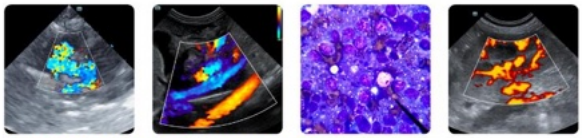

PATIENT

Calhoun Baker

SPECIES

Canine

BREED

Pomeranian

SEX

Male, neutered

AGE

10/5/2011

WEIGHT

10.4 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

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

HOSPITAL NAME

Salt Marsh

REFERRING VET

Dr. Thompson

INVOICE

13469

DATE

2/10/26

PRESENTING CLINICAL SIGNS

- Recently diagnosed Hypothyroid - Significant hairloss along trunk and hind end
- Chronic skin infections
- Luxating patellas on both hind limbs
- Previous history of CaOX bladder stones - surgically removed in 2024

ALP 283, GGT 22, USG 1.020, 3+ proteinuria, inactive sediment, 4DX negative

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder and visible portion of the pelvic urethra are normal for the degree of luminal distension. The urine is anechoic with no evidence of debris. Cystic calculi and discrete masses are not observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The prostate is normal in size (0.68 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 (4.13 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with severe loss of corticomedullary distinction. Several small cortical cysts are seen. Multiple pinpoint hyperechoic foci are observed within the cortex. Several small non-obstructive nephroliths are also seen. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (4.69 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with severe loss of corticomedullary distinction. Several small cortical cysts are seen. Multiple pinpoint hyperechoic foci are observed within the cortex. Several small non-obstructive nephroliths are also seen. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is enlarged (1.18 cm at cranial pole) (1.02 cm at caudal pole) with swollen/irregular peripheral contours. The parenchyma is heterogeneous with some loss of glandular detail. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is enlarged (1.07 cm at cranial pole) (0.73 cm at caudal pole) with swollen peripheral contours. The glandular echogenicity and detail are unremarkable. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.71 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A 0.85 x 0.68 cm multiseptated cystic nodule is observed at the cranial to mid-aspect. Pinpoint hyperechoic foci are also observed throughout the organ. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is hypoechoic relative to the spleen and slightly mottled in appearance. No distinct focal lesions are observed. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

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The gall bladder lumen is distended. The wall is thin and smooth. A small amount of echogenic debris is observed within the lumen, most of which is gravity-dependent and some of which is suspended. 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 ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

The left limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is largely isoechoic 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

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

Other

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

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory disease, infiltrative neoplasia and other hepatopathies are considered less likely.
- The gallbladder distention is likely secondary to fasting as there is no obvious evidence of a bile duct obstruction and the patient's total bilirubin is normal.
- Bilateral adrenomegaly
- Splenic dystrophic mineralization. This is typically a benign incidental finding often associated with endocrinopathies. The cystic splenic nodule may represent a benign focus or potentially an emerging vascular tumor.

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.
- Bilateral nonspecific, age-related renal changes with non-obstructive nephrocalcinosis and cortical cysts.

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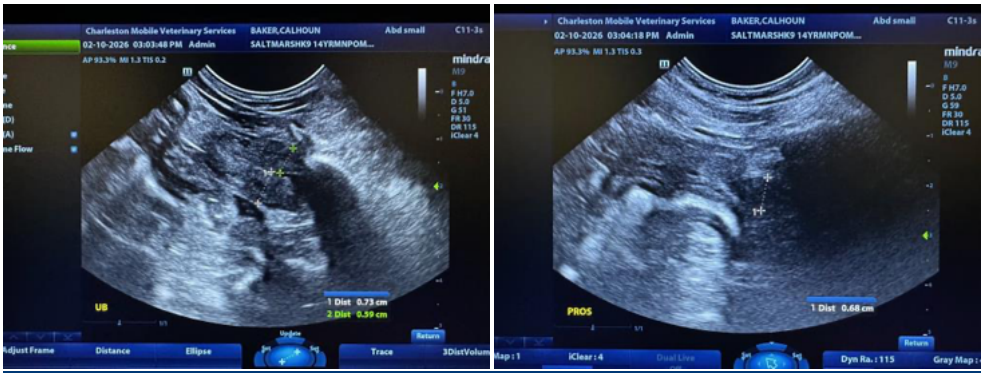
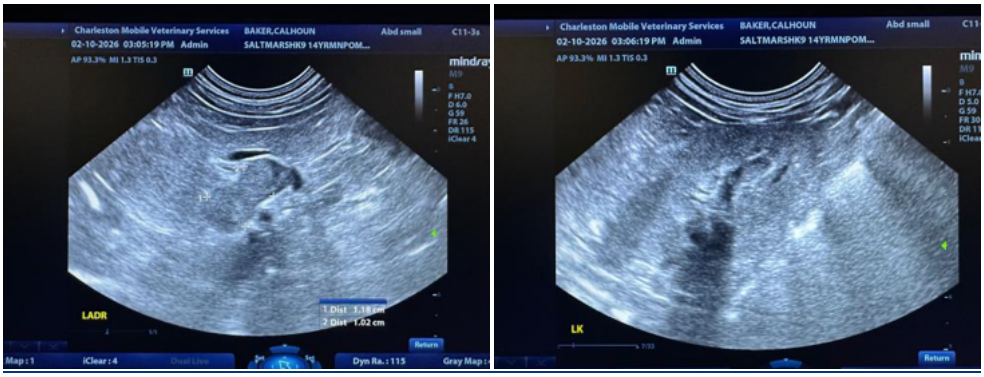
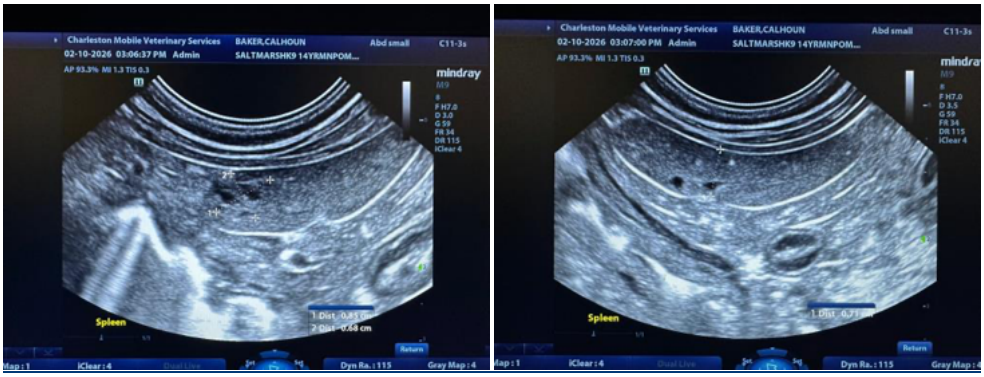
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

1. Serial monitoring (i.e., every 3-4 months) of the patient's liver values is recommended. If liver values continue to increase, a repeat abdominal ultrasound +/- hepatic tissue sampling may be warranted.
2. Consider testing for hyperadrenocorticism with a low-dose dexamethasone suppression test or ACTH stimulation test if clinical signs (i.e., PU/PD) develop in the future.
3. Regarding the gallbladder distention, consider a recheck ultrasound 2 hours following a small meal to allow for gallbladder contraction.
4. Regarding the splenic nodule, consider a recheck ultrasound in 1-2 months to assess for growth of the lesion.







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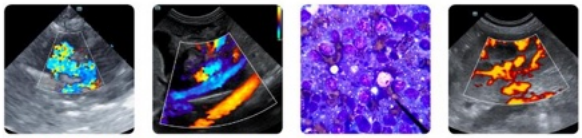

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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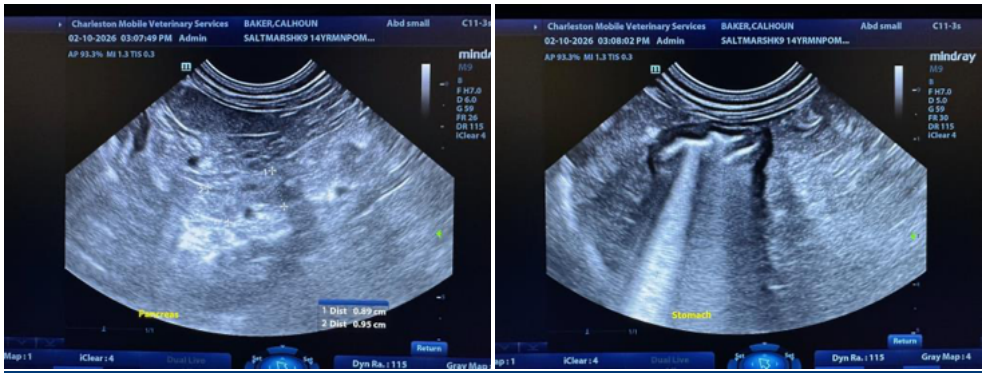

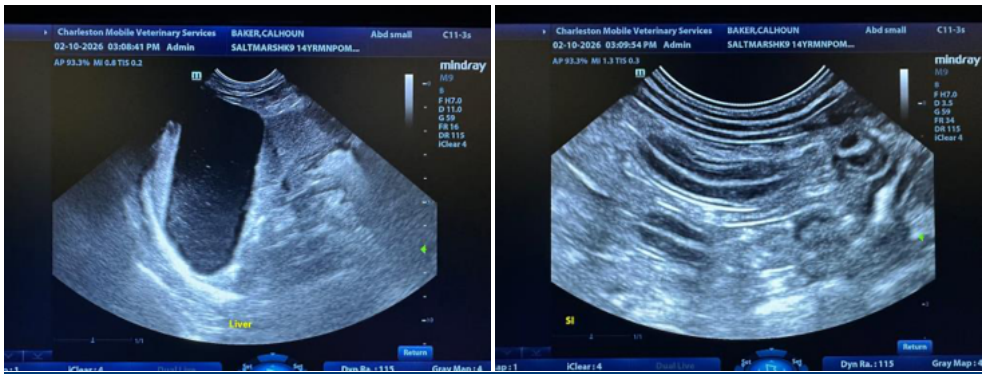

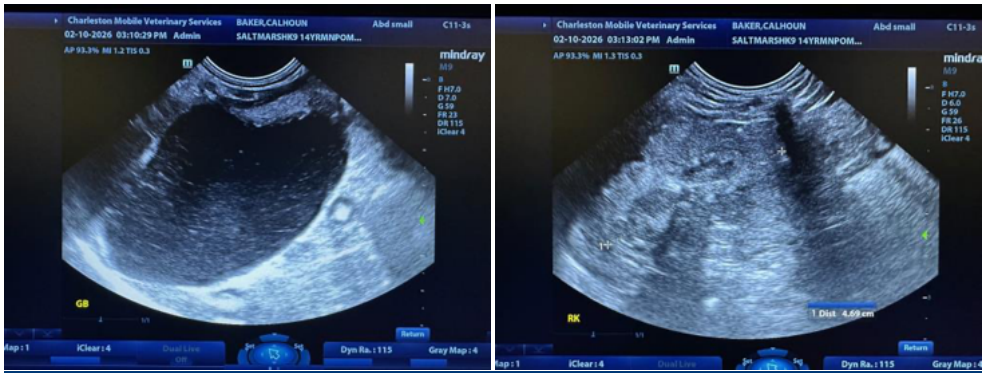

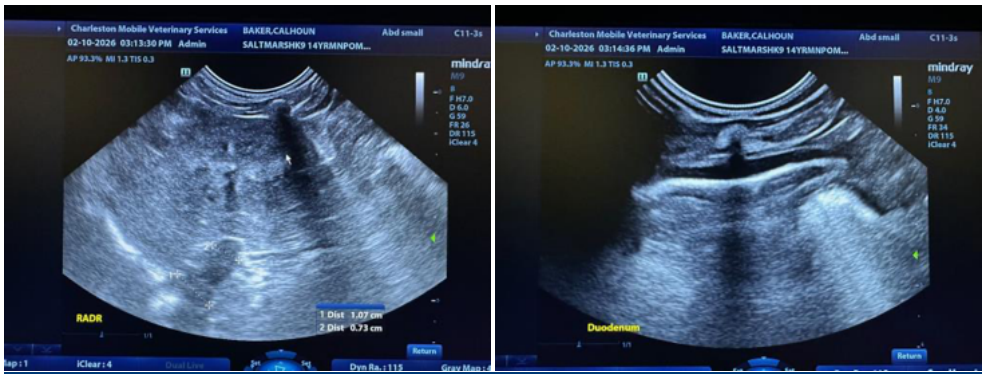

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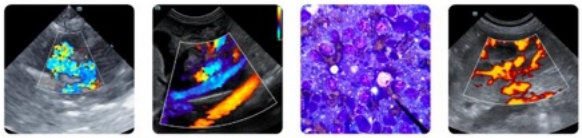

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com