



PATIENT PRESENTING CLINICAL SIGNS

PATIENT Maggie Keim

SPECIES Canine

BREED Silver Lab

SEX Female Spayed

AGE 8

WEIGHT 60.5 kg

HISTORY: Inappetence, lethargy, panting, trembling, and hind end giving out over the weekend. Increased drinking and urination. Started Numelvi (atinvicitinib) Thursday. RDVM yesterday treated with SQF, Cerenia, Gabapentin. Today trouble walking and right eye corneal edema. Weight loss of 9 lb over past year, 5 of which was over past week.

PE: Temp: 103F

OBSE: OD- diffuse corneal edema, aqueous flare, mild rubeosis iridis vs. hyphema, negative menace, positive dazzle

PETECHIAE: on abdomen

GAIT: Left medial luxating patella, crepitus bilateral stifles

SHORT SHUFFLING GAIT, AMBULATORY WITH ASSISTANCE, FORELIMB AND HINDLIMB LAMENESS, DECREASED RANGE OF MOTION IN SHOULDERS AND HIPS

ABNORMAL PE/CHEM/CBC/UA RESULTS: IOP: OS 13, OD 42 Lepto Witness: Negative PCV/TS: 50/10 EPOC: pH 7.421, pCO2 19.7 L, BE -11.6 L, TCO2 12.2 L, Glu 166 H, Lac 4.49 H, BUN 37 H, Creat 1.73 H CBC: MCV 55.9 L, MCH 20.1 L, RDW 22.6 H, Reticulocytes 9K L, Retic Hb 19.9 L, Immature neutrophils 1.04K H (9.6%) bands, Lymphocytes 0.34K L, Monocytes 1.14K H, Eosinophils 0.03K L, Platelets 15K L (<50K markedly decreased) Chem15: Glucose 169 H, Creatinine 1.9 H, BUN 42 H, TP 9.2 H, Globulin 6.3 H, ALT 131 H, ALP 1365 H, Tbili 1.8 H, Chol 426 H Abdominal/thoracic radiographs: Thorax unremarkable, liver margins rounded with suspected hepatomegaly

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

INTERPRETED BY

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

IMAGING PERFORMED BY

Lindsay Powell, CVT

HOSPITAL NAME

Hershey AEC

REFERRING VET

Dr. Leann Murphy

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DATE

6-2-26

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 is normal.

The left kidney is normal in size (7.86 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild 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 (8.23 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 hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.96 cm at cranial pole) (0.94 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 region of the right adrenal gland is evaluated. No obvious pathology is observed in this region.

Spleen

The spleen is normal in size (2.29 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.



PATIENT

Liver

Maggie Keim

The liver is normal- to prominent-in-size with smooth peripheral contours. The parenchyma is hypoechoic relative to the spleen and subtly mottled in appearance. At least one, small, hyperechoic nodule is observed on the left side. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

SPECIES

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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 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 colonic wall is normal. There is no evidence of an obstructive pattern.

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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.

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Lymph Nodes

The abdominal lymph nodes are normal/not visible.

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Free Abdomen

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

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ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Mild bilateral nonspecific age-related renal changes
- 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.

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Secondary Findings

- Mild left adrenomegaly

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*An obvious cause for the patient's thrombocytopenia is not identified in this study. Broad considerations include autoimmune disease, infectious disease (i.e., tick-borne, Leptospirosis), occult neoplasia, bone marrow disease, other.

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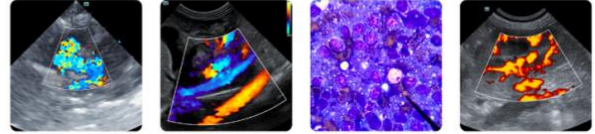
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A urinalysis with a culture and sensitivity, along with additional Leptospirosis testing (i.e., blood and urine PCR) and baseline blood pressure measurement are recommended. Given the proteinuria in the absence of infection, a UPC should also be considered.
- A comprehensive tick panel, including PCR and serology (submission to North Carolina State University's Vector Borne Disease Diagnostic Lab is recommended.
<https://cvm.ncsu.edu/research/labs/clinical-sciences/vector-borne-disease>)



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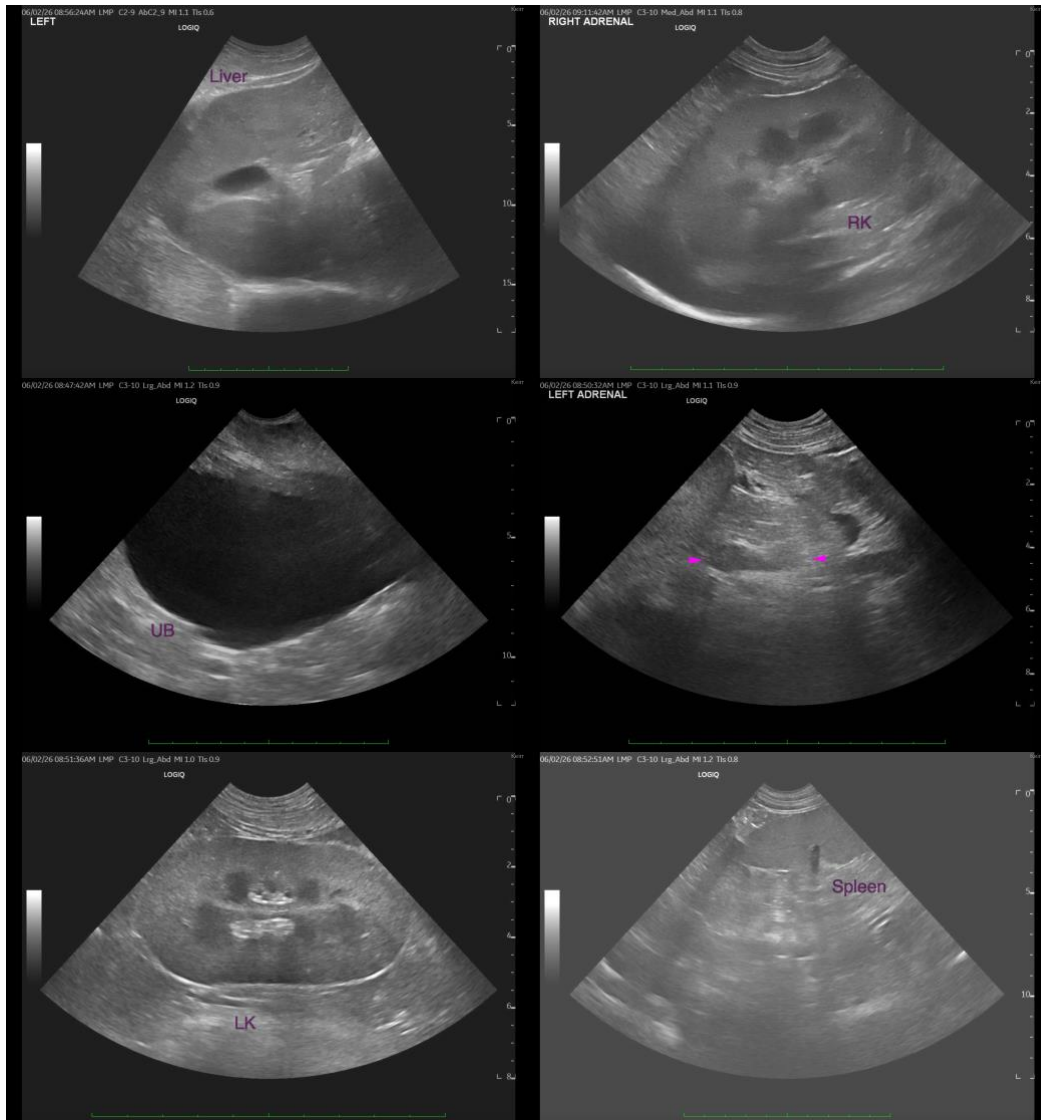
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- Three-view thoracic radiographs are recommended to assess cardiopulmonary status.
- Depending on the results of the above diagnostics, further work-up may be indicated. In the meantime, symptomatic care is recommended.



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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.



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