



**PATIENT**

Maaz Maserati Allen

**SPECIES**

Canine

**BREED**

Great Dane

**SEX**

Male, neutered

**AGE**

8 Yrs. 9 months

**WEIGHT**

135.8 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**

Sun Dog Cat Moon

**REFERRING VET**

Dr. Fetterolf

**INVOICE**

13624

**DATE**

3/24/26

**PRESENTING CLINICAL SIGNS**

Maaz was diagnosed w IMHA during spring/summer of 2025; managed by Dr. Clare at CVRC IM Department. He is no longer on Prednisone and is currently tapering off of Cyclosporine as well. He does have a h/o progressive Alk Phos since Nov/Dec of last year. Was in 900s but now 546. USG 1.023, 3+ proteinuria. Also recently diagnosed w/ proteinuria (Protein/Creatinine Ratio 2.3). Albumin low-normal at 2.7. Pt feels well. BP at home: 137/77 (99), 132/77 (94), 136/87 (100). Pt's BP today was normal at 137 mmHg. Pt sedated with Butorphanol and Acepromazine for this study.  
- History of hypercholesterolemia, responsive to psyllium husk fiber therapy

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder is minimally distended. The wall is of appropriate thickness for the level of repletion. The mucosal surface is slightly irregular. A scant amount of echogenic debris is suspended within the lumen. No cystic calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The prostate is normal in size (1.12 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 (9.09 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. A 0.61 cm cortical cyst is observed at the caudolateral aspect. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (9.52 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 hydroureter. Renal vasculature is normal.

**Adrenal Glands**

The left adrenal gland is normal in size (0.73 cm at cranial pole) (0.67 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 (1.13 cm at cranial pole) (0.68 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 prominent in size (2.54 cm in width at the level of the hilus) with a folded contour and smooth peripheral margins. The parenchyma is subtly mottled in appearance. No focal lesions are observed. Splenic vasculature is normal.

**Liver**

The liver is subjectively normal in size with normal curvilinear peripheral contours. The parenchyma is hypochoic 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 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.

***Gastrointestinal***

The gastric lumen is mildly gas 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 ileoceocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

***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.

***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 obvious evidence of pericardial or pleural effusion in the visible window.

**ULTRASONOGRAPHIC FINDINGS**

- The hepatic parenchymal changes likely represent benign, age-related parenchymal remodeling or minor regenerative nodular hyperplasia with a lower possibility of inflammatory disease, hepatotoxicosis, infiltrative neoplasia, fibrosis or other hepatopathy.
- Gallbladder debris, non-mucocele
- Bilateral nonspecific renal changes. These findings, in conjunction with the proteinuria, is suggestive of a protein losing nephropathy. Most protein losing nephropathies are idiopathic. However, they can be secondary to infectious, inflammatory, immune mediated or neoplastic disease and an underlying cause should be sought if possible.
- The mild splenomegaly may be secondary to sedation, lymphoid hyperplasia, extramedullary hematopoiesis, splenitis, antigenic stimulation or less likely, emerging neoplasia.

**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. Regarding the proteinuria, consider initiation of an angiotensin receptor blocker, omega 3 fatty acids +/- an antithrombotic agent (i.e., Clopidogrel). A prescription renal diet should also be considered. Serial monitoring of the patient's UPC, blood pressure, renal values and serum albumin is recommended to assess progression of disease.



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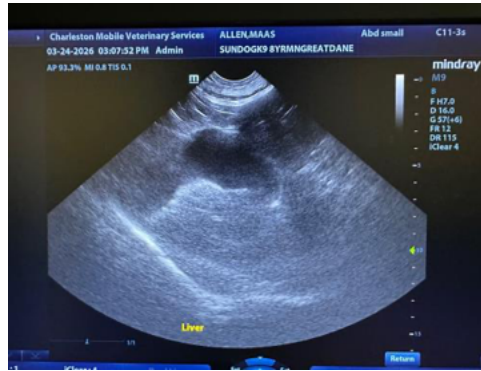
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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](mailto:info@SonoPath.com)