



**PATIENT**

Mia Frey

**SPECIES**

Canine

**BREED**

Boston Terrier

**SEX**

Female, spayed

**AGE**

3/9/2014

**WEIGHT**

**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**

Low Country Vet  
Neurology and  
Surgery

**REFERRING VET**

Dr. Freeman

**INVOICE**

13592

**DATE**

3/10/26

**PRESENTING CLINICAL SIGNS**

Presented for neuro signs. Initially thought it was the patient's eyes but that was ruled out. Hx of atypical Cushing's – takes lignans. No proteinuria. Questionable cardiomegaly on chest rads. Possible splenic mass on abdominal rads. Fever. Hypertensive. ALP 810, ALT 195, mild thrombocytopenia.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is mildly to moderately distended with mostly anechoic urine. The wall in the region of the apex is mildly thickened (up to 0.45 cm) with a slightly irregular mucosal surface. The wall tapers to a normal thickness as it extends through the cystourethral junction. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal in size (4.31 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. Mild pyelectasia is present (0.29 cm in the longitudinal plane). There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (RkAN cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

**Adrenal Glands**

The left adrenal gland is mildly enlarged (0.73 cm at cranial pole) (0.59 cm at caudal pole) with slightly swollen peripheral contours. The glandular echogenicity and detail are unremarkable. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is mildly enlarged (1.03 cm at cranial pole) (0.57 cm at caudal pole) with a slightly irregular shape. The glandular echogenicity and detail are unremarkable. The phrenicoabdominal vein and surrounding vasculature are normal.

**Spleen**

The spleen is mildly enlarged (1.75 cm in width at the level of the hilus) with occult contour and slightly swollen peripheral margins. An approximately 3 cm ill-defined isoechoic to mildly heterogeneous swelling is observed at the lateral aspect. The remaining parenchyma is relatively homogeneous. Splenic vasculature is normal with no evidence of thrombosis.

**Liver**

The liver is subjectively enlarged with swollen peripheral contours. The parenchyma is isoechoic relative to the spleen and subtly heterogeneous in appearance. 2-3 cystic areas are observed, the largest measuring 1.8 x 1.1 cm. 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 gall bladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are anechoic. 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



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intestinal wall is normal in thickness with a normal layering pattern. There is evidence of mucosal speckling in some segments. Discreet masses are not identified. The ileoceocolic 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 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. See also *Other*.

**Lymph nodes**

See *Other*.

**Free Abdomen**

There is no obvious evidence of free fluid.

**Other**

The uterine stump is visible/prominent (0.91 cm in width). The uterine lumen is empty.

A 0.77 x 0.67 cm hypoechoic structure is observed in the cranial abdomen.

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A brief echocardiogram reveals no obvious evidence of pericardial or pleural effusion in the visible window. There is no obvious evidence of cardiac masses or vegetative lesions on any of the heart valves.

**ULTRASONOGRAPHIC FINDINGS**

**Primary Findings:**

- The splenic swelling could be consistent with a benign focus (i.e., lymphoid hyperplasia or similar) with a lower possibility of an emerging tumor. Mild splenomegaly is also present.

**Secondary 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 cystic lesions within the hepatic parenchyma likely represent a benign process with a lower possibility of emerging neoplasia.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The hypoechoic nodule in the cranial abdomen may represent a prominent lymph node, nodule within the pancreas or mesentery, other.
- Mild bilateral adrenomegaly
- The small intestinal mucosal speckling may be a normal variant for this patient or could be consistent with enteritis. Correlation with the patient's clinical history is recommended.
- Mild bilateral nonspecific, age-related renal changes with left pyelectasia. The pyelectasia may be secondary to pyelonephritis, parenchymal remodeling, PU/PD (if applicable) or some combination thereof.
- Prominent uterine stump.

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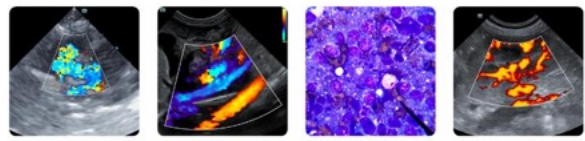
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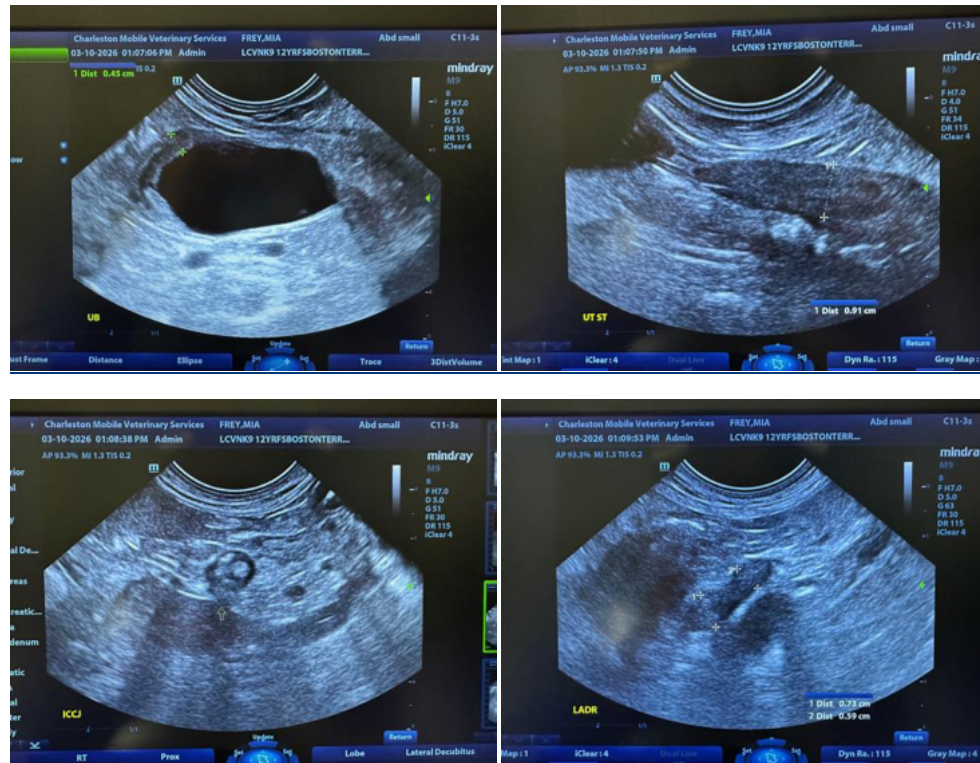
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- The urinary bladder wall changes in the region of the apex could be consistent with cystitis or may be artifactual due to lack of full repletion. Correlation with the patient's history and urinalysis findings is recommended.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

- Regarding the splenic changes, fine needle aspiration of the swelling can be considered (assuming normal clotting status). A 25-gauge needle should be used. Alternatively, consider a recheck ultrasound in 1-2 months to assess for changes.
- Regarding the patient's neurologic signs, follow up with the patient's neurologist is recommended.





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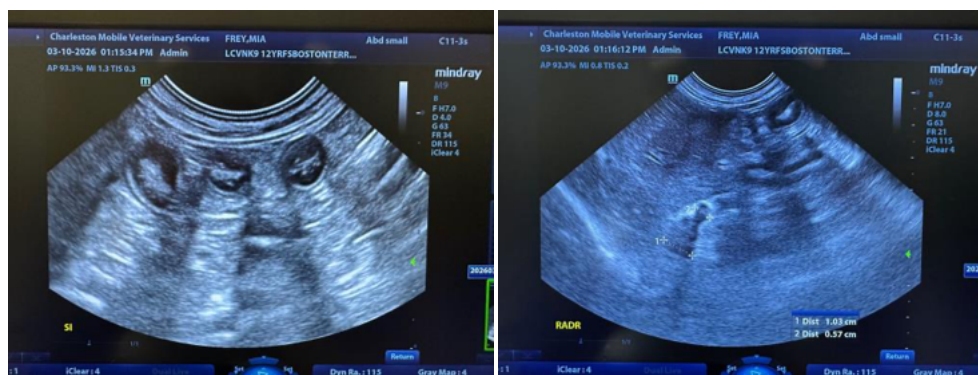
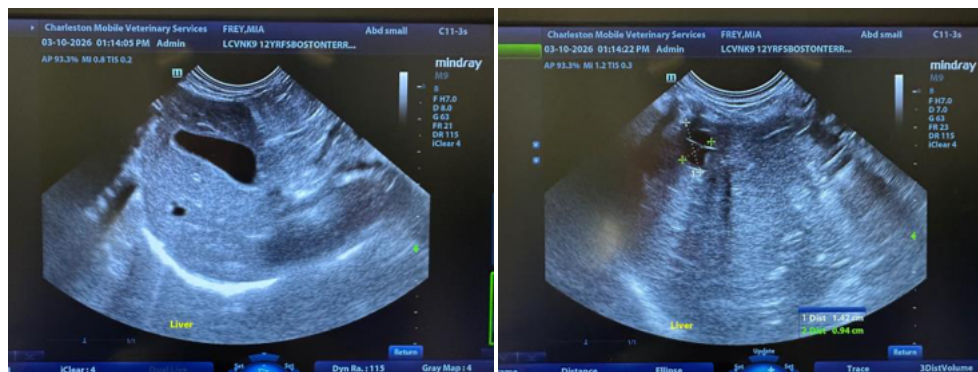
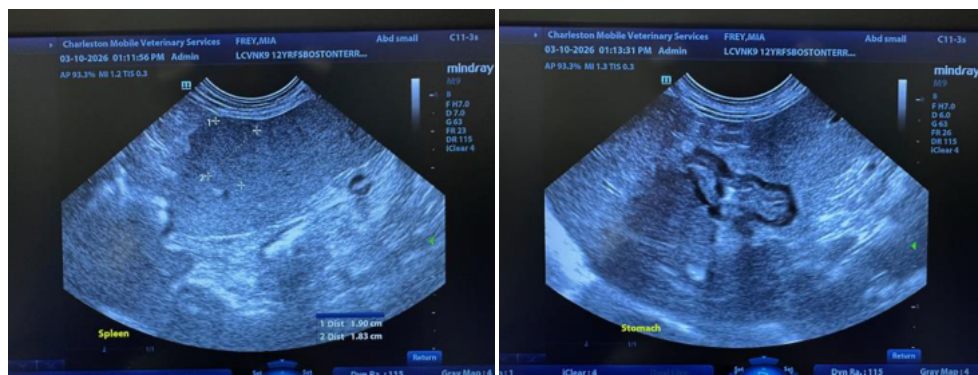
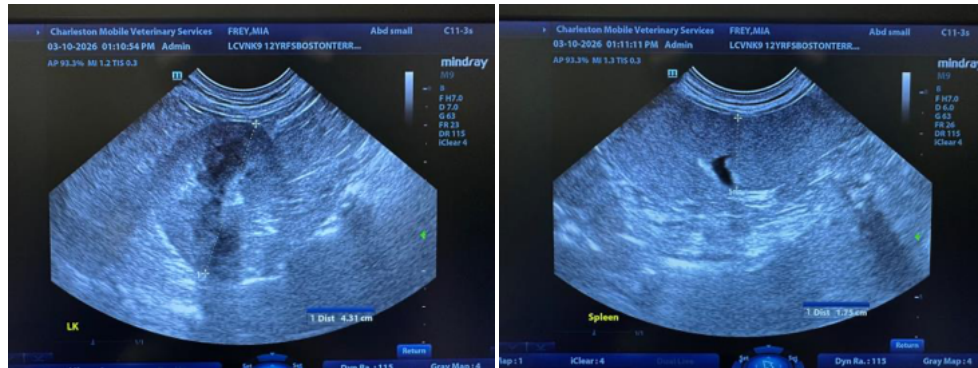
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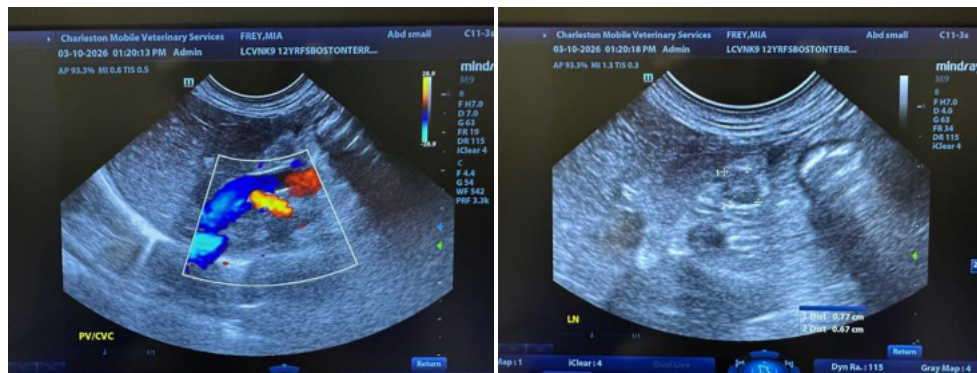
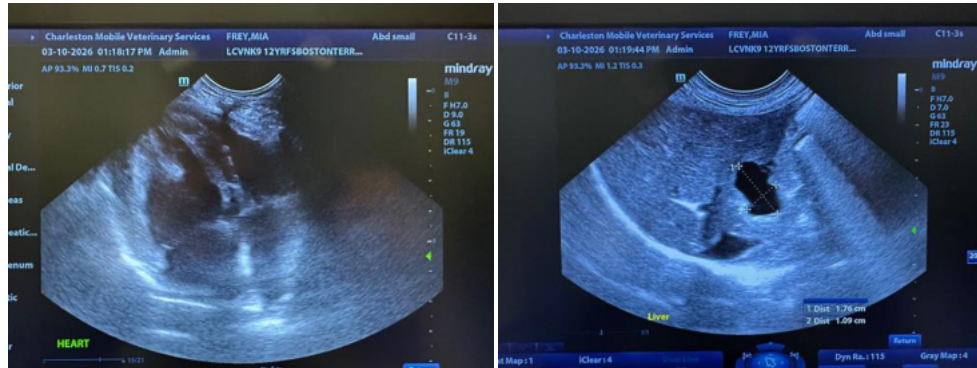
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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