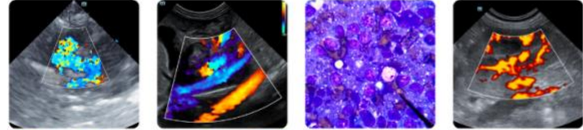
Charleston Mobile Veterinary Services
IN PARTNERSHIP WITH SONOPATH VETERINARY ULTRASOUND



Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath
www.charlestonmobile.net
info@charlestonmobile.net 800.403.5408

**PATIENT**
Minnie Hall

**SPECIES**
Canine

**BREED**
Jack Russell Terrier

**SEX**
Female Spayed

**AGE**
14

**WEIGHT**
12 lbs

**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**
23092

**DATE**
6-1-26

## PRESENTING CLINICAL SIGNS

Patient has a recent history of worsening azotemia. Creatinine 1.6. BUN 38. USG 1.015. Inactive sediment. 4dx negative. Fecal PCR infectious disease panel negative. Also, Precision PSL is mildly elevated. CBC unremarkable. T4 normal. Recent blood pressure unremarkable. Has a history of degenerative valve disease.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

***Urinary System***
The urinary bladder is mildly to moderately distended. The wall is appropriate thickness for the level of repletion. The mucosal surface in the region of the apex is slightly irregular. A scant amount of gravity-dependent mineralized sand +/- tiny calculi are observed within the lumen. The region of the trigone and the proximal urethra, visible to a depth of 1.5-2.0 cm, are normal.

The left kidney is normal in size (3.83 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. Several, small, nonobstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (4.01 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is mild loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

***Adrenal Glands***
The left adrenal gland is enlarged at the cranial pole and normal-in-size at the caudal pole (1.01 cm at cranial pole) (0.48 cm at caudal pole). A 1.08 x 0.84 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.

The right adrenal gland is normal in size (0.90 cm at cranial pole) (0.54 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 (1.37 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.

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

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masses are not identified. The ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

***Pancreas***
The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is slightly hypoechoic 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.

***Lymph Nodes***
The abdominal lymph nodes are normal/not visible.

***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

- Minor bilateral age-related renal changes with nonobstructive nephrocalcinosis
- Urinary bladder sand +/- tiny calculi

### Secondary Findings

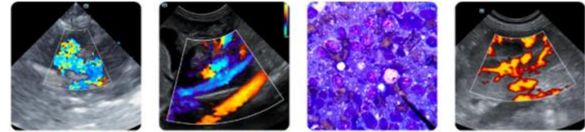
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The left adrenal nodule could be consistent with focal nodular hyperplasia, adenoma, emerging adenocarcinoma, pheochromocytoma, other.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Regarding the azotemia, consider the following:

- Urine culture and sensitivity to assess for occult infection.
- Transition to a prescription renal diet, preferably one that will neutralize the urine pH (to adjust the mineralized debris in the urinary bladder).
- Serial monitoring (i.e., every 3-4 months) of the patient’s renal values is recommended to assess progression the azotemia.

Regarding the left adrenal nodule, consider a recheck ultrasound in 2-3 months to assess for growth of the lesion. If the patient develops clinical signs of a functional adrenal tumor, further work-up may be indicated.





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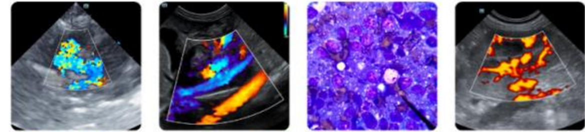



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**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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