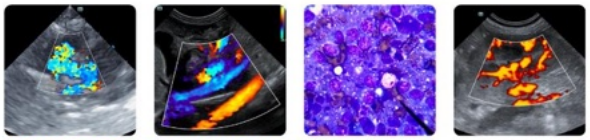




**PATIENT**
Aspen Schrader

**SPECIES**
Canine

**BREED**
Mixed breed

**SEX**
Female, spayed

**AGE**
8 Yrs. 11 months

**WEIGHT**
44.2 lbs.

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

**IMAGING PERFORMED BY**
Dr. Wilkinson

**HOSPITAL NAME**
Severna Park VH

**REFERRING VET**
Dr. Ferguson

**INVOICE**
13413

**DATE**
1/20/26

## PRESENTING CLINICAL SIGNS

History:

- presents for persistent wt. loss, lethargy, possible toothbrush ingestion, vulvar dermatitis, and lymphadenopathy on 1/12/26
- 6lb wt. loss since Dec. 2025
- BCS: 4/9
- presents for cough on 1/13/26 - started prednisone and cefpodoxime
- presents to emergency on 1/19/26 for anemia, melena, vomiting, and lethargy - discontinued prednisone. start cerenia, carafate
- persistent lymphadenopathy today. Submandibular, prescapular, and popliteal. Improved appetite, resolved melena, no V+/D+

Abnormal PE/Chem/CBC/UA Results: 1/12/26 - PCV:52%; low ALB (2.2g/dL); low TP (4.5 g/dL); low Ca (8.6 mg/dL); low Phos (2.3 mg/dL); 1+ proteinuria; moderate leukosuria 1/13/26 - chest rads show mild alveolar pattern and one small nodule within the lungs. O declined rad interp. 1/19/26 - PCV 22%; Total solids 5.0 g/dL);

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is 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 left kidney is normal in size (5.55 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. A hyperechoic medullary band is observed at the corticomedullary junction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

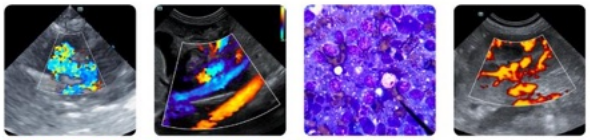
The right kidney is normal in size (5.35 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. A hyperechoic medullary band is observed at the corticomedullary junction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

### *Adrenal Glands*

The left adrenal gland is normal in size (0.37 cm at cranial pole) (0.45 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 mildly enlarged (0.97 cm at cranial pole) (0.71 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*





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The spleen is normal in size (1.77 cm in width at the level of the hilus) with a normal capsular contour. The parenchyma is subtly mottled in appearance with a coarse 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 diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A small to moderate amount of gravity-dependent echogenic to mineralized debris/sand is observed within the lumen. The cystic and common bile ducts are normal/not seen.

### *Gastrointestinal*

The gastric lumen is minimally to mildly distended with fluid and some echogenic debris. A scant amount of shadowing material is also observed within the lumen. 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 left limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic 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*

A 0.85 x 0.75 cm sublumbar lymph node is visualized. In addition, a few enlarged hypoechoic medial iliac lymph nodes are seen, one of the nodes measuring 3.11 x 1.57 cm. A 2.48 x 0.87 cm jejunal lymph node is also seen.

### *Free Abdomen*

There is no obvious evidence of free fluid. The peritoneal cavity is normal. There is no evidence of inflammation or effusion.

## ULTRASONOGRAPHIC FINDINGS

**Primary Findings:**

- The abdominal lymphadenopathy could be consistent with emerging neoplasia (i.e., lymphoma), lymphoid hyperplasia, lymphadenitis, other.

**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. Correlation with the patient's liver values is recommended.
- Minor bilateral, age-related renal changes
- Gallbladder debris/sand, non-mucocele
- Mild right adrenomegaly

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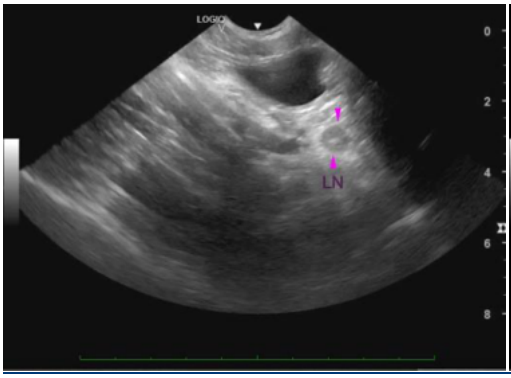
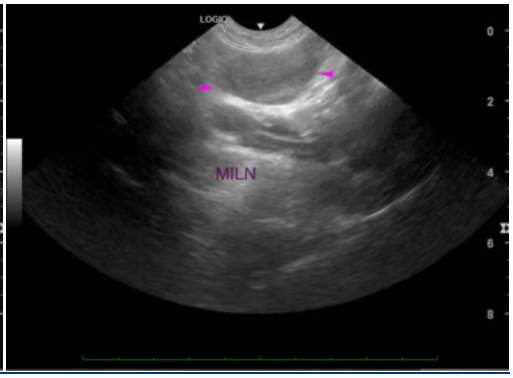
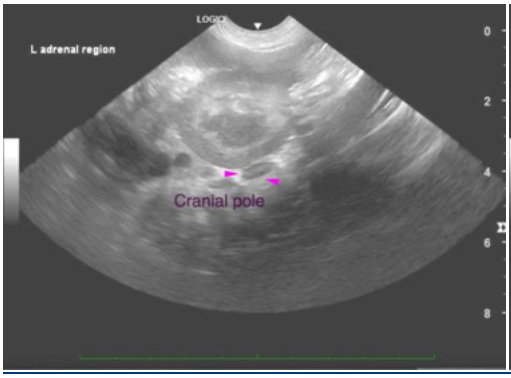
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or antigenic stimulation with a lower possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).

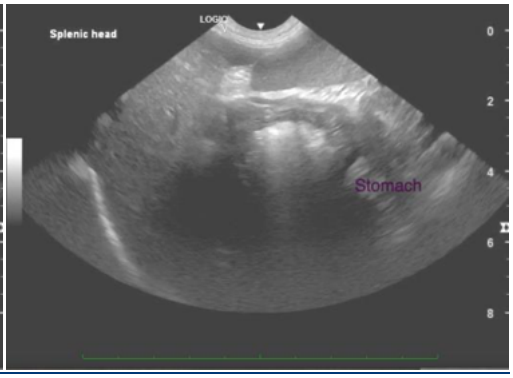
## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Fine needle aspiration of the enlarged medial iliac lymph nodes is recommended (if accessible and if clotting status is appropriate). A 25-gauge needle should be used. Also consider aspiration of any enlarged peripheral lymph nodes. Depending on results, consultation with a board-certified oncologist may be warranted.
- Other diagnostic/therapeutic considerations could include the following:
  1. Fecal evaluation for ova and Giardia
  2. Prophylactic deworming with fenbendazole
  3. GI panel including serum cobalamin, folate, TLI, PLI and resting cortisol level
- In the meantime, symptomatic care is recommended.



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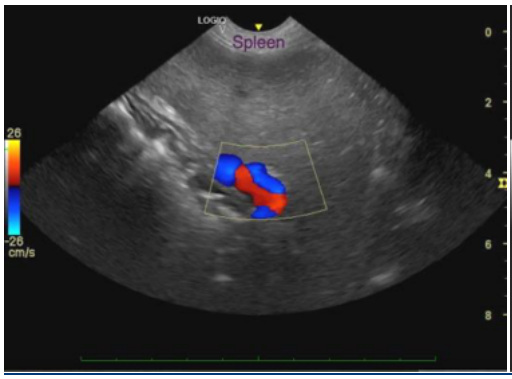


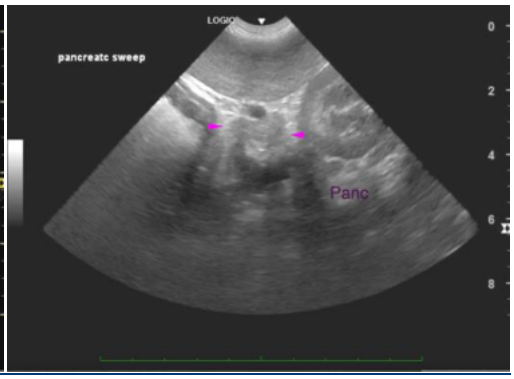



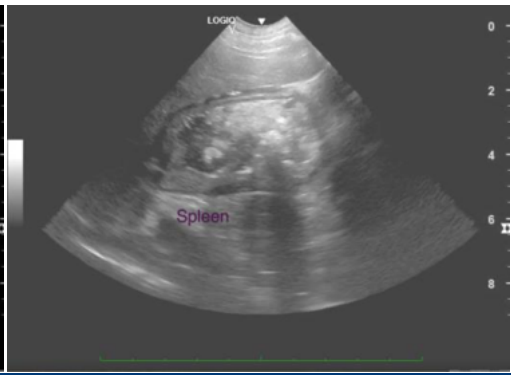


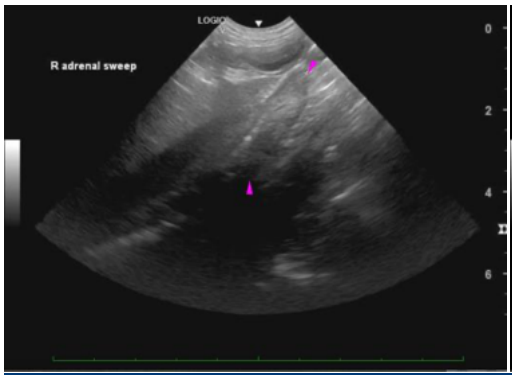


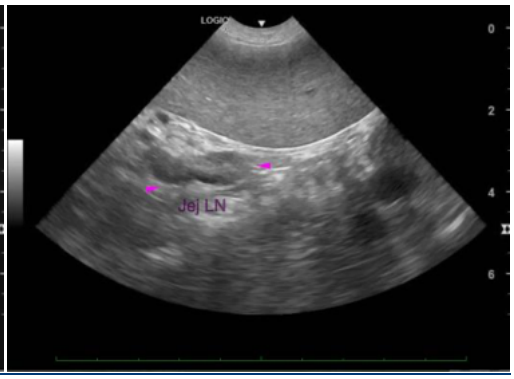


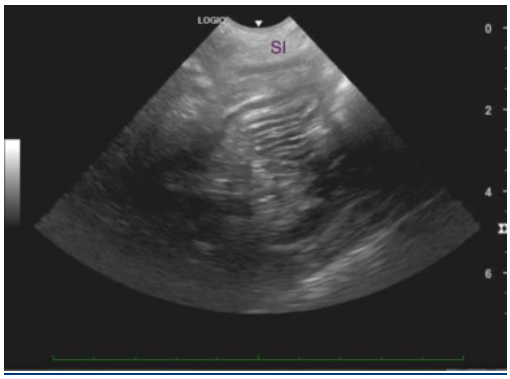

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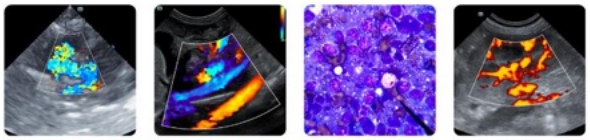

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**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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