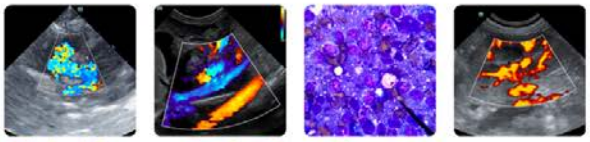


PATIENT

Lex Castillon

SPECIES

Canine

BREED

Mix

SEX

Neutered Male

AGE

10 Years

WEIGHT

8.42 kg

INTERPRETED BY

Brad Harris, DVM, DACVECC, DACVIM (cardiology)

IMAGING PERFORMED BY

Dr. Wayland

HOSPITAL NAME

Wilvet South

REFERRING VET

Dr. Wayland

INVOICE

72554

DATE

12/14/25

PRESENTING CLINICAL SIGNS

History: Around 3pm O got home, O's mom said that pt had been walking around like he was drunk. Pt tensed up and started seizing, lasted maybe 30-40seconds. Pt laid down after that, had foam coming out of his mouth. In clinic pt seems to be improved, walking around like normal. About 2months ago pt had a similar episode (just walking drunk) but it resolved on its own. Emergency Exam Slightly overweight with a BCS of 6 out of 9, moderate to severe dental disease, otherwise normal physical exam.

Abnormal PE/Chem/CBC/UA Results: Diagnostics Chem 17: glucose 39, low. Ammonia: 125, slightly elevated, likely not significant. CBC: unremarkable. Full abdominal ultrasound pending. Insulin glucose ratio pending.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are unremarkable with normal wall thicknesses and normal tone. The ureters were not visualized, which is a normal finding. There is a mild amount of suspended echogenic mobile debris. The ureteral papillae appear normal. There is no evidence of inflammatory, infiltrative, or neoplastic disease.

The kidneys are normal in size. The cortices are mildly hyperechoic with a slight decrease in normal corticomedullary distinction. The cortex to medulla ratio is appropriate with no significant pyelectasia or pelvic dilation. Left kidney measures 4.78 cm. Right kidney measures 4.25 cm.

Adrenal Glands

The left adrenal gland is visualized and has 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. Left measures 0.64 cm x 2.04 cm.

The right adrenal gland is not definitively visualized. However, there is no mass effect or evidence for vascular invasion in the right hepatorenal quadrant.

Spleen

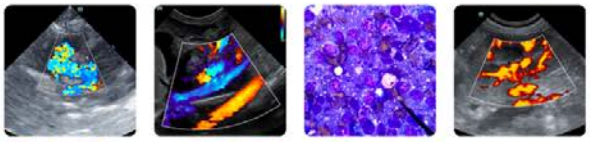
The spleen measures 1.12 cm at the hilus. It is smooth with homogeneous parenchyma and hyperechoic to liver and renal cortical parenchyma. The capsule is without noticeable irregularity or deformation. The splenic vasculature is normal without signs of congestion, spontaneous echo contrast, or thrombosis. No evidence of acute or chronic inflammatory, neoplastic, or infarct are documented.

Liver

The liver is subjectively normal liver size, contour, and structure. Parenchymal echogenicity is naturally coarse and hypoechoic to the spleen. Vasculature is within normal limits with no evidence of congestion. The gallbladder contains a mild amount of suspended echogenic debris and dependent sediment. There is no evidence of intra- or extra-hepatic biliary dilation. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach is moderately distended with echogenic ingesta. Within that in the gastric fundus there are two rounded, hypoechoic shadowing structures that may represent additional normal ingesta. However, foreign material can't be definitively excluded. There is no evidence of pyloric outflow obstruction



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noted at this time. The visible small intestine is non-distended with normal wall thickness and maintenance of normal wall layering. The colon contains normal shadowing feces.

Pancreas

The visible pancreas is isoechoic to surrounding omental fat. The pancreatic duct and capsular contour are normal. There is no overt evidence of active inflammatory or neoplastic disease.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- The urinary bladder contains echogenic, suspended debris contrasted with anechoic urine. This is often related to urinary tract infection but may represent exfoliated debris or sterile inflammation.
- The kidneys are relatively normal in size and structure, and cortex:medulla ratio (cortex 1/3 of medulla) is essentially maintained. There is age-related loss of the normal smooth capsular contour and C/M junction definition. The cortices are largely uniform in texture with mild hyperechogenicity expected for this patient's age. There is no evidence of pelvic dilation present.
- The gallbladder contains echogenic, suspended and dependent unorganized debris. This is not yet to the level of an organized mucocele, however early/developing mucocele cannot be ruled out. This dependent sediment is often an incidental finding or may be associated with concurrent endocrine disease such as hyperadrenocorticism or diabetes mellitus.
- The shadowing material within the gastric fundus may represent normal ingesta. However, foreign body can't be definitively excluded. This appears to be non-obstructive at this time and is likely an incidental finding.
- The normal appearance of the pancreas does not excluded an occult insulinoma as a potential cause of the hypoglycemia noted.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A urinalysis and urine culture via cystocentesis are recommended to evaluate the urinary tract changes for potential urinary tract infection.

An ACTH stimulation test is indicated to evaluate for potential hypoadrenocorticism. A baseline/resting cortisol less than 0.52 µg/dL significantly increases the index of suspicion for hypoadrenocorticism.

Pre- and post-prandial bile acids are recommended for further evaluation of the hypoglycemia.

Additionally, an abdominal CT with angiography may be required to further evaluate the pancreas for potential nodules or mass lesions.

Ultimately, an exploratory laparotomy with pancreatic biopsies as well as liver biopsy and histopathology may be required for identification and therapy of insulinoma should the insulin to glucose ratio be consistent with potential insulinoma.

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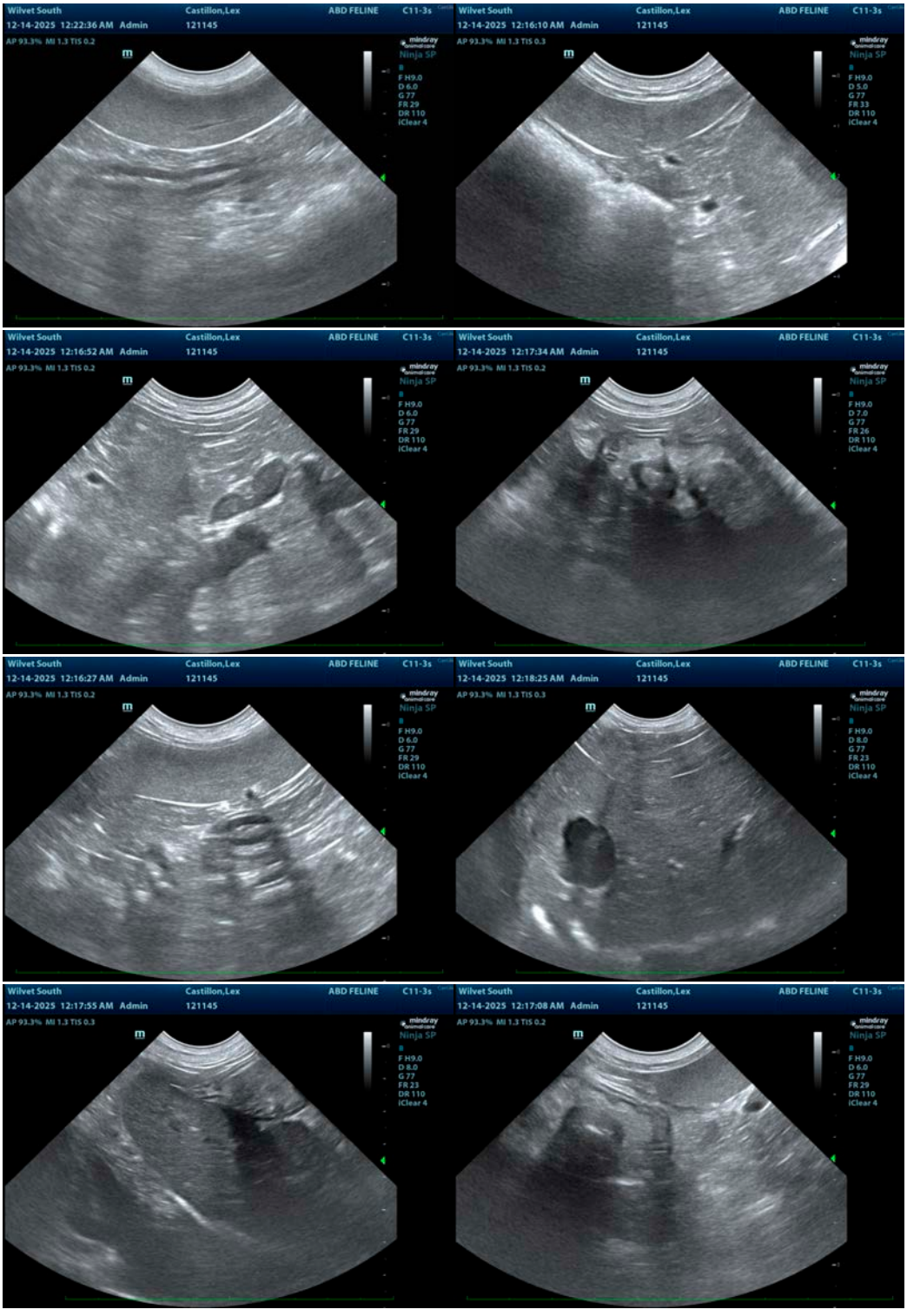

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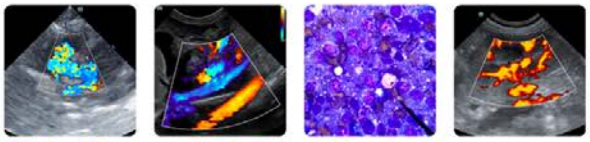

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Brad Harris, DVM, DACVECC, DACVIM (cardiology)

info@SonoPath.com