**PATIENT**

Rocko Luigi Cauzillo

**SPECIES**

Canine

**BREED**

Corgi

**SEX**

Neutered male

**AGE**

13 years

**WEIGHT**

34.4 pounds

**INTERPRETED BY**R. McKenzie Daniel, DVM,  
DABVP (Canine and Feline)**IMAGING PERFORMED BY**

Amy Mayhew LVT

**HOSPITAL NAME**

SVS Imaging Michigan

**REFERRING VET**

Family Pet Practice

**INVOICE**

10091ag

**DATE**

03/01/2022

**PRESENTING CLINICAL SIGNS**

History: Recheck AUS, recent onset PU/PD. Seizure history (idiopathic epilepsy) currently on Phenobarbital, Pot Bromide, Zonisamide, Keppra. Also on Denamarin, Fish oil, Dasuquin, Florazil currently. Eats RC HP. No current V/D, E/D well.

Abnormal PE/Chem/CBC/UA Results: See attached BW and previous AUS report

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN****Urinary System**

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some mildly increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. Previously noted cysts remain static. Mild pyelectasia was present in the left kidney. The left kidney measured 6.2 cm in length. The right kidney measured 6.4 cm in length. An example of left kidney cyst measured 0.98 cm in diameter. An example of right kidney cyst measured 0.77 cm in diameter.

The residual prostate is normal in size and contour with mildly echogenic to non-homogeneous parenchyma. No overt evidence of prostatic pathology observed. The residual prostate measured 0.97cm in diameter.

The area of the aortic trifurcation is free of pathology.

**Adrenal Glands**

Left adrenal gland exhibited mild prominent size with uniformly hypoechoic parenchyma. The left adrenal gland measured 0.86 cm width at the caudal pole and 0.73 cm width at the cranial pole. Right adrenal gland exhibited mild prominent size with uniformly hypoechoic parenchyma. The right adrenal gland measured 0.63 cm width at the caudal pole and 0.50 cm width at the cranial pole.

**Spleen**

The spleen was overall normal in size with areas of mild asymmetrical medial capsule contour. Generalized parenchymal heterogeneity exhibiting subtle areas of decreased parenchymal echogenicity to indistinct hypoechoic non expansive nodules was observed. An example of hypoechoic parenchyma measured 0.94 cm in diameter. Previously noted static appearing non homogenous to focally hyperechoic caudal splenic nodule measuring 2.3 cm x 1.3 cm appeared to mildly distort the splenic capsule yet is without evidence of parenchymal escape.

**Liver**

The liver exhibited generalized enlargement. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. Intermittent mildly hypoechoic to mixed echogenic intraparenchymal nodules are observed. An example of a nodule in the caudal left liver measured 1.9 cm in diameter. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non distended in size with moderate nondependent yet non organized debris. The cystic duct and common bile ducts were normal without evidence of dilation.

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**Gastrointestinal**

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was contained minor retained anechoic fluid.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material.

Normal visible colon wall layers were present with subjective semi formed to soft feces in lumen.

**Pancreas**

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

**Free Abdomen**

No overt lymphadenopathy or peritoneal effusion was present.

**ULTRASONOGRAPHIC FINDINGS**

- Bilateral chronic renal changes with static cysts, minor left kidney pyelectasia.
- Static caudal splenic nodule with concurrent areas of indistinct decreased splenic parenchyma echogenicity-nodules suggestive of myelolipoma. The areas of decreased echogenicity are suggestive of areas of lymphoid hyperplasia, hematopoiesis or potential incidental splenitis. Neoplastic criteria is considered unlikely.
- Hepatopathy exhibiting generalized parenchymal remodeling with intermittent nonspecific intraparenchymal nodules-subjectively benign, vacuolar/reactive hepatopathy, nonspecific hepatitis with parenchymal remodeling or hematopoiesis in areas of nodular/regenerative hyperplasia suspected. Neoplastic criteria is considered a less likely differential diagnosis.
- Moderate gallbladder debris (non-mucocele).
- Pancreatic remodeling-suspect age related/patient variant. Potential for low grade to chronic pancreatitis is possible.
- Subjective mild prominent bilateral adrenal glands-nonspecific.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered.

Leptospirosis titer/PCR could be considered if clinically indicated. Screening UCCR +/- LDDST is warranted if clinical suspicion of hyperadrenocorticism given the recent onset of PU/PD and presence of thrombocytosis.

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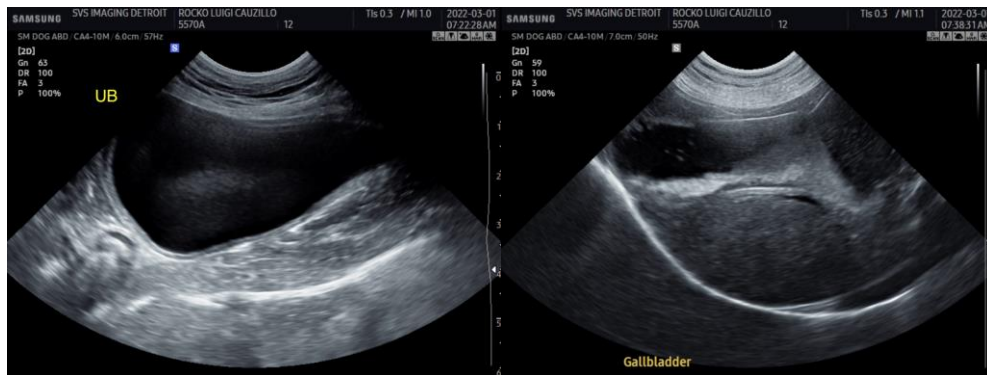
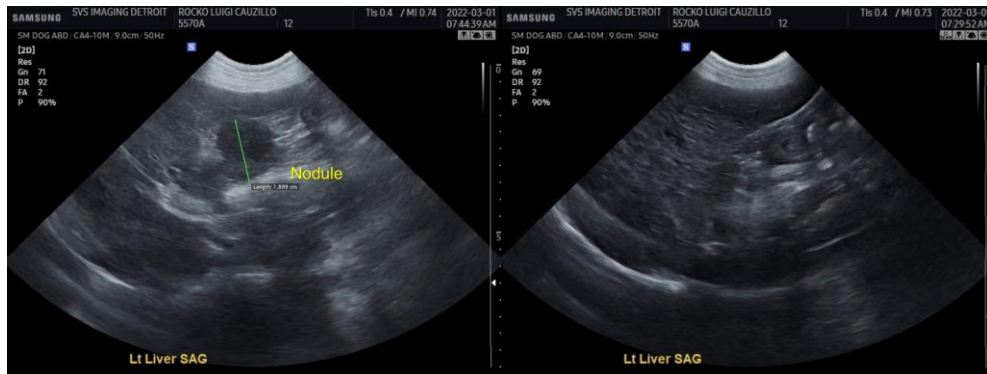
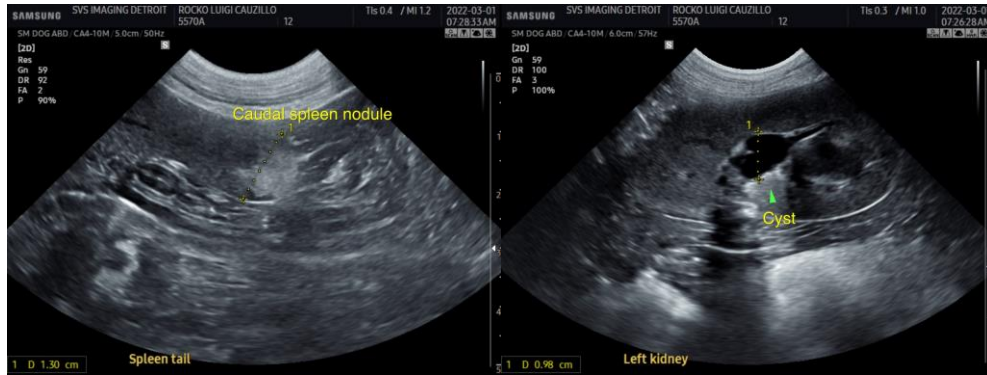
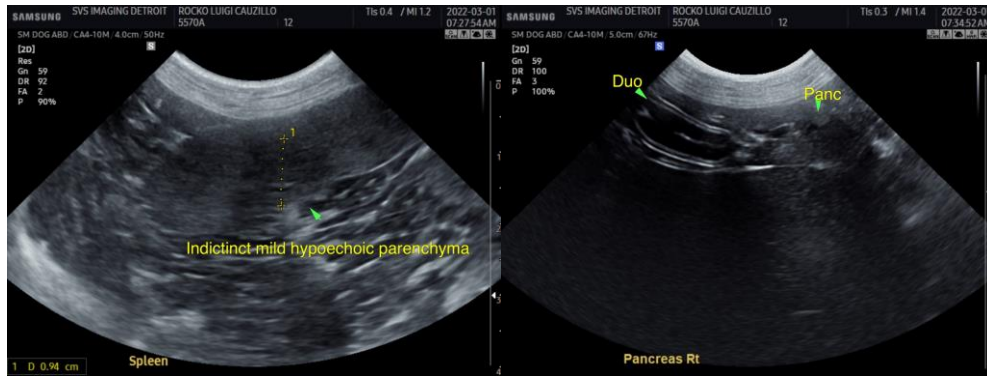
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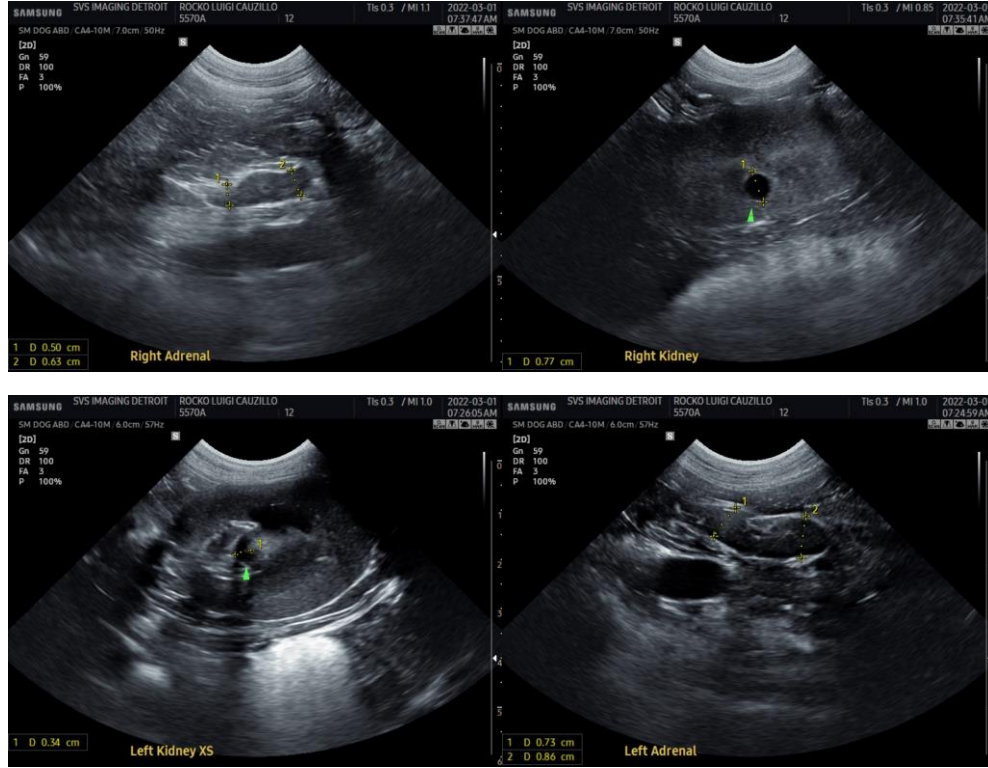
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)  
info@SonoPath.com