



PATIENT

Michelangelo Carter

SPECIES

Canine

BREED

Shih Tzu Mix

SEX

Neutered Male

AGE

10 Years

WEIGHT

7.9 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Tiffany Moore

HOSPITAL NAME

Lone Mountain Animal
Hospital

REFERRING VET

Dr. Tiffany Moore

INVOICE

15479

DATE

04/25/26

PRESENTING CLINICAL SIGNS

History of hypercalcemia on BW - previous AH rec'd parathyroid gland removal. P not clinical. No v/d

Abnormal PE/Chem/CBC/UA Results: hypercalcemia 13.5

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** and trigone presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized, and anechoic urine was present. No evidence of inflammatory or neoplastic changes were noted. Ureteral papillae were normal. A small amount of urethral sand appeared to be present.

The **kidneys** revealed normal size and structure, corticomedullary definition and ratio for this age. The cortices presented largely uniform texture with normal echogenic relationship to liver and spleen. Medullary structure differed distinctly from the cortex. The capsules were acceptably uniform without significant irregularities. The left kidney measured 4.87 cm in length. The right kidney measured 4.6 cm in length. A cortical infarct was present in the dorsal cortex of the left kidney with slight nonobstructive pinpoint mineralizations. Slight pyelectasia was present in the right kidney.

Adrenal Glands

Both **adrenal glands** were visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measured 0.48 cm width. The right adrenal gland measured 0.47 cm width.

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 submitted revealed subjectively normal liver size, contour, and structure. Parenchymal echogenicity was naturally coarse and hypoechoic to the spleen. Vascular and biliary tracts were of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy was evident. No overt structural evidence of inflammatory, infiltrative or regenerative pathology was evident.

Minor gallbladder sand with minor suspended striating bile was present with minor overdistention yet not to the level of mucocele formation.

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



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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.

Free Abdomen

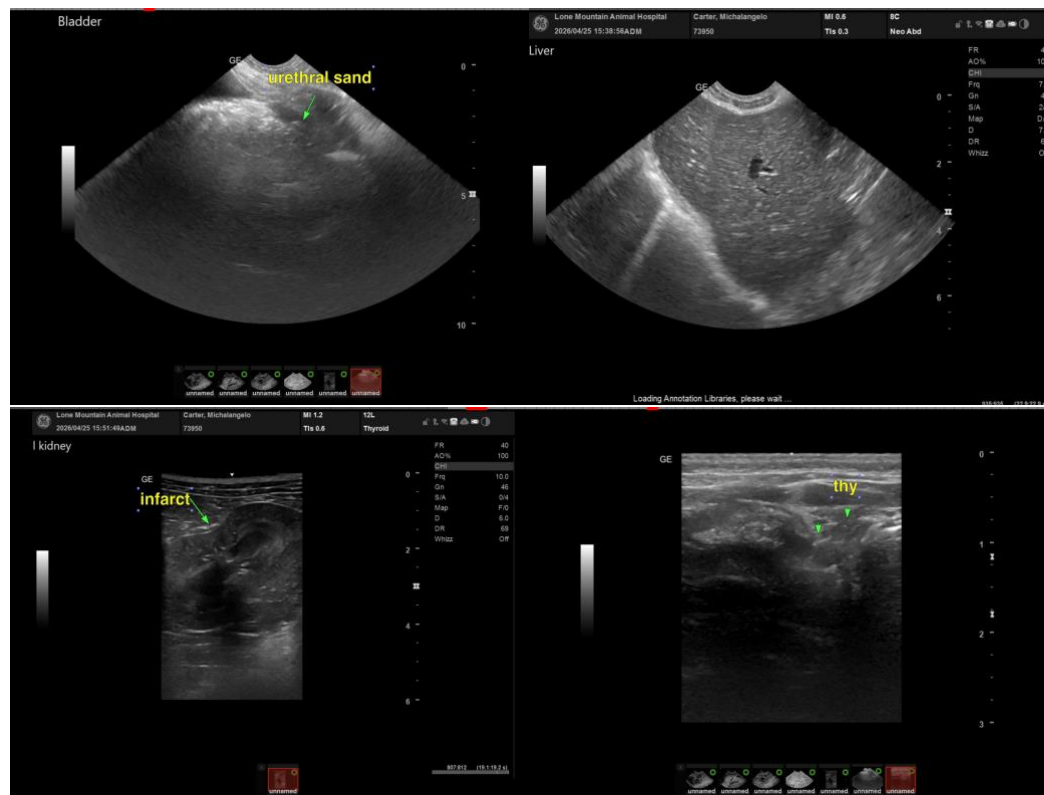
Limited views of the thyroid and parathyroid region were supplied with no gross pathology was present, however, cannot rule out parathyroid adenoma.

ULTRASONOGRAPHIC FINDINGS

- Minor renal mineralization.
- Minor gallbladder sand and over distention.
- Minor urethral sand.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Ursodiol therapy could be justified in this patient. No evidence of primary cause of hypercalcemia. If hypercalcemia panel is suggestive for primary hypercalcemia, further imaging of the thyroids is indicated.





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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,

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CANINE HYPERCALCEMIA

<http://www.sonopath.com/CanineHypercalcemia>

Description: Hypercalcemia is defined as either a persistently elevated total calcium serum (> 12 mg/dl) or ionized calcium (> 1.45 mmol/l) concentration. Clinical signs are often absent with mild hypercalcemia (< 13 mg/dl). In fact, hypercalcemia is often only discovered when serum biochemistry is done for unrelated reasons. Clinical signs are usually mild when the serum calcium concentration is less than 14 mg/dl; however, signs become more readily apparent when the concentration exceeds 15 mg/dl. Life-threatening cardiac arrhythmias can develop when the serum calcium exceeds 18 mg/dl.

Common etiologies of hypercalcemia include humoral hypercalcemia of malignancy (HHM), hypoadrenocorticism, chronic kidney disease (CKD), hypervitaminosis D, and primary hyperparathyroidism. Less common etiologies include bone neoplasia, osteomyelitis, hypertrophic osteodystrophy, granulomatous disease, calcium supplementation, and oral phosphate binders.

Clinical Signs: Common clinical signs include polyuria, polydipsia, lethargy, inappetence, and weakness. With chronic hypercalcemia, calcium oxalate and calcium phosphate uroliths can form, resulting in clinical signs suggestive of lower urinary tract disease. Systemic signs of illness are suggestive of HHM.

Diagnostics: One important etiology of hypercalcemia is laboratory error; therefore, hypercalcemia should always be confirmed before embarking on any further diagnostic evaluation. Results of a CBC, serum biochemistry panel, and urinalysis, in conjunction with a patient history and findings from a physical examination, can often provide enough information to arrive at a diagnosis. The appendicular skeleton, peripheral lymph nodes, abdominal cavity, and rectum should all be carefully palpated for masses, lymphadenopathy, hepatomegaly, splenomegaly, and/or pain in the long bones. The following diagnostic tests are helpful for identifying an underlying malignancy: thoracic and abdominal radiographs; abdominal ultrasound; cytological evaluation of aspirates of the liver, spleen, lymph nodes, and bone marrow; determination of serum ionized calcium, parathyroid hormone (PTH), and parathyroid hormone-related protein concentration (PTHrP); and ultrasound of the neck. Ascertaining the concentrations of serum ionized calcium, PTH, and PTHrP helps differentiate primary hyperparathyroidism from HHM. The finding of one or more enlarged parathyroid glands upon conducting an ultrasound of the neck supports a diagnosis of primary hyperparathyroidism.



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Hypoadrenocorticism-induced hypercalcemia usually occurs in conjunction with hyponatremia, hyperkalemia, and prerenal azotemia. With HHM and primary hyperparathyroidism, serum phosphorus concentration is often in the low to low-normal reference range. If the serum phosphorus concentration is high but kidney function is normal, hypervitaminosis D or osteolysis should be suspected.

It can be difficult to determine whether kidney failure is primary or secondary to hypercalcemia when hyperphosphatemia and hypercalcemia coexist with azotemia. Serum ionized calcium concentrations are typically normal or decreased in cases of renal failure and increased in cases of hypercalcemia caused by other disorders.

Sternal and hilar lymphadenopathy is common with lymphoma-induced hypercalcemia and can be readily identified on thoracic radiographs. In cases of multiple myeloma, discrete lytic lesions in the vertebrae or long bones, hyperproteinemia, proteinuria, and plasma cell infiltration in the bone marrow may be present. Cytological evaluation of the peripheral lymph nodes, bone marrow, and spleen can be helpful in identifying lymphoma.

Increased serum ionized calcium concentrations, detectable serum PTHrP concentrations, and non-detectable serum PTH concentrations are all diagnostic for HHM. Lymphoma is the most common etiology of HHM, but other tumors, such as apocrine gland adenocarcinoma and various carcinomas (e.g. mammary gland, squamous cell, bronchogenic), can all give rise to hypercalcemia. Increased serum ionized calcium, normal to increased serum PTH, and non-detectable PTHrP concentrations are diagnostic of primary hyperparathyroidism.

Differentials for Hypercalcemia: "HARD IONS"

Hyperparathyroid

Addison's

Renal

D-toxicity

Idiopathic

Osteolytic

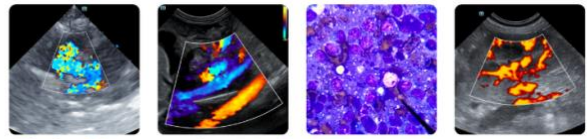
Neoplastic

Spurious

PTH tumor: Elevated total and ionized Ca, low PTHrP, and normal/high PTH. Keeshonds, German Shepherds, and Golden Retrievers are all predisposed.

Addison's disease: Elevated total and normal ionized Ca, elevated BUN, hypoalbuminemia and hyperkalemia.

Renal failure: Elevated to normal total Ca, low ionized Ca, low PTHrP, elevated PTH, azotemia, and low urine specific gravity.



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Vitamin D toxicity: Elevated total and ionized Ca, low PTHrP, and normal/low PTH.

Hypercalcemia of malignancy (HHM): Elevated total and ionized Ca, high PTHrP, and low PTH.

Granulomatous disease: Elevated total and ionized Ca, low PTHrP, and low PTH.

Renal failure: Elevated to normal total Ca, low ionized Ca, low PTHrP, elevated PTH, azotemia, and low urine specific gravity.

Treatment: Therapies for hypercalcemia are aimed at correcting the underlying etiology; however, because prolonged hypercalcemia can result in kidney damage, the use of fluid therapy, furosemide, and possibly prednisone is indicated in all cases to reduce serum calcium levels. Suggested dosages include saline (0.9% 120-180 ml/kg day IV), furosemide (1-4 mg/kg PO TID), and prednisone (0.25 mg/kg PO Q24hr).

References:

Chew DJ, Schenck PA, Jaege JQ. Clinical disorders of hypercalcemia and hypocalcemia in dogs and cats. Proceedings from the American College of Veterinary Internal Medicine, Charlotte, NC, June 4-7, 2003.

Feldman EC. Disorders of the parathyroid glands. In: Ettinger SJ, Feldman EC, ed. *Textbook of Veterinary Internal Medicine, 7th ed.* St. Louis, MO: Saunders Elsevier; 2010:1722-50.

Peterson ME. Hypercalcemia in dogs & cats: differential diagnosis & treatment. Proceedings from the Western Veterinary Conference, Las Vegas, NV, February 19-23, 2012.