 months) of the patient's liver values is recommended. If values continue to increase, a repeat abdomen ultrasound +/- a more advanced hepatic work-up (i.e., tissue sampling) 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.

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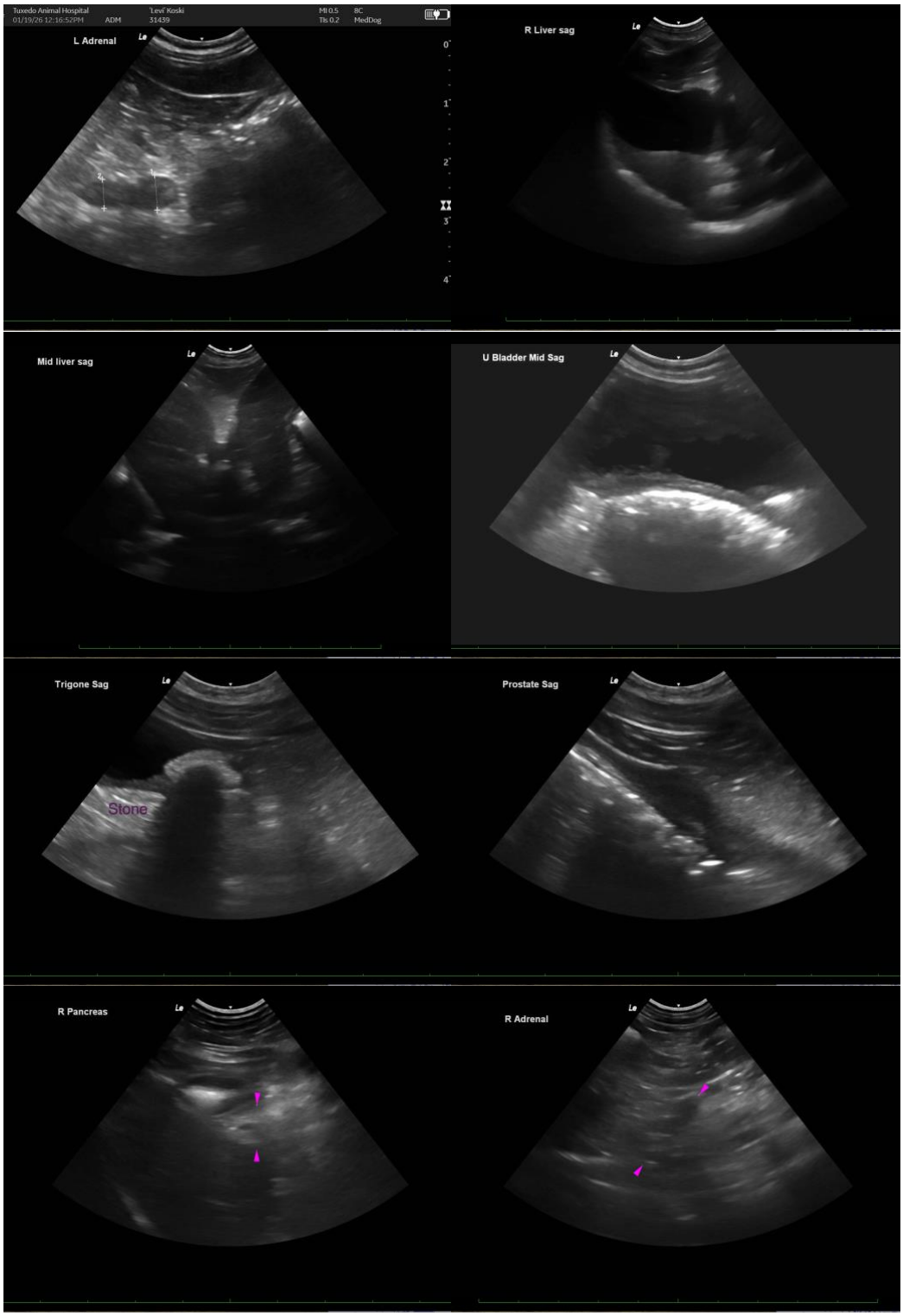

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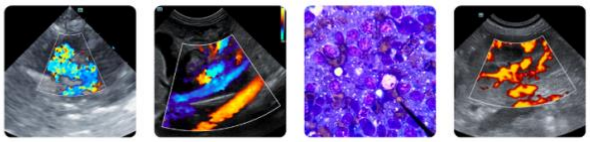

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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