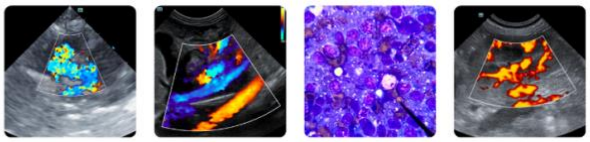


PATIENT

Lucy Davis

SPECIES

Canine

BREED

Boxer Mix

SEX

Female Spayed

AGE

9 years 5 mos

WEIGHT

84 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Megan Cassels-Conway, DVM

HOSPITAL NAME

Central Broward AH

REFERRING VET

Janeen Lezcano, DVM

INVOICE

22305

DATE

11-24-25

PRESENTING CLINICAL SIGNS

History: P has hx of recurrent bacterial cystitis at times asymptomatic. Could also be symptoms go undetected by owners. No v/d/c/s, eating well. Hx of atopy, adequately controlled. Hx of hooded vulva. No hx of urinary incontinence per o or detected on PE. PE unremarkable with exception of OA in CF and stifle joints.

Abnormal PE/Chem/CBC/UA Results: 2/2025: UA: SG: 1.037, 1+ prot, pyuria, rods (>100/hpf), E coli, some resistance noted on UCS (amoxi/clavamox), tx w TMS x 2 weeks, o did not follow up w rec recheck/UA/UCS. 10/2025: CBC: WNL, Chem: creat; 1.0, T4: 1.6, UA: SG: 1.017, pyuria, bacteriuria, no crystals noted; unable to do UCS at the time. Tx with baytril for 2 weeks based on previous UCS. 11/25: 1 week off abx: UA: SG: 1.042, 1+ prot, quiet sediment, struvite crystals 11-20/hpf, UCS: no growth

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness. 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 visible portion of the proximal urethra are normal.

The left kidney is normal in size (7.21 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. An ill-defined hyperechoic medullary band is observed at the corticomedullary junction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal in size (7.48 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. An ill-defined hyperechoic medullary band is observed at the corticomedullary junction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is normal in size (0.62 cm at cranial pole) (0.48 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 caudal pole of the right adrenal gland is visualized and is normal in size (0.60 cm in width) with a normal shape, glandular echogenicity and detail. Surrounding vasculature is normal.

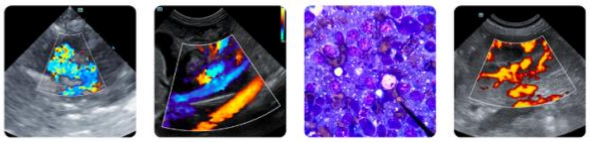
Spleen

The spleen is normal in size (2.36 cm in width at the level of the hilus) with a normal capsular contour. The parenchyma is subtly mottled in appearance. A 0.84 cm irregular, hypoechoic nodule is observed at the mid- to caudal aspect. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and slightly mottled in appearance. No distinct focal lesions are observed. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The gallbladder is of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. 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 ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

Lymph Nodes

The abdominal lymph nodes are normal/not visible.

Free Abdomen

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The hepatic parenchymal changes are most consistent with minor age-related parenchymal remodeling, with a lower possibility of an emerging hepatopathy.
- Minor bilateral, nonspecific age-related renal changes
- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or antigenic stimulation with a low possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia). The hypoechoic hepatic nodule trends toward the benign (i.e., focus of lymphoid hyperplasia or similar) with a lower possibility of emerging neoplasia.

*An obvious cause for the patient's recurring urinary tract infections is not identified in this study. Considerations include structure malformation (i.e., recessed vulva), decreased patient immuomity, defect in the glycosaminoglycan layer of the urinary bladder, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Consider a consideration with a board-certified surgeon regarding the recessed vulva. A prolonged antibiotic course (i.e., 3-4 weeks) may be indicated to treat the patient's infection. A urine culture and sensitivity halfway through the treatment regimen, and again 5-7 days after the last dose, are recommended. Other considerations include the use of cranberry supplementation, and the use of baby wipes in the perianal region following bowel movements to reduce bacterial load in this region.
- Regarding the splenic nodule, consider fine-needle aspiration (if accessible, and if clotting status is appropriate). A 25-gauge needle should be used. Alternatively, consider a recheck ultrasound in 1-2 months to assess for growth of the lesion.

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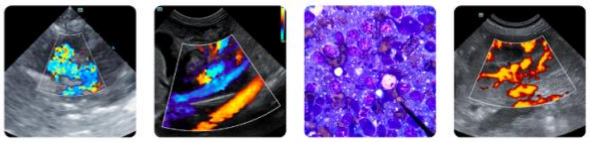

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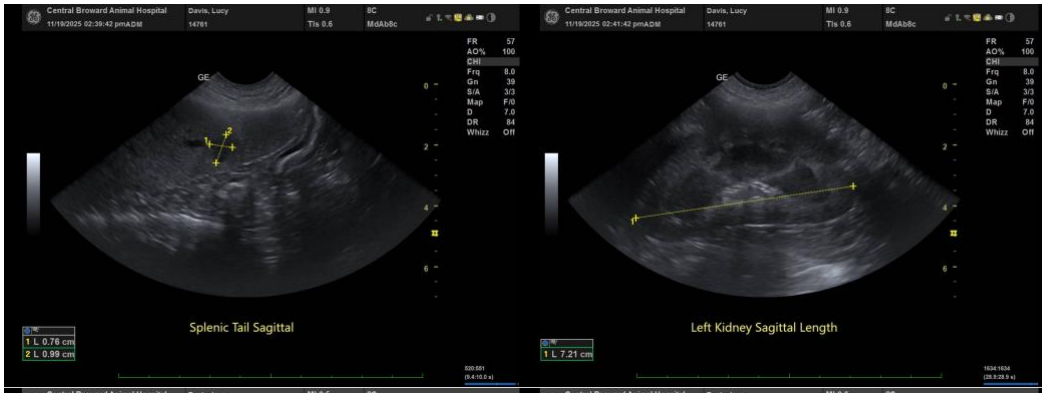

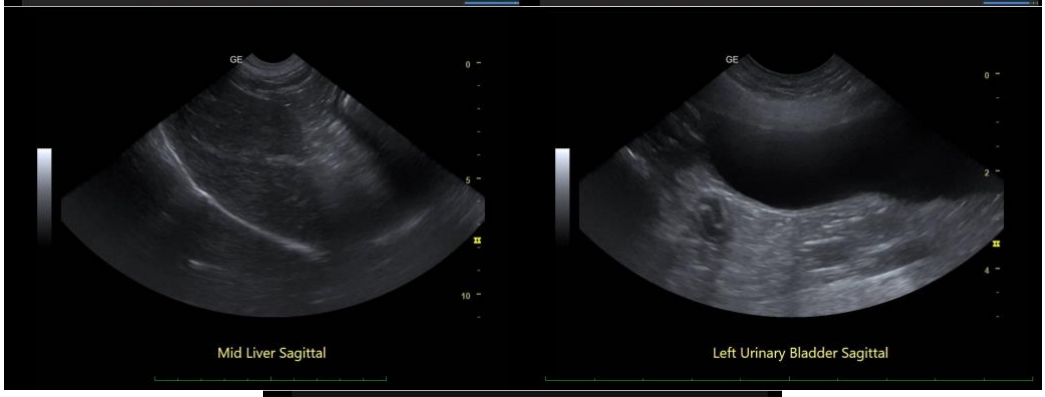

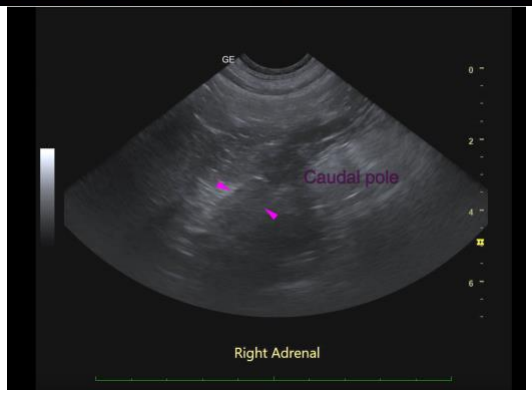

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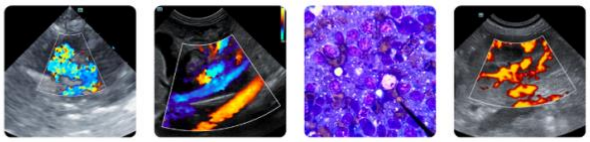

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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