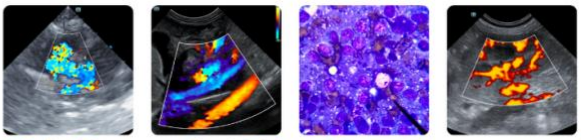



**PATIENT**

August Kocaqi

**SPECIES**

Canine

**BREED**

Yorkshire Terrier

**SEX**

Neutered Male

**AGE**

14

**WEIGHT**

5.6 kg

**INTERPRETED BY**

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

**IMAGING PERFORMED BY**

Amanda Stewart

**HOSPITAL NAME**

Hamilton Reg EVC

**REFERRING VET**

Hasbum

**INVOICE**

23141

**DATE**

6-8-26

## PRESENTING CLINICAL SIGNS

History: Patient presented to HREVC on Jun 3rd, 2026, for anorexia, vomiting, and abdominal pain. Initial diagnostics revealed severe azotemia, and an AFAST showed a right renal cyst, subjective hepatomegaly, and a fluid-distended stomach. He was treated as an outpatient with SQ fluids and medications but failed to improve. He re-presented on Jun 5th, 2026, and was hospitalized for ongoing care.

Current Medications: NG Tube placed June 6th: 14ml/hr of Gastro low fat liquid - taking well // Hospitalized on IV fluids: Plasmalyte at 20 ml/hr. // Methadone 0.2 mg/kg IV q 6 hours (started 21:00 on Jun 5th). // Maropitant 1 mg/kg IV q 24 hours (started 03:00 on Jun 6th). // Mirtazapine 7.5 mg PO q 24 hours (started 22:00 on Jun 5th). // Metoclopramide 5mg/mL 0.34mL IV q6hrs (started 13:00 on Jun 7th)

Abnormal PE/Chem/CBC/UA Results: Jun 3rd, 2026 (Admission 1): -Chem: Creatinine 453 umol/L, BUN >46 mmol/L, Phosphorus 4.88 mmol/L, ALT 182 U/L. -Urinalysis (cystocentesis): USG 1.014, mild proteinuria, hematuria, >1 non-hyaline cast/lpf. -CBC: Mild non-regenerative anemia (Hct 37.2%). -AFAST: Large focal cyst on the right kidney, subjective loss of corticomedullary boundary on the right kidney, subjective hepatomegaly, fluid-distended stomach. Jun 5th, 2026 (Admission 2): -Chem: Creatinine 378 umol/L, BUN >46.4 mmol/L, ALT 178 U/L. -Pancreatic Lipase: >2000 U/L. June 7th AM: -Urea readable now - 324 -Creat 299 -Alt back to WNL

Primary Question to Be Answered in This Examination: Are there any abnormal masses, what is the stated of the pancreas (currently being treated for pancreatitis), insulinoma?

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder is moderately distended. The wall is normal in thickness. At the apical aspect, a 1.1 x 1.1 cm out-pouching of the bladder wall is seen. Echogenic debris is observed within the out-pouching. The mucosal surface of the urinary bladder is smooth. No cystic calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The region of the prostate is not visualized due to its pelvic location.

The left kidney is normal in size (4.63 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild- to moderate loss of corticomedullary distinction. The cortex is isoechoic relative to the spleen. A few, small, cortical cysts are seen. Trace pyelectasia is present. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (4.49 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild- to moderate loss of corticomedullary distinction. The cortex is isoechoic relative to the spleen. Some echogenic debris is observed within the cyst. A few, smaller cortical cysts are also seen. Trace pyelectasia is present. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

### *Adrenal Glands*

The left adrenal gland is mildly enlarged (0.72 cm at cranial pole) (0.62 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 (0.80 cm at cranial pole) (0.50 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule,

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cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

***Spleen***

The spleen is normal in size (1.51 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A 1.5 x 1.0 cm hyperechoic- to heterogenous nodule is observed near the cranial- to mid-aspect. Splenic vasculature is normal.

***Liver***

The liver is subjectively enlarged with slightly swollen peripheral contours. The parenchyma is hypoechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular and biliary tracts are of normal volume with no evidence of congestion.

The gallbladder lumen is moderately distended. The wall is thin and smooth. A small amount of adhered 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 masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

***Pancreas***

The base and limbs of the pancreas are visible with normal curvilinear peripheral contours. The parenchyma is largely hyperechoic 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.

## ULTRASONOGRAPHIC FINDINGS

### Primary Findings

- Bilateral nonspecific age-related renal changes with trace pyelectasia and cortical cysts
- The splenic nodule could be consistent with a benign lesion (i.e., myelolipoma, focus of lymphoid hyperplasia, or similar). Alternatively, an emerging tumor is possible.
- The out-pouching at the urinary bladder apex is suspicious for a congenital urachal diverticulum.

### Secondary Findings

- Mild hepatomegaly
- Mild left adrenomegaly
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

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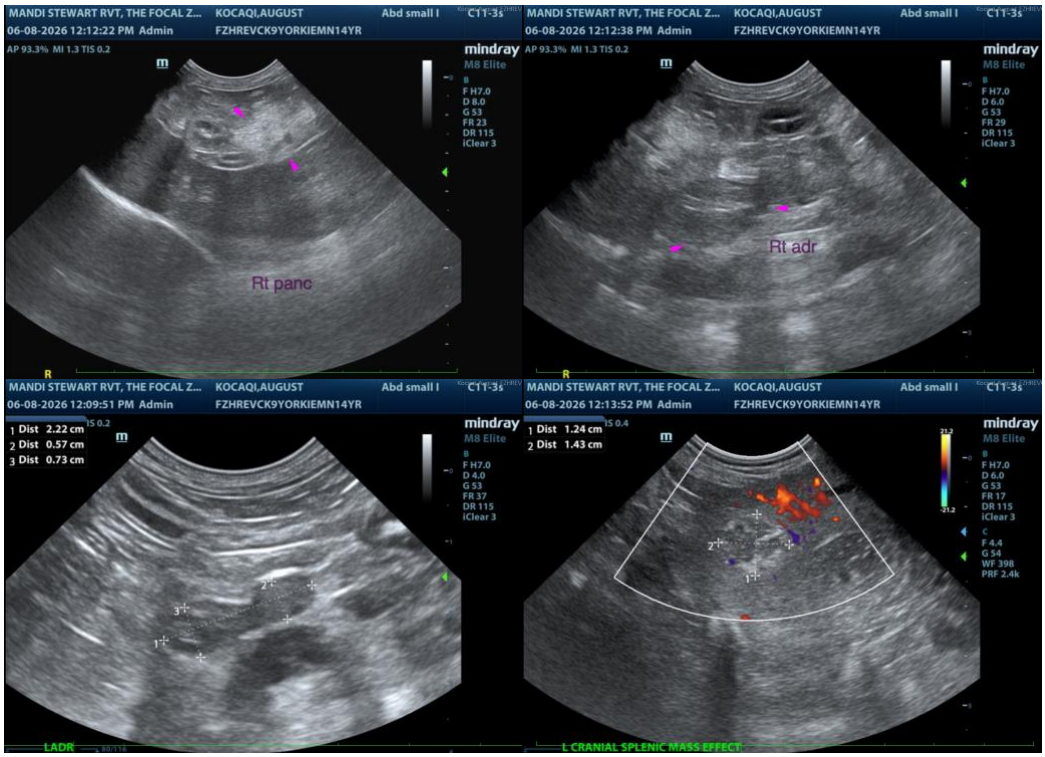
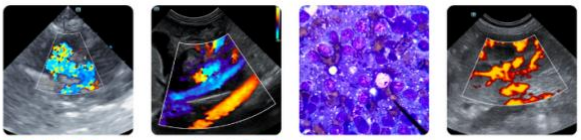
## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the azotemia, consider the following:
  - Urine culture and sensitivity is recommended.
  - UPC if proteinuria is present in the absence of infection.
  - Baseline blood pressure measurement should also be obtained to assess for systemic hypertension.
  - Leptospirosis testing (i.e., blood and urine PCR, serology) can also be considered, particularly if the clinical suspicion for disease is high.
  - While awaiting test results, IV fluid diuresis and other symptomatic measures are recommended, with serial monitoring of the patient's renal values to assess progression of the azotemia.
- Regarding the splenic nodule, consider the following:
  - Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
  - Ultrasound-guided fine-needle aspiration (assuming normal clotting status). A 25-gauge needle should be used.
- Regarding the suspected urachal diverticulum, a contrast cystourethrogram can be considered for further confirmation.



New Jersey Mobile
FUELED BY SONOPATH VETERINARY ULTRASOUND



Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath www.SonoPath.com
info@sonopath.com 800.838.4268

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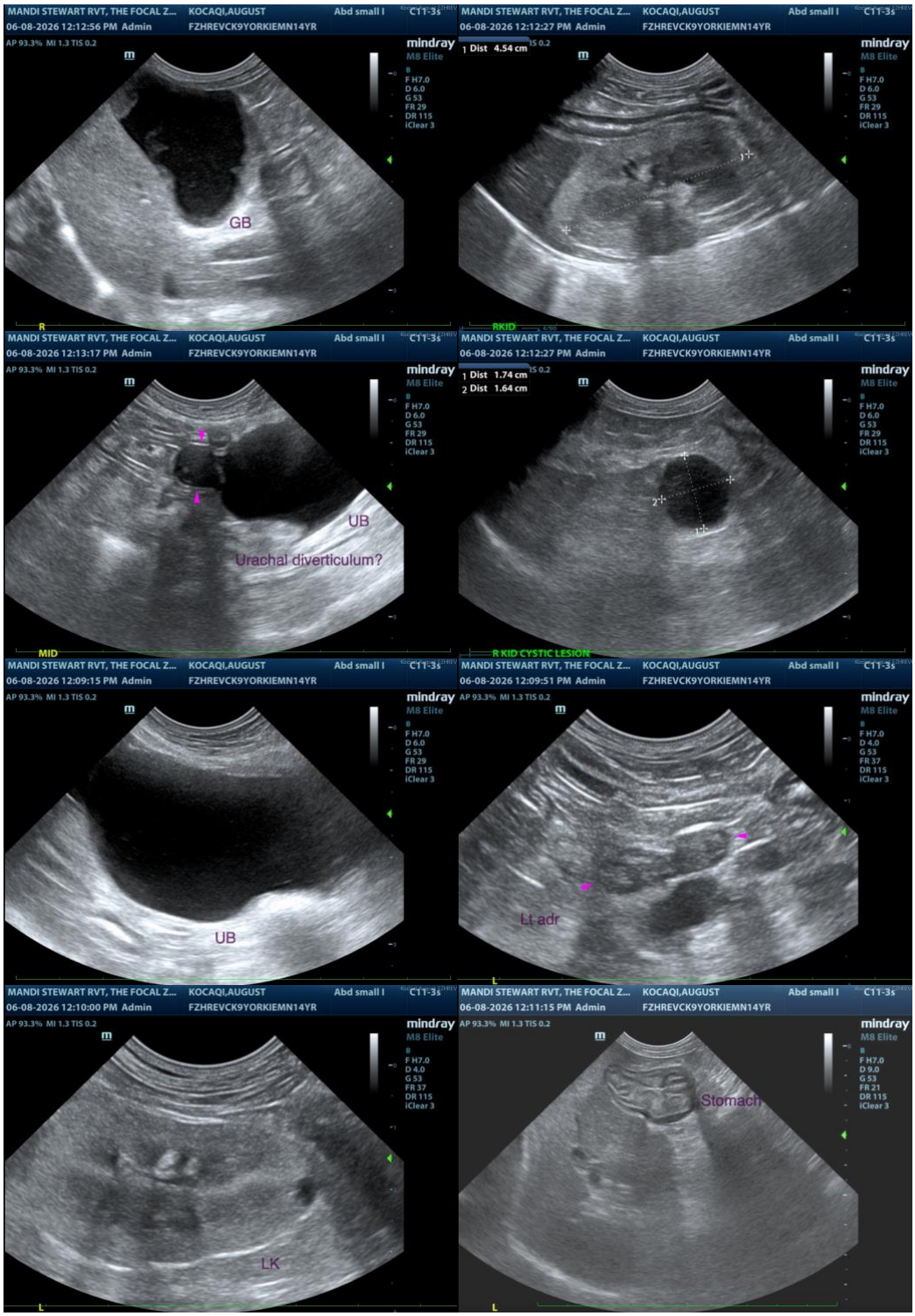

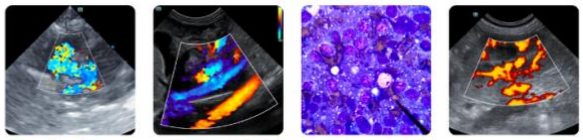



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**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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