



PATIENT

Cooper Lewis

SPECIES

Canine

BREED

Labradoodle

SEX

Neutered Male

AGE

02/07/2017

WEIGHT

20.4 Kg

INTERPRETED BY

Andrea Nicastrò DVM
Diplomate ACVIM
(Sm Animal Internal Med)

**IMAGING
PERFORMED BY**

Andrea Nicastrò DVM
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME

VCA Palmetto AH

REFERRING VET

Dr Vivian Ghiorzi

INVOICE

22220

DATE

12-5-25

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: PU/PD, onset ~ 14 days ago; Urinary accidents intermittently, including in his sleep (he never needed to go out overnight, these are great, very observant clients); FAST bladder scan showed an abnormal area near the trigone which looks like a diverticulum.

Abnormal lab-work values (Normal BW from 04/2025): Glycemia is 104 mg/dL today (fasting overnight); UA in house showed some leukocytes, trace glucosuria - submitted to Antech; Full BW panel is pending. ALP 132. ALT 216. USG 1.009, no proteinuria, inactive sediment. 4dx negative. CBC and T4 unremarkable
Current Medications: Amoxi/Clav 500/125 mg 1/2 PO BID 10 days - started today.

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 (0.85 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 (6.08 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal in size (6.14 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.63 cm at cranial pole) (0.57 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 normal in size (0.65 cm at cranial pole) (0.65 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 subjectively normal-in-size with a normal capsular contour. There is appropriate echogenicity and echotexture. One-to-two small myelolipomas are observed in the region of the hilus. Splenic vasculature is normal.

Liver

The liver is subjectively enlarged, with swollen peripheral contours. The parenchyma is isoechoic relative to the spleen and heterogenous in appearance. At least two hypoechoic-to-heterogenous, "target-like" nodules are observed within the parenchyma (one measuring 1.25 cm in its longest dimension, the other measuring 0.79 cm in its longest dimension). Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1: 1.

The gallbladder lumen is moderately distended. The wall is thin and smooth. A small amount of echogenic



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debris is adhered to the mucosal surface. The cystic and common bile ducts are normal/not seen.

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Gastrointestinal

The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileoceocolic junction and colonic wall are normal. What appear to be heterogenous fecal balls are observed in the lumen of the ascending colon. There is no obvious 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

A 1.02 x 0.36 cm medial iliac lymph node is visible but not overtly enlarged.

Free Abdomen

There is no obvious evidence of free fluid.

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

The hepatic changes are nonspecific and could be secondary to inflammatory disease (i.e., cholangiohepatitis, chronic hepatitis), Leptospirosis, hepatotoxicosis, infiltrative neoplasia (i.e., lymphoma), vacuolar hepatopathy, regenerative nodular hyperplasia, other hepatopathy, or some combination thereof.

*Considerations for the patient's PU/PD include occult urinary tract infection, underlying hepatopathy (i.e., cholangiohepatitis, chronic hepatitis, Leptospirosis, infiltrative neoplasia, hepatotoxicosis (i.e., copper), and/or other hepatopathy), Cushing's disease, diabetic insipidus, psychogenic polydipsia, other.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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- A urine culture and sensitivity is recommended, preferably on a pre-antibiotic sample.
- Leptospirosis testing (i.e., blood and urine PCR, serology) is also recommended, particularly if clinical suspicion for disease is high.
- Pre- and postprandial serum bile acids should also be considered to assess for hepatic dysfunction.
- Depending on the results of the above diagnostics, further work-up (i.e., hepatic tissue sampling) may be warranted.

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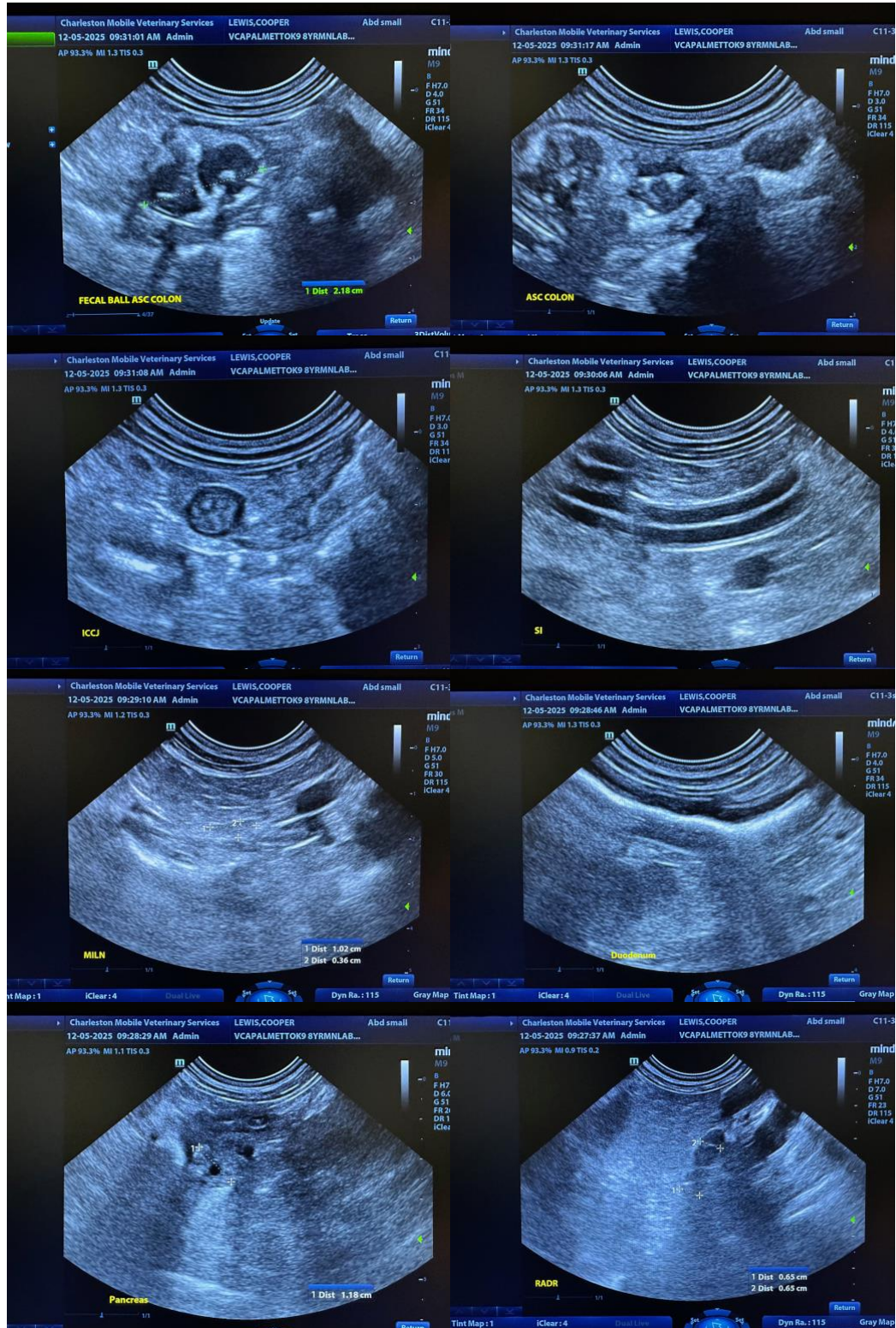
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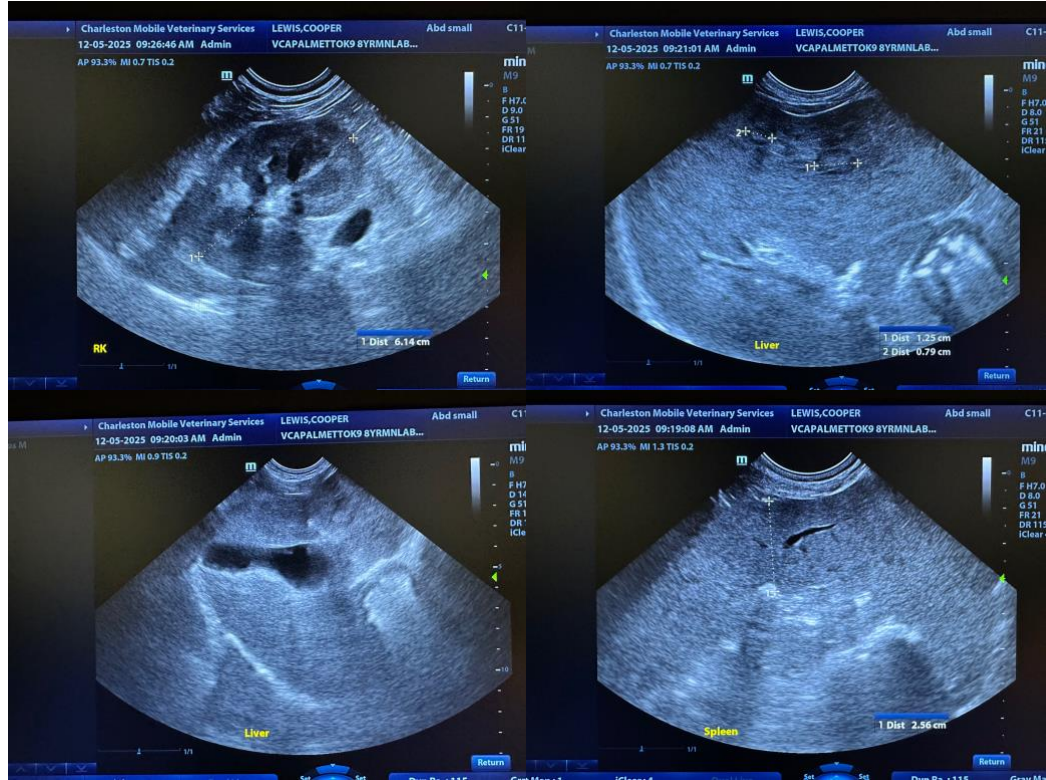
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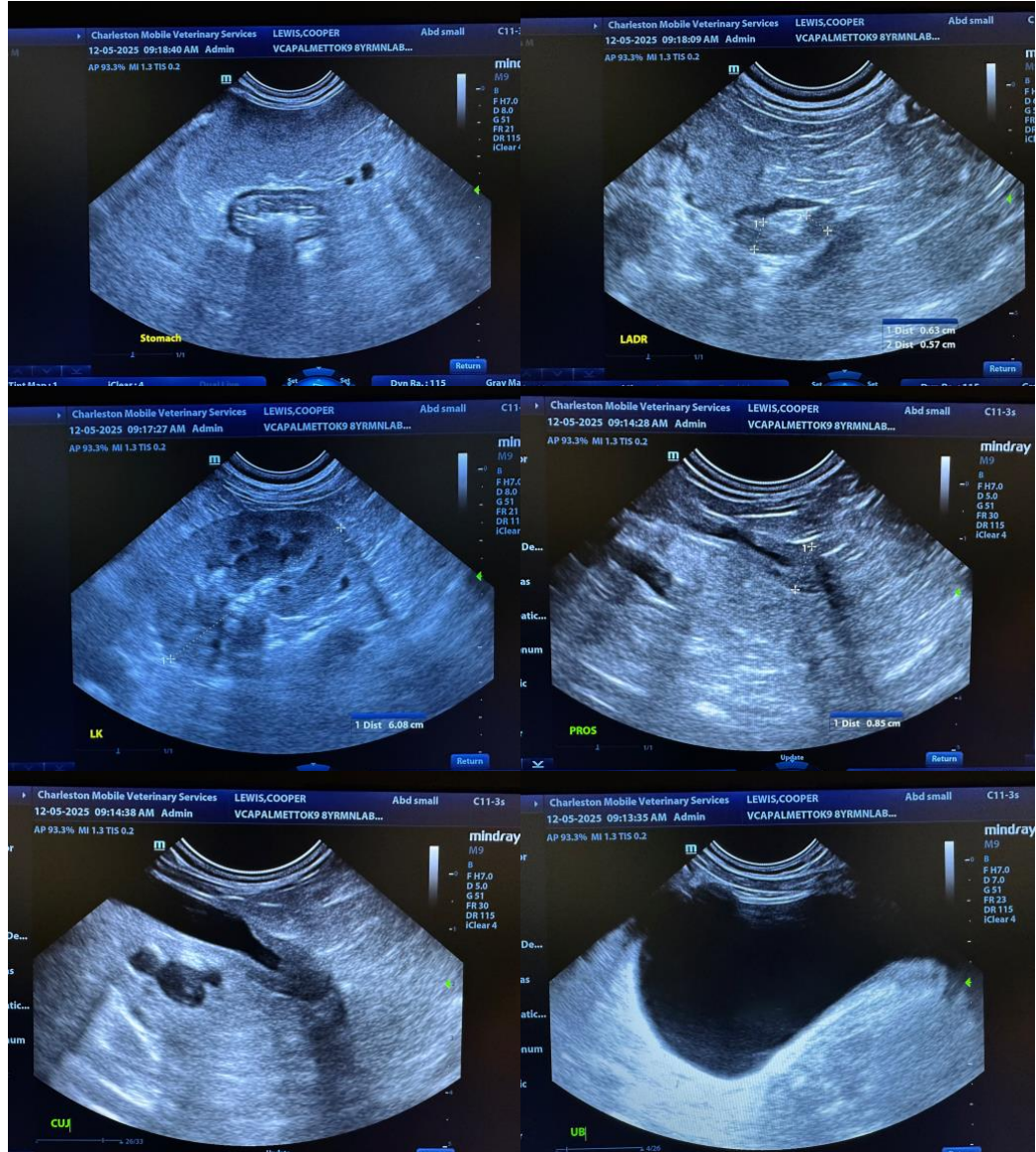
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
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