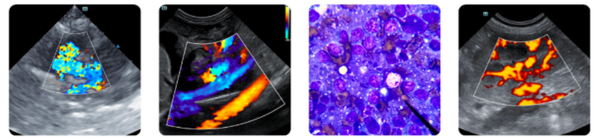


PATIENT

Captain Morgan Tilberry

SPECIES

Canine

BREED

Pitbull

SEX

MN

AGE

12 years

WEIGHT

35.4 kg

INTERPRETED BY

Bradley Harris, DVM, DACVECC, DACVIM (cardiology)

IMAGING PERFORMED BY

Melissa Randolph

HOSPITAL NAME

Shores Veterinary Emergency Center

REFERRING VET

Dr. Laurie Brewer

INVOICE

10989

DATE

12/19/2025

PRESENTING CLINICAL SIGNS

*went to rdvm yesterday 12/18 for inappetence and lethargy. Not eating well for about 1 week with increased vomiting. Has been shaking at home. Bloodwork and xrays done by rDVM. Treated with cerenia injection as outpatient. Has history of chronic intermittent vomiting. Occasional coughing also chronic. H/O chronic vomiting every 1-2 days after drinking large amt water. H/O approx 12# wt loss since March (90# to 78#). admitted for supportive care; iv fluids, cerenia, buprenorphine, pantoprazole *concern for weight loss, vomiting, anorexia, hypercalcemia, dehydration; r/o neoplasia, infectious, inflammatory, other.

Abnormal PE/Chem/CBC/UA Results: *PE: Temp 103.4; subtle pain; Reactive to abdominal palpation, Mildly tensing on palpation; intestines palpate as ropey; Muscle atrophy, Bilateral HL atrophy with decreased mobility *12/18 rDVM Chem: Phos 2.2 L, Ca 15.6 H, K 3.4 sl L, TP 8.5 H, Glob 4.8 H, ALT 132 H *CBC: WNL *AXR: Unremarkable *12/19: EPOC: iCa 2.21 H, lactate 5.66 H, BG 133 H, Hct 56% *True Rapid 4Dx: Negative X 4 *CXR: WNL *AXR: Stomach empty. Slightly decreased serosal detain pyloric region on V/D views. Possibly thickened bowel segment mid abdomen on lateral but not present all views.

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 are no uroliths or sediment noted, and anechoic urine is present. The ureteral papillae appear normal. There is no evidence of inflammatory, infiltrative, or neoplastic disease.

The kidneys are normal in size. The cortices are hyperechoic with a decreased corticomedullary definition. There are multiple renal cortical cysts noted bilaterally with a normal cortex to medulla ratio and no significant pyelectasia or pelvic dilation The capsules are mildly irregular bilaterally. Left kidney measures 6.9 cm, and the right kidney measures 7.94 cm.

Adrenal Glands

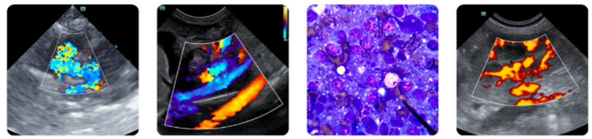
The left adrenal gland is visualized and has normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. Left adrenal measures 0.74 cm x 2.1 cm.

The right adrenal gland is not definitively visualized.

Spleen

The spleen 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. The spleen measures 1.73 cm at the hilus.

Liver



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The liver is subjectively normal liver size, and contour with a diffusely heterogenous or mottled parenchymal pattern. Vasculature is within normal limits with no evidence of congestion. There is no overt hepatic lymphadenopathy documented.

The gallbladder contains a mild amount of unorganized suspended echogenic debris and dependent sediment. The gallbladder walls are appropriately thin with no evidence of intra- or extra-hepatic biliary dilation. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach contains a mild amount of gas but the pylorus and pyloroduodenal junction are patent. The small intestines are free of stasis and peristaltic activity, with no significant dilation noted. There is normal wall thickness and acceptable curvilinear mural detail. The pyloric-duodenal junction and ileocecocolic junction are patent, and the colon contains normal shadowing feces. There is no evidence of shadowing obstructive material or overt infiltrative disease noted. No associated abnormal lymphatic activity is documented.

Pancreas

The pancreas is not definitively visualized.

Free Abdomen

There is no definitive lymphadenopathy, or free fluid noted.

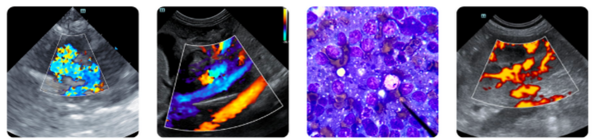
ULTRASONOGRAPHIC FINDINGS

- There is increased renal cortical echogenicity and thickening with a mildly irregular capsular contour. Multifocal cystic cortical changes are noted. This is secondary cystic formation consistent with chronic age related degeneration and remodeling. There is no evidence of abscessation or suspicion of neoplasia.
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory, immune-mediated, metabolic, or endocrine disease. Infiltrative neoplasia or acute hepatitis cannot be ruled out.
- 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.
- Normal appearance of the stomach and lack of significant evidence of peritonitis or pancreatic inflammation do not exclude chronic infiltrative disease such as inflammatory bowel disease or other chronic enteropathy, nor does it rule out occult active pancreatitis as an underlying etiology of the clinical signs.

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.

Fine needle aspirates of the liver with cytology are recommended. A coagulation profile and platelet estimate prior to sampling are indicated to ensure the absence of coagulopathy. Occasionally some



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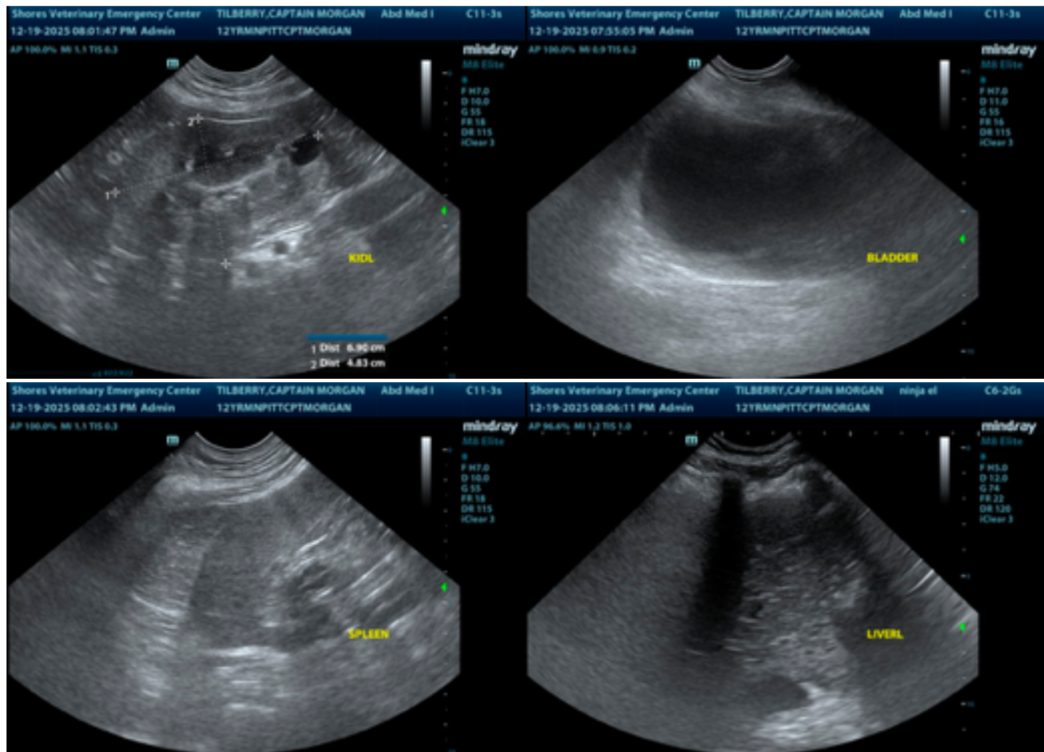
tissues are poorly exfoliative, or cytology is non-specific, in which case biopsy with histopathology may be required for a definitive diagnosis.

A gastrointestinal panel (TLI, PLI, B12, folate) via Texas A&M gastrointestinal laboratory is indicated to further evaluate for potential chronic enteropathy. Ultimately, gastrointestinal biopsies may be required for a definitive diagnosis.

A Spec CPLI is recommended to further evaluate the pancreas for evidence of active pancreatitis.



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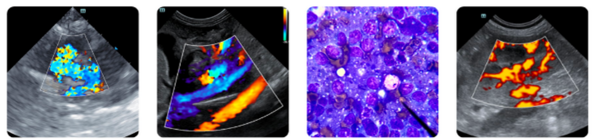

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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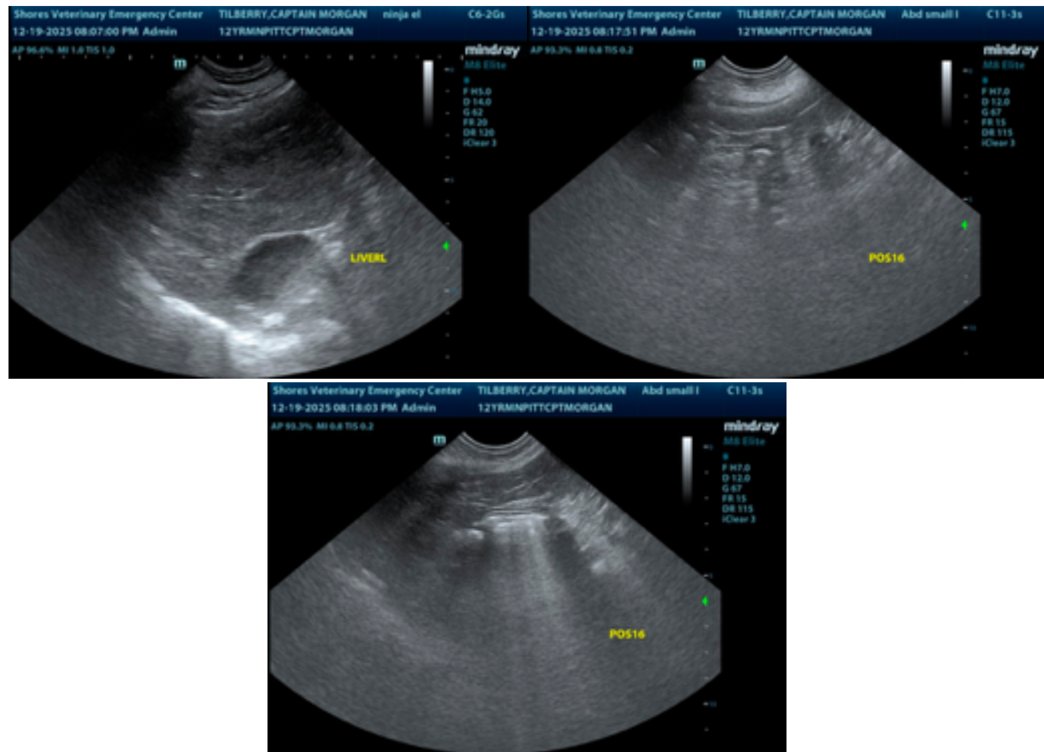

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Bradley Harris, DVM, DACVECC, DACVIM (cardiology)

info@SonoPath.com