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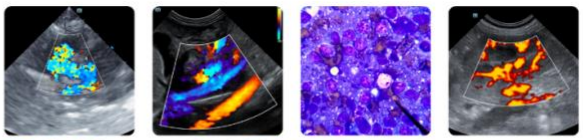

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Jax Mull

SPECIES

Canine

BREED

Mixed

SEX

Male Neutered

AGE

7/2/2013

WEIGHT

42.8

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 Pruitt

INVOICE

22599

DATE

2-23-26

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Presents for met check prior to MCT removal and newly onset PU/PD over the last month.

PE: Multiple cutaneous and subcutaneous masses, mild hip OA suspect R hip, dental attrition, lenticular sclerosis; left lateral flank subcutaneous nodule firm, ~ 10 x 10 mm (MCT on cytology)

Abnormal lab-work values - 1/27/2026: Creatinine 1.7 (0.5-1.6 mg/dL), thrombocytosis (606), total T4 wnl, UA - 1.021/pH 7/1+ protein/2+ glucose despite normoglycemic.

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 (1.29 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 (5.41 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.

The right kidney is normal in size (6.26 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 left adrenal gland is normal in size (0.55 cm at cranial pole) (0.66 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 (1.03 cm at cranial pole) (0.59 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 (2.06 cm in width at the level of the hilus) with a normal capsular contour. The parenchyma is subtly mottled in appearance. A 0.53 x 0.41 cm hyperechoic nodule is observed at the lateral aspect, near the mid- to caudal pole. 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.

The gallbladder is of normal contours and contains some dependent echogenic debris. The wall is normal in

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thickness. No choleliths are observed. The cystic and common bile ducts are normal/not seen.

Gastrointestinal
The gastric lumen is mildly fluid-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 ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas
The body of the pancreas is visualized, and is normal- to slightly prominent-in-size, with smooth peripheral contours. The parenchyma is slightly hypoechoic relative to surrounding omental fat. No focal lesions are observed. The pancreatic duct is not overtly dilated.

Lymph Nodes
Two-to-three prominent mesenteric lymph nodes are visualized (one measuring 1.44 x 0.59 cm).

Free Abdomen
There is no obvious evidence of free fluid.

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The splenic parenchyma changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis or splenitis with a lower possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia). The hyperechoic splenic nodule is most consistent with a benign myelolipoma, with a lower possibility of more insidious splenic pathology.
- Mild bilateral nonspecific age-related renal changes. The presence of glucosuria in a patient that is euglycemic is suggestive of proximal tubular disease. Therefore, further testing for Fanconi syndrome is warranted.

Secondary Findings

- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The pancreatic changes may be a normal variant for this patient or could be consistent with mild, chronic pancreatitis. Correlation with clinical findings is recommended.
- Minor gastric fluid retention

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the splenic changes, consider fine-needle aspiration (assuming normal clotting status). A 25-gauge needle should be used. Given the history of mast cell tumor, the patient should be pre-treated with diphenhydramine to reduce the risk of mast cell degranulation with aspiration.

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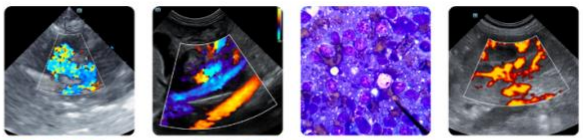

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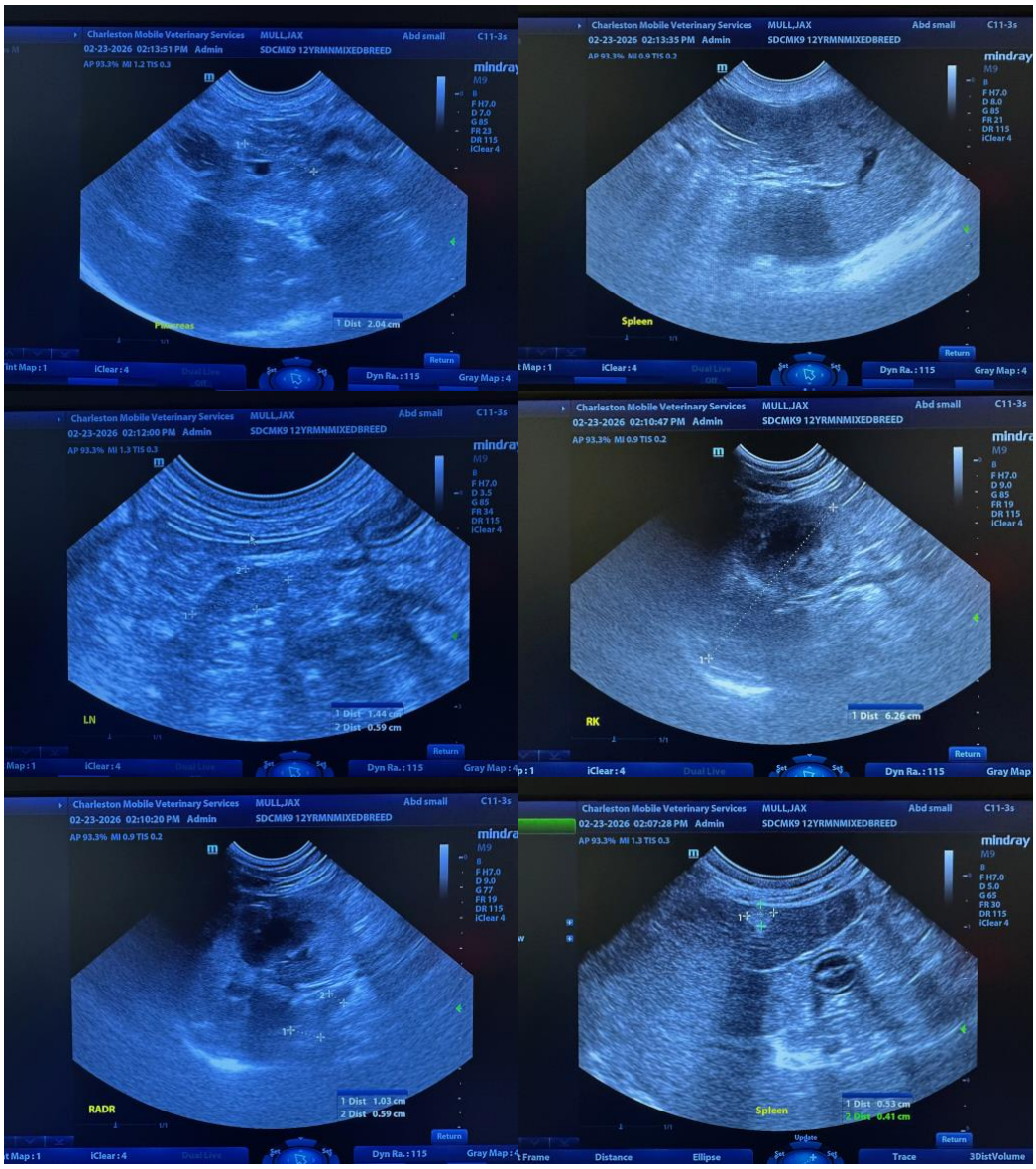
- Regarding the patient's PU/PD and glucosuria (in the absence of hyperglycemia), consider the following:

    1. Urine culture and sensitivity to assess for occult infection
    2. Urine amino acid assay (PennGen lab)



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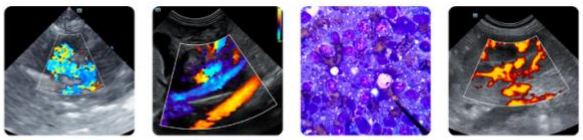

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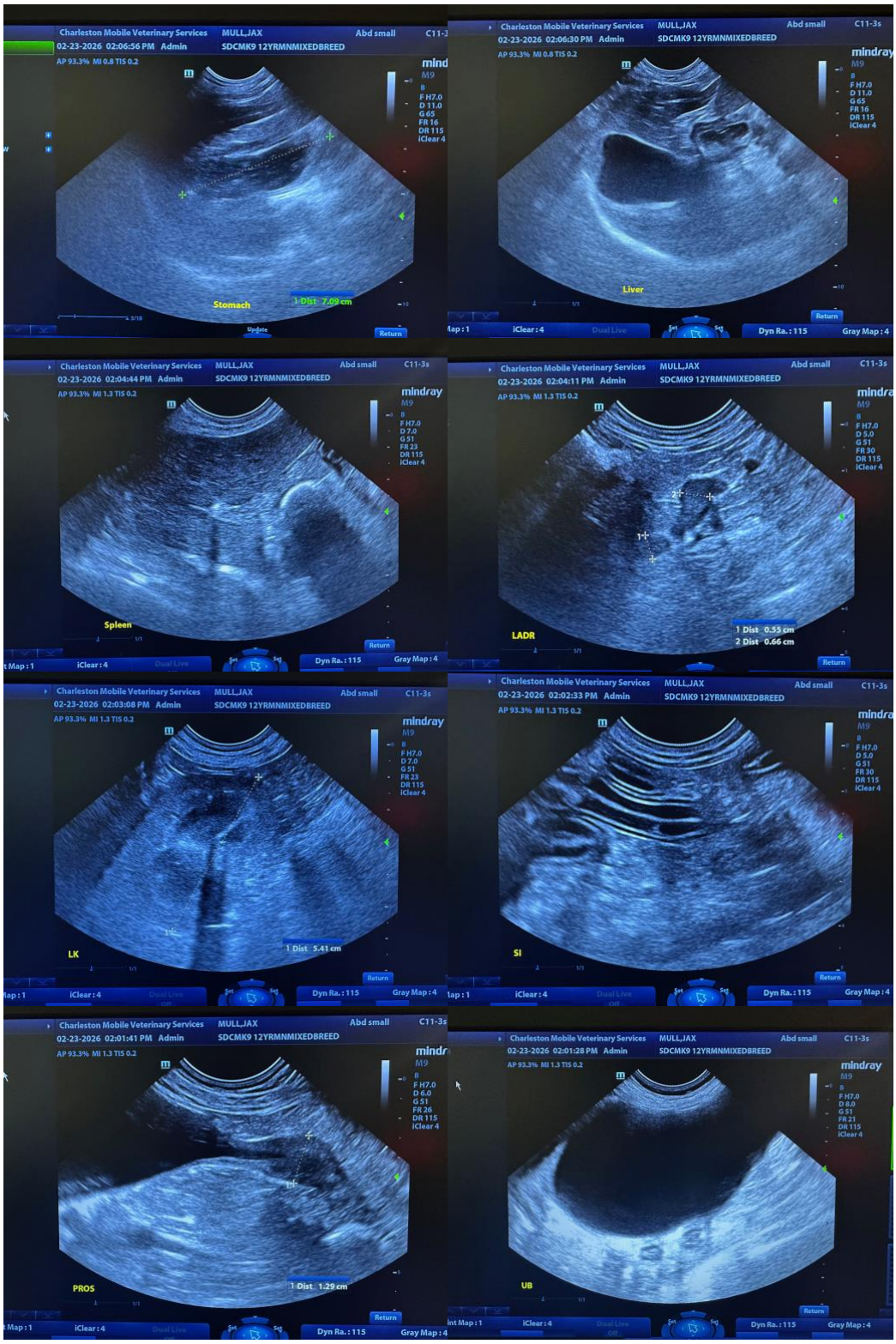

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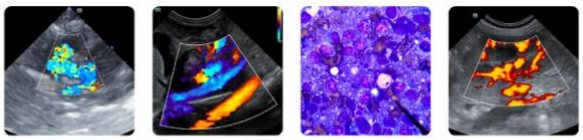

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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