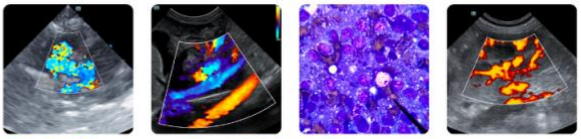



**PATIENT**

Nugget Almanzar

**SPECIES**

Canine

**BREED**

Yorkie

**SEX**

Neutered Male

**AGE**

14 Years 5 Months

**WEIGHT**

6.3

**INTERPRETED BY**

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

**IMAGING PERFORMED BY**

Dr. Nader Shafik

**HOSPITAL NAME**

Kew Gardens Animal Hospital

**REFERRING VET**

Dr. Nader Shafik

**INVOICE**

15366

**DATE**

04/22/26

## PRESENTING CLINICAL SIGNS

early CKD

Abnormal PE/Chem/CBC/UA Results: Urine protein creatinine ratio high.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder, residual prostate and proximal urethra were not visualized.

Normal size and asymmetrical 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 increased echogenicity and moderate loss of corticomedullary symmetry and definition expected for the age of the patient. Suspect cortical infarcts and focal areas of medullary mineral were present. The left kidney measured 3.5 cm in length. The right kidney measured 3.8 cm in length.

### *Adrenal Glands*

The left and right adrenal glands were not definitively visualized.

### *Spleen*

The discernable spleen exhibited subjective mild enlargement, capsule asymmetry and variable heterogeneous to echogenic parenchyma.

### *Liver & Gallbladder*

The liver presented subjective mildly enlarged with normal vascular volume. Heterogeneous remodeled parenchyma exhibiting variable coarse echotexture. An ill-defined to discrete nonhomogenous ventrocaudal liver nodule was visualized measuring 1.7 cm in diameter.

The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

### *Gastrointestinal*

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material.

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 apparent formed feces in lumen.

### *Pancreas*

The pancreas was not definitively visualized.

### *Free Abdomen*

Irregularly extensive to expansive mixed echogenic nodular to cavitated mass was present in the mid to cranial abdomen measuring at least 6,0 cm to 7.0 cm in diameter appearing to extend into the area of the spleen as well as effacing the caudal aspect of the stomach and area of the caudal liver. A

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possible cranial abdomen hypoechoic to swollen nonhomogenous mesenteric lymph node was present measuring 2.1 cm x 1.5 cm. Mid to cranial abdomen mild hyperechoic omentum. No obvious visualized peritoneal effusion.

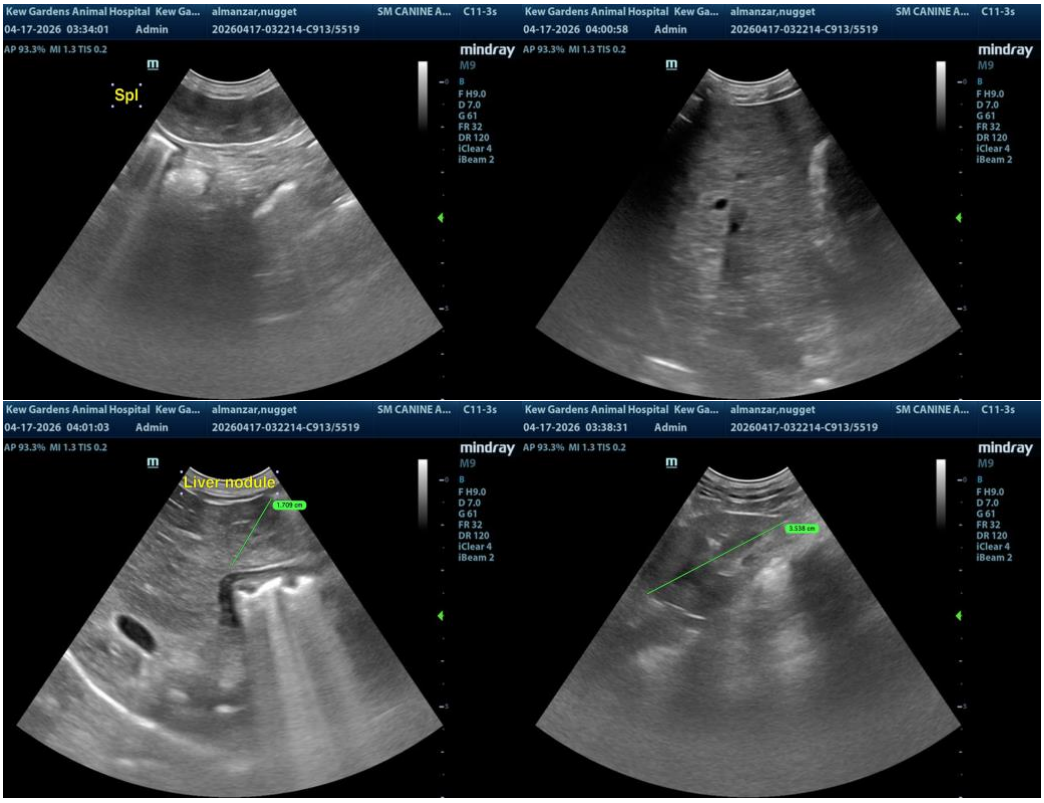
## ULTRASONOGRAPHIC FINDINGS

- Asymmetrically enlarged nonhomogenous discernable spleen.
- Hepatomegaly with indistinct nonhomogenous intraparenchymal nodule.
- Unspecified mid to cranial abdomen mass.
- Bilateral nonspecific chronic renal changes.
- Possible hypoechoic swollen cranial mesenteric lymphadenopathy with hyperechoic omentum.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Splenic origin for the unspecified mass is favored although non-splenic mass origin cannot be definitively excluded. Regardless, evidence of multicentric neoplastic criteria is likely given indistinct hepatic nodule and possible hypoechoic to swollen cranial mesenteric lymphadenopathy.

Assuming normal clotting status, mass FNA cytology using a 25-gauge needle could be considered for further clarification. Assuming no pathology on three view chest radiographs, abdominal CT would be ideal for further assessment. Monitoring of UPC ratio as well as screening culture/sensitivity for renal staging if evidence of inflammatory sediment on urinalysis is recommended.



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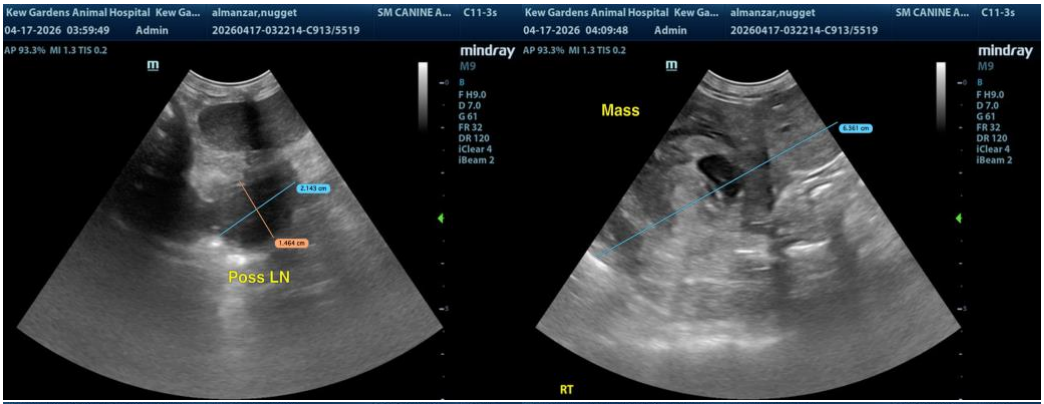


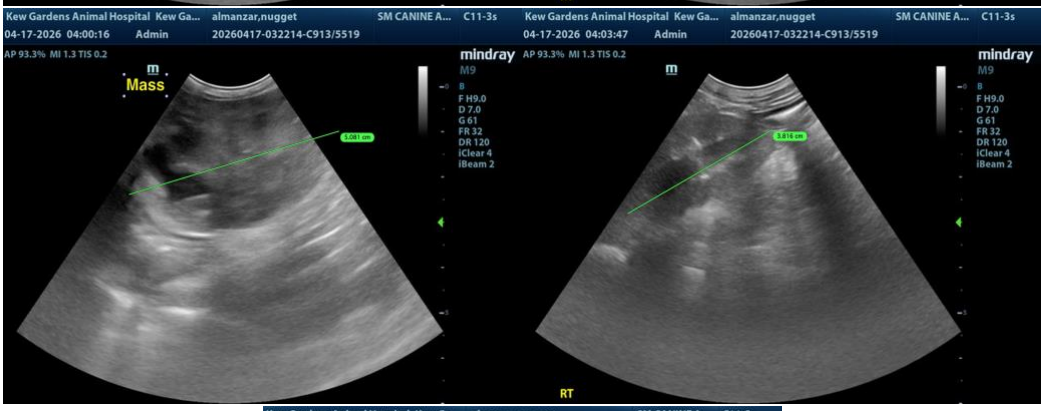


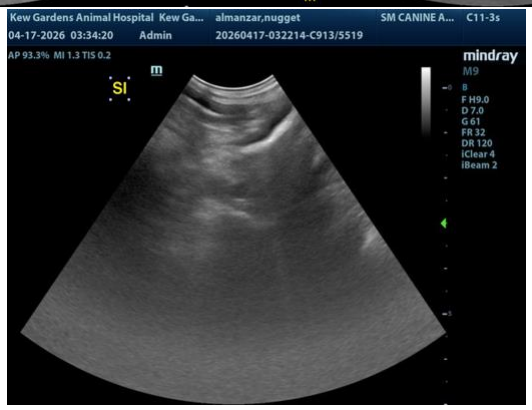


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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.

**R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)**

info@SonoPath.com