



PATIENT

Ziggy McCrary

SPECIES

Canine

BREED

Corgi

SEX

Intact male

AGE

6 years

WEIGHT

35.2 lbs

INTERPRETED BY

Remo Lobetti, BVSc,
MMedVet (Med), PhD,
Dipl. ECVIM (Internal
Medicine)

IMAGING PERFORMED BY

Dr. Hollway

HOSPITAL NAME

Valley Green VH

REFERRING VET

Dr. Oberer-Gerber

INVOICE

69484

DATE

12/10/25

PRESENTING CLINICAL SIGNS

History: ER Visit 7/19/2025: Fever, Vomiting, Dribbling urine, Suspect prostatitis vs. abscess vs. neoplasia vs. other (based on AUS), IMTP, Anaplasma (+), LYME (+). AUS at ER indicated concern for prostatic cyst vs neoplasia at the time. FNA was declined. General ADR with chronically increased WBCs and intermittent blood D+. Further imaging declined until 12/8/25. AXR/CXR to IDX: CONCLUSIONS: Interstitial consolidation within the left cranial lung lobe is consistent with bronchopneumonia. Bronchitis due to infectious, inflammatory/allergic or environmental causes may be present concurrently. Generalized hepatomegaly most likely represents a nonspecific vacuolar hepatopathy, as with endocrine disease or long-term exogenous steroid administration. Hepatitis or infiltrative neoplasia cannot be ruled out. Reduced prostatomegaly, most consistent benign prostatic hyperplasia. Presumed prostatitis noted on the previous examination is resolved. PE: QAR. ~3% dehydrated. Uncomfortable with ABD palp, splinting/grunting, esp with palpation of cranial ABD. No obvious HM. Lungs clear bilat, though mild-mod increase in respiratory effort. INTACT male w/ 2 symmetrical, non-painful testicles. Occasional twitching of dorsal neck. NEW bilateral muscle atrophy of the temporalis muscles. AUS many months ago. Fur still has not regrown.

Abnormal PE/Chem/CBC/UA Results: 12/8/25 IMHA/TP --> has been on chronic steroids since 7/2025 Chronically increased WBCs and borderline anemia NEW --> Bronchopneumonia, Pancreatitis, Hepatomegaly + increased LES -- r/o infiltrative disease vs secondary to steroid use vs other C6 Quant = 13 (NOT an active infection) PT/PTT = NSF BP = 133mmHg CBC: HCT 38.4% normal but borderline low WBC 18.47 HIGH - chronic Neut 15.47 HIGH - chronic Mono 1.21 HIGH - chronic Eos 0.04 LOW BASO 0.15 HIGH - chronic CHEM ALT = 182 HIGH --> NEW ALP 1261 HIGH --> NEW (r/o chronic steroids vs other) Lytes: NSF T4 = 0.9 LOW -- r/o real vs euthyroid sick syndrome cPL = 329 HIGH -- r/o pancreatitis UA - floor sample 1.012 7pH 2+ protein Otherwise quiet sediment

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is full with a normal thickness and smooth appearance of the wall. Normal anechoic urine with no sediment or uroliths evident.

Normal appearance of the trigone area, proximal urethra, and iliac blood vessels.

Normal appearance and size of the iliac lymph nodes. Ureters not visualized, which can be considered a normal finding.

Normal renal size (left measured 6.7 cm, right measured 7.0 cm), architecture, echogenic appearance, cortico-medullary differentiation, which maintains a 1:3 cortex to medulla ratio, pelvis, and capsule. No infarcts, mineralization or renoliths evident. Normal color flow pattern is evident in both kidneys.

The prostate is enlarged with irregular shape and hyperechogenic appearance. A few, parenchymal cysts are present and measure up to 0.9 x 1.6 cm in size. Normal appearance of the periprostatic tissue. FNA was taken of the prostate. Normal size and appearance of the testicles. The left testicle measured 3.7 cm in length and the right testicle measured 3.4 cm in length.



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Adrenal Glands

Normal shape, echogenic appearance, size, position, and appearance of the visible peri-adrenal vasculature. Left adrenal gland measured 0.57 cm in width. The right adrenal gland measured 0.41 cm and 0.49 cm in width.

Spleen

Normal size and echogenic appearance. Smooth homogenous parenchyma and regular curvilinear capsule. Normal volume of the splenic vasculature without any overt congestion or thrombosis evident. No inflammatory, neoplastic, infarction, or infiltrative changes evident. The spleen measured 1.4 cm in width.

Liver

The liver is enlarged with rounded edges, diffuse increased echogenic appearance, normal portal markings, and regular curvilinear capsule. No nodules or masses evident. Normal appearance of the hepatic and portal vasculature.

Gallbladder

The gallbladder is full containing normal anechoic bile. Normal thickness and echogenic appearance of the wall. Normal size and appearance of the cystic and common bile duct.

Gastrointestinal

Normal appearance of the stomach, duodenum, small intestine, ileo-cecal junction, and colon with no loss of layering, 1:3 muscularis to mucosa ratio, normal wall thickness and peristaltic activity, and no distension of the lumen.

Pancreas

The visible sections of the pancreas are of normal size and echogenic appearance with a regular capsule. Normal echogenic appearance of the mesentery and fat surrounding the pancreas.

Free Abdomen

Normal mesenteric lymph nodes.

No ascites evident.



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ULTRASONOGRAPHIC FINDINGS

- Cystic prostatomegaly.
- Hepatopathy.

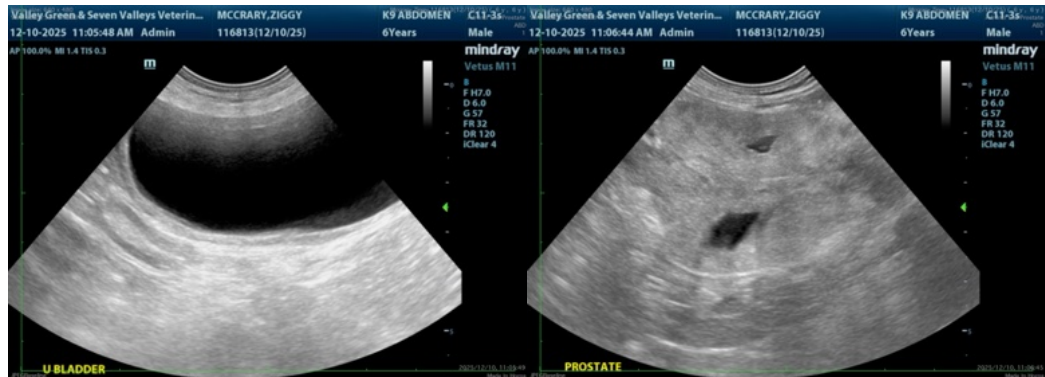
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Etiologies for the cystic prostatomegaly would be benign cystic hyperplasia and prostatitis. The most likely etiology for the hepatopathy would be secondary to the cortisone therapy with reactive hyperplasia, vacuolar and metabolic differential diagnosis, hepatitis and infiltrative neoplasia would be highly unlikely differential diagnosis.

As the pancreas appears ultrasonographically normal the elevated CPL is most likely secondary to the cortisone therapy.

Further assessment and therapy would be based on the pending cytology results. Management of the prostatomegaly would either be surgical or chemical castration.

Chemical castration would be the use of osaterone acetate, delmadinone acetate, or deslorelin acetate. This is less invasive and safer than surgical castration in systemically ill and potentially unstable patients.





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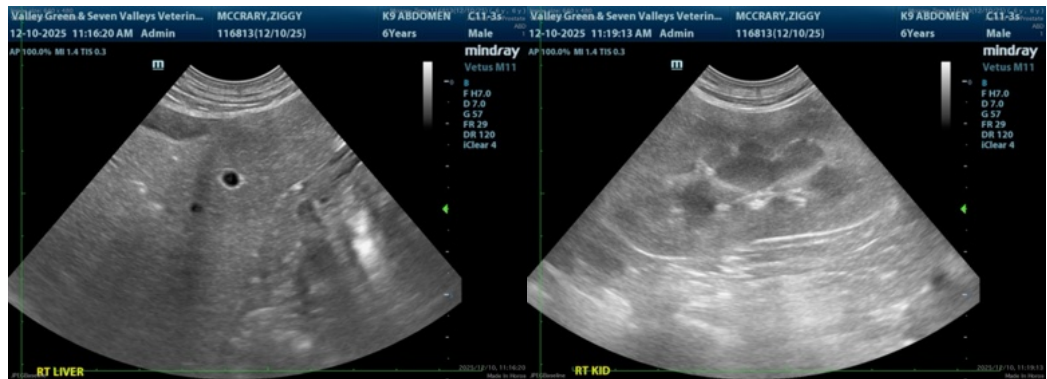
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Remo Lobetti, BVSc, MMedVet (Med), PhD, Dipl. ECVIM (Internal Medicine)

info@sonopath.com