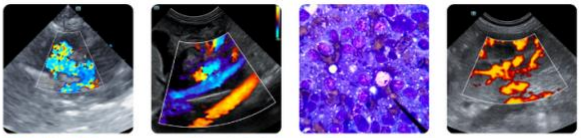


PATIENT

Diva Raciti

SPECIES

Canine

BREED

Petit Basset Griffon Vendeen

SEX

Spayed Female

AGE

14 Years 4 Months

WEIGHT

24.3

INTERPRETED BY

Eric Lindquist, DMV, DABVP (CFM), Cert. IVUSS

IMAGING PERFORMED BY

Vincent Ravancho, CVT

HOSPITAL NAME

Packanack AH

REFERRING VET

Dr. Katz

INVOICE

35090

DATE

12/26/25

PRESENTING CLINICAL SIGNS

History: Hematuria/Straining to urinate Clinical findings: grainy enyunro on Vulva, perianal mass (hx) Current medications: Levothyroxine 0.3 mg SID.

Abnormal PE/Chem/CBC/UA Results: ALT 366 ALP 582 Neut 13.68 USG: 1.023

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** revealed minor apical wall thickening at moderate repletion, measuring 0.45 cm. Micropolypoid changes were noted. Pelvic urethra was imaged 4.0 cm beyond the cystourethral junction: no evident pathology. The bladder was otherwise unremarkable. The iliac trifurcation was unremarkable.

The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some mild age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for this age patient. Medullary structure differed distinctly from that of the cortex. The left kidney measured 4.75 cm. The right kidney measured 5.29 cm. Slight pyelectasia was noted in the right kidney.

Adrenal Glands

The **left adrenal gland** was enlarged at the caudal pole with heterogenous parenchymal changes and capsular expansion without capsular escape, measuring 1.4 cm at the caudal pole x 2.42 cm in length and 0.64 cm at the cranial pole.

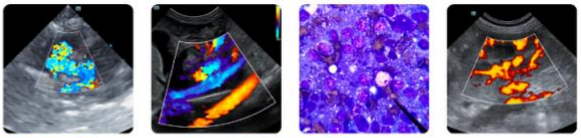
The cranial pole of the **right adrenal gland** was heterogenous, measuring 1.4 cm at the cranial pole and 0.58 cm at the caudal pole x 2.74 cm in length.

Spleen

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes were noted.

Liver

The **liver** images from right and left intercostal as well as subcostal views revealed subjectively normal liver size, contour, and structure. Some moderate age-related parenchymal remodeling was noted but likely not clinically significant at this time. Vascular and biliary tracts were of normal volume, and no evidence of congestion was noted. The gallbladder presented some dependent debris with essentially normal contour. The cystic and common bile ducts were normal. No overt evidence of active inflammatory, infiltrative or regenerative pathology was noted but should be paired with current or



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past LE elevations regarding any clinical significance to this presentation. The hepatic lymph nodes were unremarkable.

Gastrointestinal

Examination of the **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.

Pancreas

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

ULTRASONOGRAPHIC FINDINGS

- Left adrenal nodule, concerning for adenoma- mild potential for adenocarcinoma or pheochromocytoma. This is an incidental finding and appears resectable.
- Heterogenous cranial pole of the right adrenal gland
- Minor apical bladder wall thickening with micropolypoid changes
- Moderate degenerative renal changes with slight right kidney pyelectasia
- Nonspecific chronic hepatopathy, given the hepatic presentation with liver enzyme profile.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Assessment for any evidence of UTI is recommended and empirical management. Urine culture and sensitivity are indicated. There was no overt evidence of bladder masses or calculi at the time of the sonogram, however, cannot rule out past history of passage of calculi that may be contributing to the clinical signs. Examination of the vaginal vestibule and urethral meatus is warranted to assess for any distal urethral pathology, even though the urethra was imaged from an abdominal approach to 4.0 cm past the cystourethral junction without evident pathology in that position. There is no evidence of metastatic disease owing to the perianal mass.

Note that 30% of Addisonian dogs are atypical and have normal sodium potassium ratios. Screening can be performed with a urine cortisol to creatinine ratio (UCCR) of less than 2.0 ug/dl is indicated as a screening for Addison's. This has near a 100% negative predictive value. UCCR less than 1.4 ug/dl is 100% sensitive and 97 % specific for Addison's. If the UCCR is greater than 2.0 ug/dl and Addisonian signs are present, then disease induced adrenal burnout may be the case. UCCR measures a 12-hour cortisol whereas baseline cortisol is a moment in time and fluctuates. Therefore, a UCCR is more sensitive and specific than baseline cortisol. Otherwise, baseline cortisol could be utilized if > 2.0 then this is negative also for Addison's, yet less sensitive and specific. Therefore, baseline UCCR is

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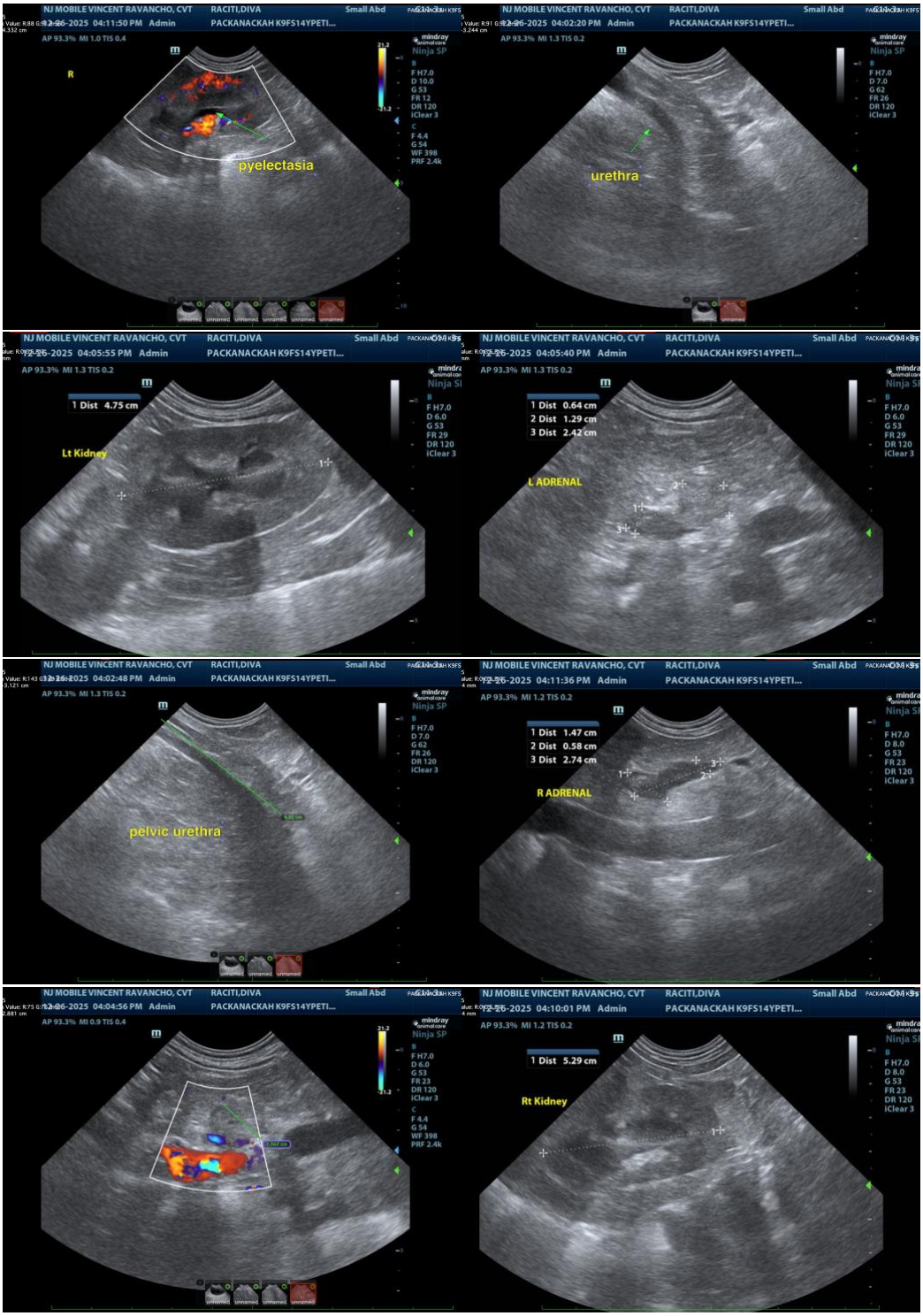
considered the best screening test. Therefore, if UCCR is less than 2.0 then full ACTH stimulation would be recommended for the diagnosis of Addison's. This is based on Del Baldo, et.al JVIM 2022



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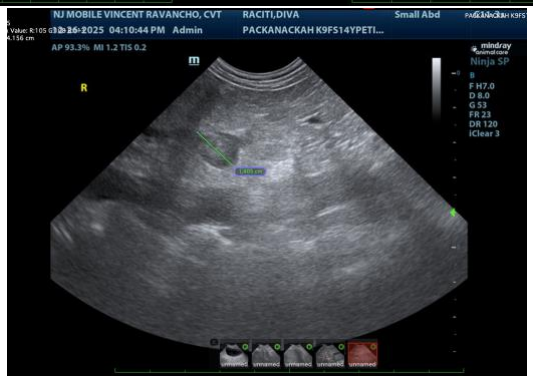

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP(CFM), Cert. IVUSS,
CEO, Owner, Founder -- SonoPath.com
info@SonoPath.com