



**PATIENT**

Huck Schroff

**SPECIES**

Canine

**BREED**

Shepherd mix

**SEX**

Male Neutered

**AGE**

12/14/2015

**WEIGHT**

51 lb

**INTERPRETED BY**

Andrea Nicastro DVM  
Diplomate ACVIM  
(Sm Animal Internal Med)

**IMAGING  
PERFORMED BY**

Andrea Nicastro DVM  
Diplomate ACVIM  
(Sm Animal Internal Med)

**HOSPITAL NAME**

Sun Dog Cat Moon

**REFERRING VET**

Dr Abby Clayton

**INVOICE**

22218

**DATE**

11-6-25

**PRESENTING CLINICAL SIGNS**

Clinical Exam Findings: Clingy behavior and pacing at night for past week. E/d/u/d normally, normal energy, no v/d. Hx of azotemia - consistent values compared to May 2025. Possible organomegaly right cranial abdomen, no free fluid on FAST scan.

Abnormal lab-work values: BUN 55, Creat 3.8. USG 1.018. No proteinuria. Inactive sediment. Recently positive for Ehrlichia on serology but negative PCR. Has been acting clingier lately.  
Blood pressure measurement today normal.  
Current Medications: Carprofen PRN, fish oil, joint supplement  
Patient sedated with butorphanol for this study.

**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 the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (1.23 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 (6.19 cm in length) with an irregular shape. The cortex is variably thickened. There is severe loss of corticomedullary distinction. Numerous cortical cysts are seen. Hyperechoic shadowing diverticular foci are visualized. Trace pyelectasia is present. There is no evidence hydroureter. Renal vasculature is normal.

The right kidney is normal in size (5.63 cm in length) with an irregular shape. The cortex is variably thickened. There is severe loss of corticomedullary distinction. Numerous cortical cysts are seen. Hyperechoic shadowing diverticular foci are visualized. There is no evidence of pyelectasia or hydroureter. Renal vasculature is normal.

**Adrenal Glands**

The left adrenal gland is normal in size (0.44 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 right adrenal gland is enlarged at the cranial pole and normal-in-size at the caudal pole (1.09 cm at cranial pole) (0.40 cm at caudal pole). A 1.17 x 1.09 cm hyperechoic to heterogenous nodule is observed at the cranial aspect. Glandular echogenicity and detail at the caudal aspect are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

**Spleen**

The spleen is normal in size (1.64 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 contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative, or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1: 1.



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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 ileoceocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

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**Pancreas**

The right 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.

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**Lymph Nodes**

Two-to-three prominent mesenteric lymph nodes are visualized (one measuring 0.80 x 0.49 cm).

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**Free Abdomen**

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

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**Other**

A brief echocardiogram reveals no obvious evidence of right atrial or auricular mass. There is no obvious evidence of pericardial effusion.

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**ULTRASONOGRAPHIC FINDINGS**

**Primary Findings**

- Bilateral chronic renal changes. Possible causes for the sonographic renal changes include renal dysplasia, prior insult (i.e., infection, toxin, hypotensive event, other), other. Varying-sized cortical cysts are also present.

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**Secondary Findings**

- Minor pancreatic parenchymal remodeling in the right limb
- The right adrenal nodule could be consistent with focal nodular hyperplasia, adenoma, emerging adenocarcinoma, pheochromocytoma, other.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

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\*An obvious cause for the patient's clinical signs is not definitively identified in this study. Considerations include orthopedic or neurologic disease, abdominal discomfort, underlying metabolic issue, other.

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

- A urine culture and sensitivity is recommended to assess for occult infection. Serial monitoring of the patient's renal values and blood pressure is recommended to assess progression of disease.

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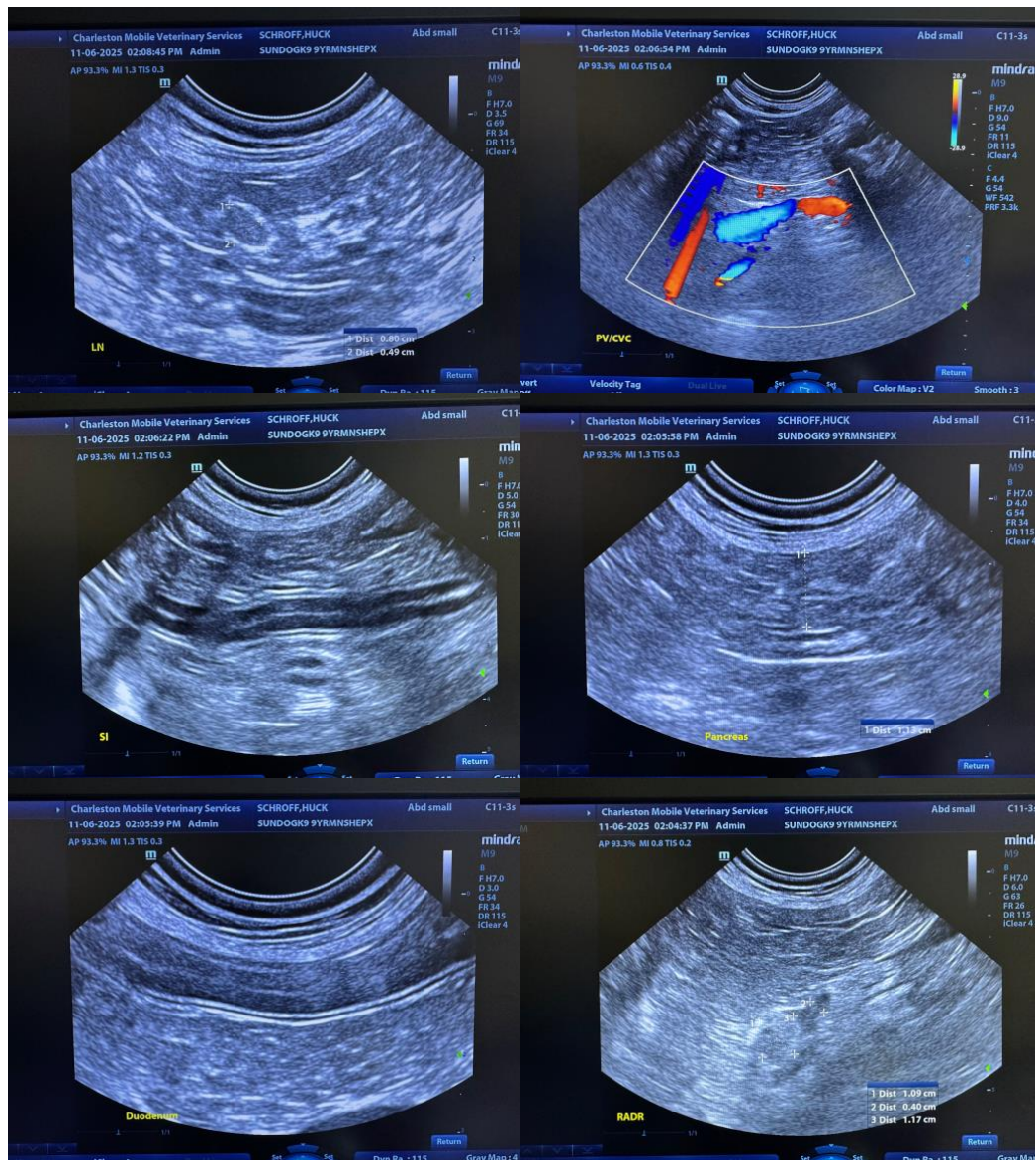
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- Regarding the right adrenal nodule, consider a recheck ultrasound in 1-2 months to assess for growth of the lesion. If the patient becomes clinical for a functional tumor, further testing (i.e., low-dose dexamethasone suppression test, urine/blood metanephrine levels) may be warranted.
- Regarding the patient's current clinical signs, consider empirical treatment for pain (i.e., gabapentin). If there is no improvement in the patient's clinical signs, further work-up may be indicated.





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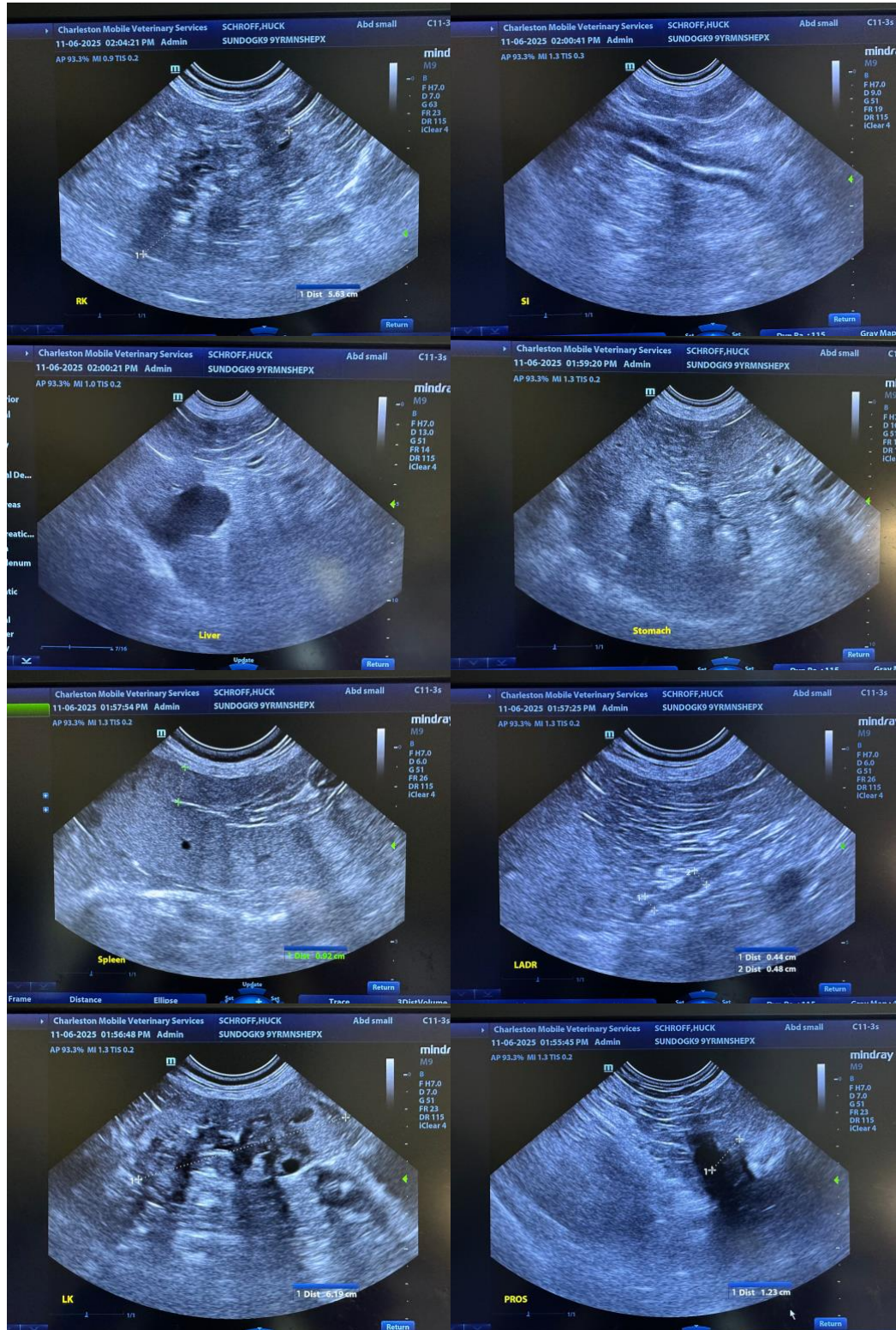
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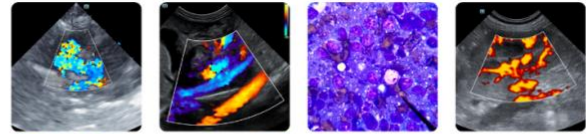
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)**  
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