

PATIENT

Molly Maheu

SPECIES

Canine

BREED

Boxer

SEX

Female, spayed

AGE

9 Yrs.

WEIGHT

34.7 kgs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Burns

HOSPITAL NAME

Wilvet Salem

REFERRING VET

Dr. Burns

INVOICE

13301

DATE

11/4/25

PRESENTING CLINICAL SIGNS

History: O noticed a couple weeks ago that her legs will splay out and she will slip more. She does drag her left hind leg sometimes. Took to rDVM and they put her on Carprofen, then stopped it and started Meloxicam. Didn't seem to help. She has been hesitant to jump on things as well. Last week had 1 episode of vomiting, very nauseated and drooling a lot. O stopped the Meloxicam. She has been declining over the weekend, acting more lethargic, decreased appetite, not eating at all today and refusing treats. She did drink water. No more vomiting since or drooling. Today her back end went out from under her and fell. Gum color has been pink today. She had 1 episode where she may have urinated on the couch 1-2 days ago. Tonight just started panting out of nowhere, then stopped. Trembling sometimes when breathing in. O took p's thermometer at home and it was 103.4. Neurologic- Appropriate mentation. Normal cranial nerve. CP delayed to absent on LH limb, scuffed toenails present, CP delayed but present on RH limb. Normal CP in thoracic limbs, Withdrawal present, superficial pain intact. **Abnormal PE/Chem/CBC/UA Results:** Bw: CBC: HCT 40.6 (N), WBC 15.24 (N), Neut 12.91 (H), Lymph 1.25 (N), Mono 0.93 (N), Plt 205 (N) Chem10: Glob 4.6 (H), ALT 138 (H), ALP 466 (H) UA: USG: 1.010, pH 8, trace protein, glucose/ketones/bilirubin negative, WBC < 1/hpf, RBC < 1/hpf, no bacteria detected, no crystals detected

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 is normal.

The left kidney is normal in size (6.98 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (7.41 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The caudal pole of the left adrenal gland is visualized and is normal in size (0.61 cm in width) with a normal shape. The glandular echogenicity and detail are unremarkable. Surrounding vasculature appears normal.

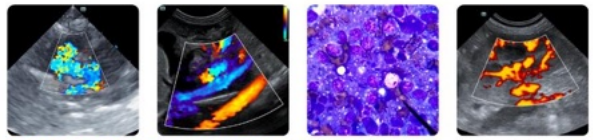
The right adrenal gland is normal in size (1.21 cm at cranial pole) (0.75 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.83 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 subjectively normal in size with normal peripheral contours. The parenchyma is isoechoic relative to the spleen. At the caudal aspect approximately mid-liver, a 3.4 x 3.0 cm hyperechoic to

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heterogeneous mass/lesion is visualized. The remaining parenchyma is homogeneous. Vascular and biliary tracts are of normal volume with no evidence of congestion.

The gall bladder lumen is moderately distended. The wall is mildly thickened (up to 0.41 cm), irregular and hyperechoic to mineralized. A small amount of gravity-dependent echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric 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 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:**

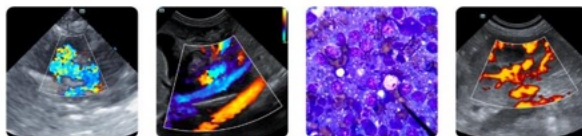
- The gallbladder wall mineralization (a.k.a. "porcelain gallbladder") is most consistent with cholecystitis. However, in rare instances it can be associated with biliary carcinoma.
- The hepatic mass/lesion at the caudal aspect could be consistent with neoplasia (i.e., adenoma, adenocarcinoma), regenerative nodule, inflammatory focus, other. The diffuse hepatic parenchymal changes are most consistent with a benign process (i.e., vacuolar hepatopathy (i.e., endocrine, idiopathic)) with a lower possibility of inflammatory disease, infiltrative neoplasia, hepatotoxicosis or other hepatopathy.

Secondary Findings:

- Mild bilateral, nonspecific, age-related renal changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. Given the patient's gait abnormalities, consider spinal radiographs as well as referral to a board certified neurologist for further diagnostics (i.e., MRI).
2. Three-view thoracic radiographs are also recommended to assess cardiopulmonary status, particularly given the patient's age.
3. A T4/free T4 by equilibrium dialysis should also be considered as hypothyroidism can be associated with neuropathies.
4. Regarding the hepatic lesion, consider an abdominal CT scan and/or histopathology for further evaluation.



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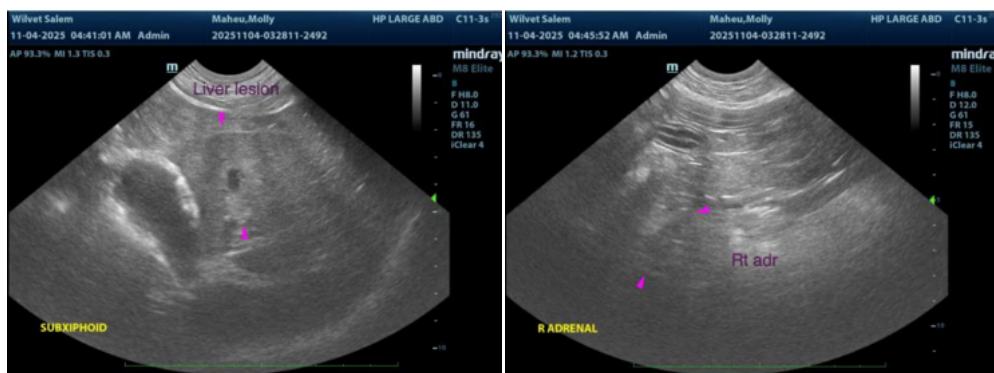
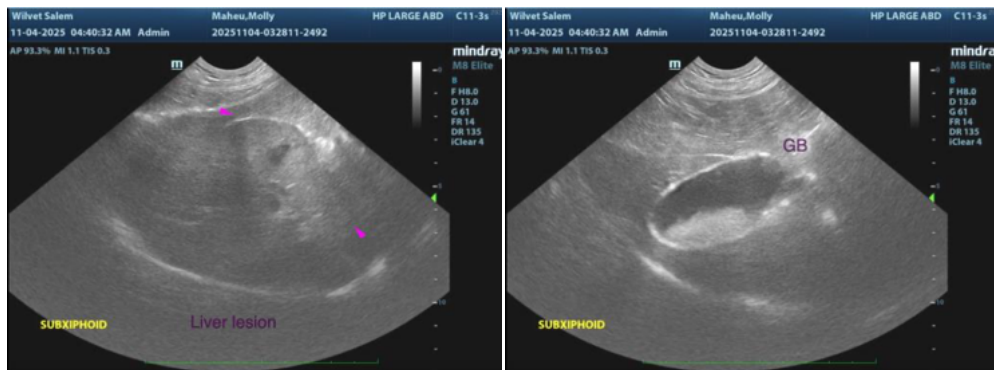
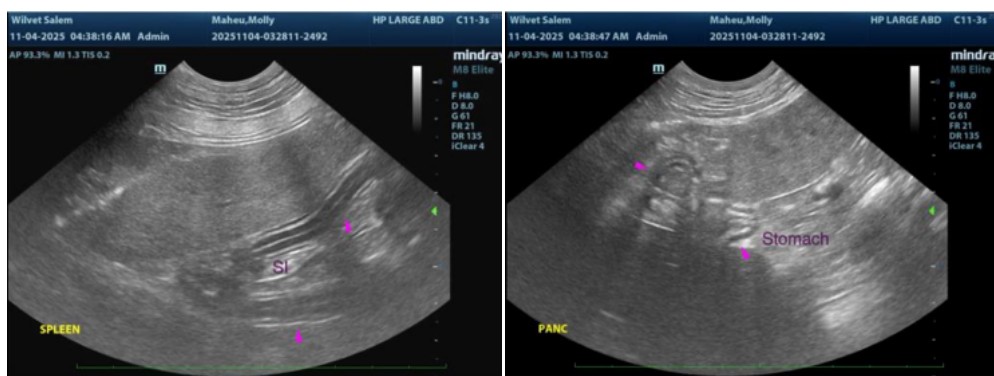
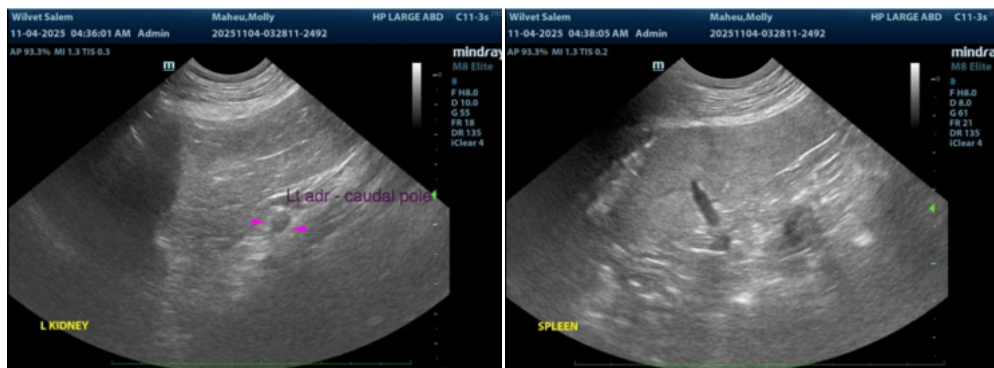
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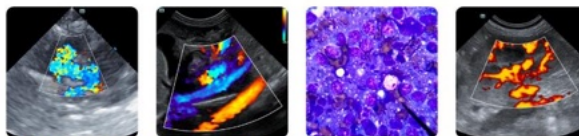
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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