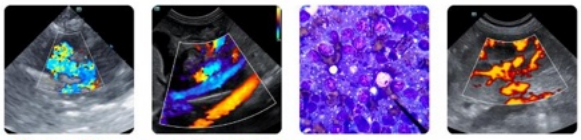


DATE

1/5/26

PATIENT

Jackson Werneke

SPECIES

Canine

BREED

Chinese Crested

SEX

Male, neutered

AGE

1/3/2016

WEIGHT

14.8 lbs.

INTERPRETED BY

Andrea Nicastro, DVM, Diplomate ACVIM (*Small Animal Internal Medicine*)

HOSPITAL NAME

Everhart VH

REFERRING VET

Dr. McDonald

INVOICE

13368

PRESENTING CLINICAL SIGNS

Patient History: ~10 y/o MN Chinese Crested Dog presenting for recheck after ER visit for aspiration pneumonia and chronic vomiting. P has been drinking water excessively, then vomiting, and suspect that's what led to the pneumonia. However, at ER they also noted that the liver looked big, and recommended ultrasound with rDVM once P was feeling better. VEG recommended abx until 2 weeks after resolution of clinical signs - P still has occasional cough (could be related to the murmur as well), sent home another 2 weeks of abx and then recommended O's call to check in to see if symptoms aren't resolved by that time. ER recommended HP diet in case vomiting is food related, but O homecooks chicken and rice with pumpkin, and doesn't think that the vomiting is food-related. Declined prescription diet for now. HX of seizures, 2-3 per month each 2-3 minutes long - managed on Pheno and Potassium Bromide. Last Pheno levels were in July, consider recheck within the next couple of months (O's declined today to focus on the Pneumonia). HX grade 3-4/6 heart murmur. Murmur grade: 3-4/6

Current Medications: KBR 90mg 12/15/2025, CLAVACILLIN 125MG TABLET 12/17/2025, ONDANSETRON 4MG TABLET 12/17/2025, PHENOBARBITAL 15/16.2MG (1/4GRAIN) TABLET 12/15/2025
Labwork Results: Diagnostics attached, reported as: At ER, elevated platelets (628) and ALT (142) - continue to monitor, recommend SA600 in 3-6 months.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed by: Stephanie Warga RDCS, RVT.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. Luminal contents are mostly anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (0.70 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal in size (4.36 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (4.27 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.51 cm at cranial pole) (0.56 cm at caudal pole) with a slightly irregular shape. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.57 cm at cranial pole) (0.45 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.97 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. Several varying sized hyperechoic nodules are observed throughout the organ. Splenic vasculature is normal.

Liver

The liver is subjectively enlarged with swollen peripheral contours. The parenchyma is isoechoic relative to the spleen and subtly mottled in appearance. A 1.7 x 1.5 cm hypoechoic nodule is observed on the right side adjacent to the diaphragm. In addition, a 0.53 x 0.53 cm hyperechoic nodule is observed at the caudal aspect on the left side. Vascular and biliary tracts are of normal volume with no evidence of congestion.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A small amount of mobile echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is slightly hyperechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Lymph nodes

A few prominent mesenteric lymph nodes are visualized, one measuring 2.93 x 0.40 cm. Surrounding mesentery is mildly hyperechoic.

Free Abdomen

There is no obvious evidence of free fluid.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The diffuse hepatic parenchymal changes are non-specific and could be secondary to vacuolar hepatopathy (i.e., endocrine, idiopathic), regenerative nodular hyperplasia, age-related parenchymal remodeling or less likely, inflammatory disease, infiltrative neoplasia, hepatotoxicosis or other hepatopathy. The hyperechoic hepatic nodule trends toward the benign (i.e., meylolipoma, regenerative nodule) with a lower possibility of emerging neoplasia or other pathology. The hypoechoic hepatic nodule could be consistent with a regenerative nodule, inflammatory focus, emerging tumor (i.e., adenoma, adenocarcinoma), other.

Secondary Findings:

- Bilateral nonspecific age-related renal changes.

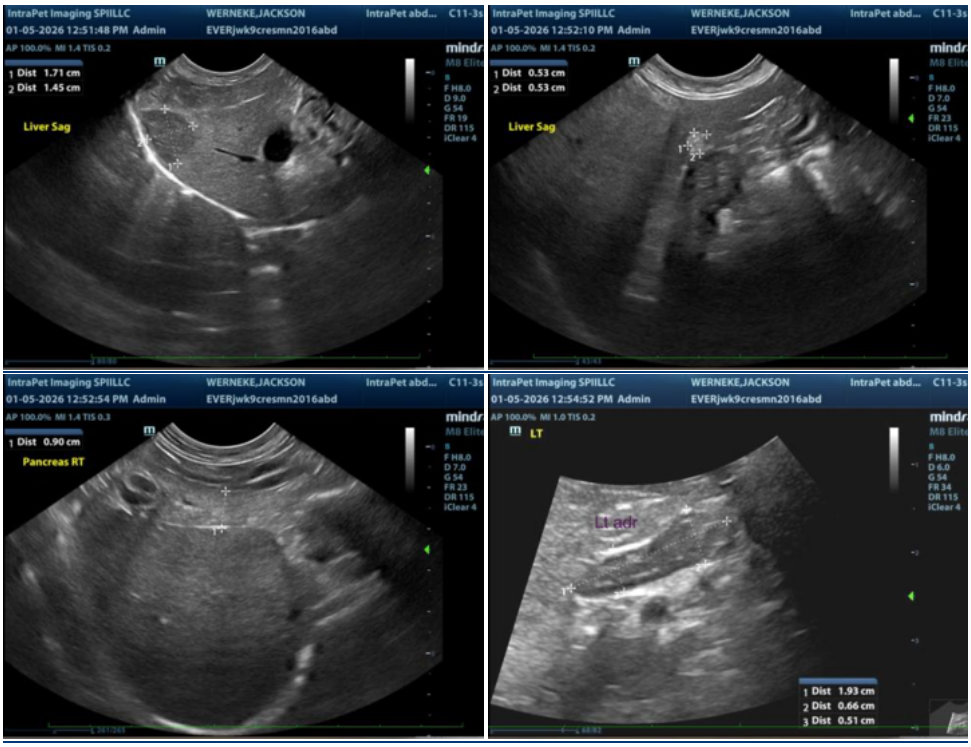
- Mild left adrenomegaly
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The hyperechoic splenic nodules are most consistent with meylolipomas with a lower possibility of more insidious splenic pathology.

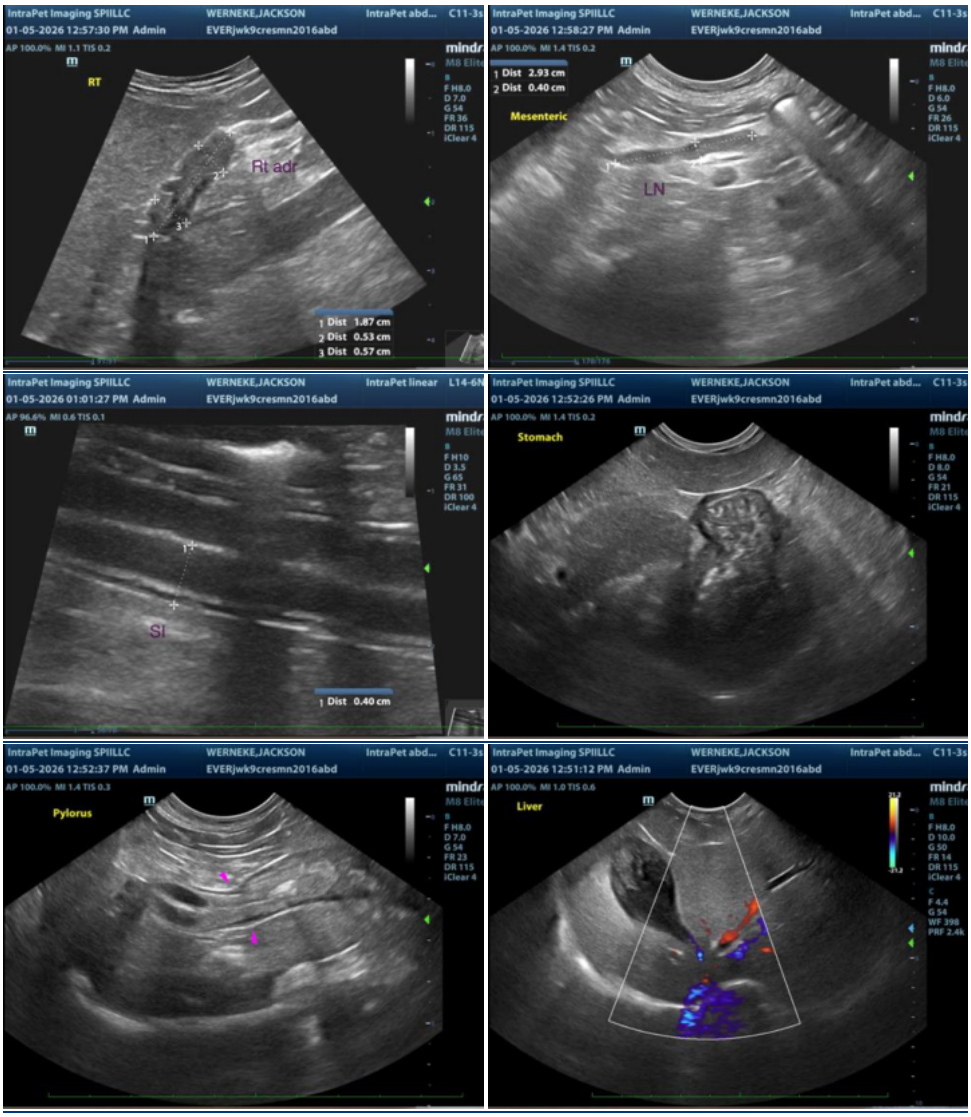
*An obvious cause for the patient's chronic vomiting is not identified in this study. Considerations include a microscopic enteropathy (i.e., food allergy/intolerance, inflammatory bowel disease, infectious/parasitic disease, esophageal disease), underlying metabolic issue, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Regarding the chronic vomiting, consider the following:

1. Fecal evaluation for ova and Giardia
2. GI panel including serum cobalamin, folate, TLI, PLI and resting cortisol level
3. Limited antigen or hydrolyzed protein diet trial
4. Further evaluation for megaesophagus/esophageal dysfunction
5. +/- endoscopic or surgical GI biopsies (once the patient's aspiration pneumonia has resolved).





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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine) info@SonoPath.com