



PATIENT

Parker Krebs

SPECIES

Canine

BREED

Beagle

SEX

Neutered Male

AGE

9 Years

WEIGHT

41.4

INTERPRETED BY

Bradley Harris, DVM,
DACVECC, DACVIM
(cardiology)

IMAGING PERFORMED BY

Dr. Jessie Evoniuk

HOSPITAL NAME

State Avenue Vet
Clinic

REFERRING VET

Dr. Jessie Evoniuk

INVOICE

12878

DATE

12/30/25

PRESENTING CLINICAL SIGNS

Presented to SAV 11/11 for annual, bord. Had noted weight loss, pale gums, stiffness, lethargy, decreased appetite. Chem Ca 12.9, Glc 154, Na 137 K 5.7, PLT 613. Idexx resting cort <3. O declined further testing. Started Carprofen for OA. Seen elsewhere 11/15 ADR, V+, uncomfortable. BUN 29, Ca 13.1, Glc 156, Na 134, K 6.1., Abd rads taken. Hospitalized. Vtech cort 30ug/dL . so concluded not Addison's. Started Metro, Gabapentin, Cerenia, IV fluids, Dexamethasone, GI support 11/19 recheck-up/down mood, lethargic, loosing balance, normal prop noted, painful TL junction. Rads Concern of L1-L2, T11-12. 11/24- Anorexia, inappetence. Hungry but eating. Breathing rapidly. BUN 69, Creat 2.2, Phop 7, Ca 12.7, Gluc 175, K+ 6.5, pancreatic lipase Normal, US of R cranial abd- painful, noted thickened cranial bladder lining. Their R/o discospondylitis/TCC, other, renal disease. SQ fluids, Cerenia, Augmentin, d/c NSAID. started Pred 15mg PO BID, tapering. 12/190 recheck with concern of painful hips, struggling to walk. severe pain noted caudal thoracic/TL junction,. Returned 12/30 to SAVC for reported 24 hour episodes with severe lethargy, not eating, nausea/V+ after times of stress or excitement (ie grooming, visitors, etc). Seems not himself but aware. No reported seizures. O reports it as crashing. Currently on SID Pred took yesterday. Responds after episode within 24 hour and more normal. Also noted gas/burping, general indigestion concerns.

Abnormal PE/Chem/CBC/UA Results: BP systolic ~160, HR 160-180, Temp WNL. Panting. Today's bloodwork" Alkaline Phosphatase 957 U/L; Alanine Aminotransferase 277 U/L; Blood Urea Nitrogen 30 mg/dL; Calcium 12.5 mg/dL; Glucose 136 mg/dL; Sodium 136 mmol/L; Potassium 6.6. NA:K 20.6

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder contains a shadowing dependent urolith in the urinary bladder apex. The bladder wall is normal in thickness with normal layering. The trigone is patent with no evidence of urethral pathology. The ureteral papillae appear normal. The remainder of the urine was anechoic.

The kidneys are normal in size and structure. The cortices are mildly hypoechoic with a decrease in corticomedullary definition. The cortex to medulla ratio is appropriate with no significant pyelectasis or pelvic dilation. The capsules are minimally irregular. The left kidney measures 5.66 cm. The right kidney measures 4.95 cm.

Adrenal Glands

Both adrenal glands are not distinctly visualized.

Spleen

The spleen is subjectively prominent with a diffusely mottled or heterogeneous reticular pattern. The splenic vasculature is normal without signs of congestion, spontaneous echo contrast, or thrombosis.

Liver

The liver is subjectively enlarged and hyperechoic with a diffusely mottled or heterogeneous parenchyma. The vasculature is normal with no evidence of congestion.

The gallbladder has thin walls which contain anechoic bile. There is no evidence of intra- or extra-hepatic biliary dilation. The cystic and common bile ducts were normal. No hepatic lymphadenopathy is documented. There is no overt structural evidence of inflammatory, infiltrative or regenerative pathology evident.



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Gastrointestinal

The stomach is minimally distended with echogenic fluid and apparently linear shadowing material that appears to be nonobstructive. The pylorus and pyloroduodenal junction appear patent. The small intestine is nondistended 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

There is no significant lymphadenopathy or free fluid.

ULTRASONOGRAPHIC FINDINGS

- 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 mildly enlarged spleen with a coarse/mottled reticular pattern is most consistent with a reactive spleen, or possible splenitis. Round cell neoplasia is considered less likely but cannot be definitively excluded.
- 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 hyperechoic shadowing structure within the stomach may represent normal ingesta, however, a gastric foreign material cannot be definitively excluded. This is likely considered to be an incidental finding for this patient, however, given the vague nature of the clinical signs, it is possible that this may also be related to the patient's abdominal pain.

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 spleen and liver with cytology are recommended. A coagulation profile and platelet estimate prior to sampling are indicated to ensure the absence of coagulopathy. Occasionally some tissues are poorly exfoliative, or cytology is non-specific, in which case biopsy with histopathology may be required for a definitive diagnosis. Consider fasting and serial abdominal imaging to further evaluate the gastric material. Alternatively, abdominal radiographs may be useful in identifying the nature of the gastric material as well as gastric endoscopy in order to potentially facilitate minimally invasive removal.



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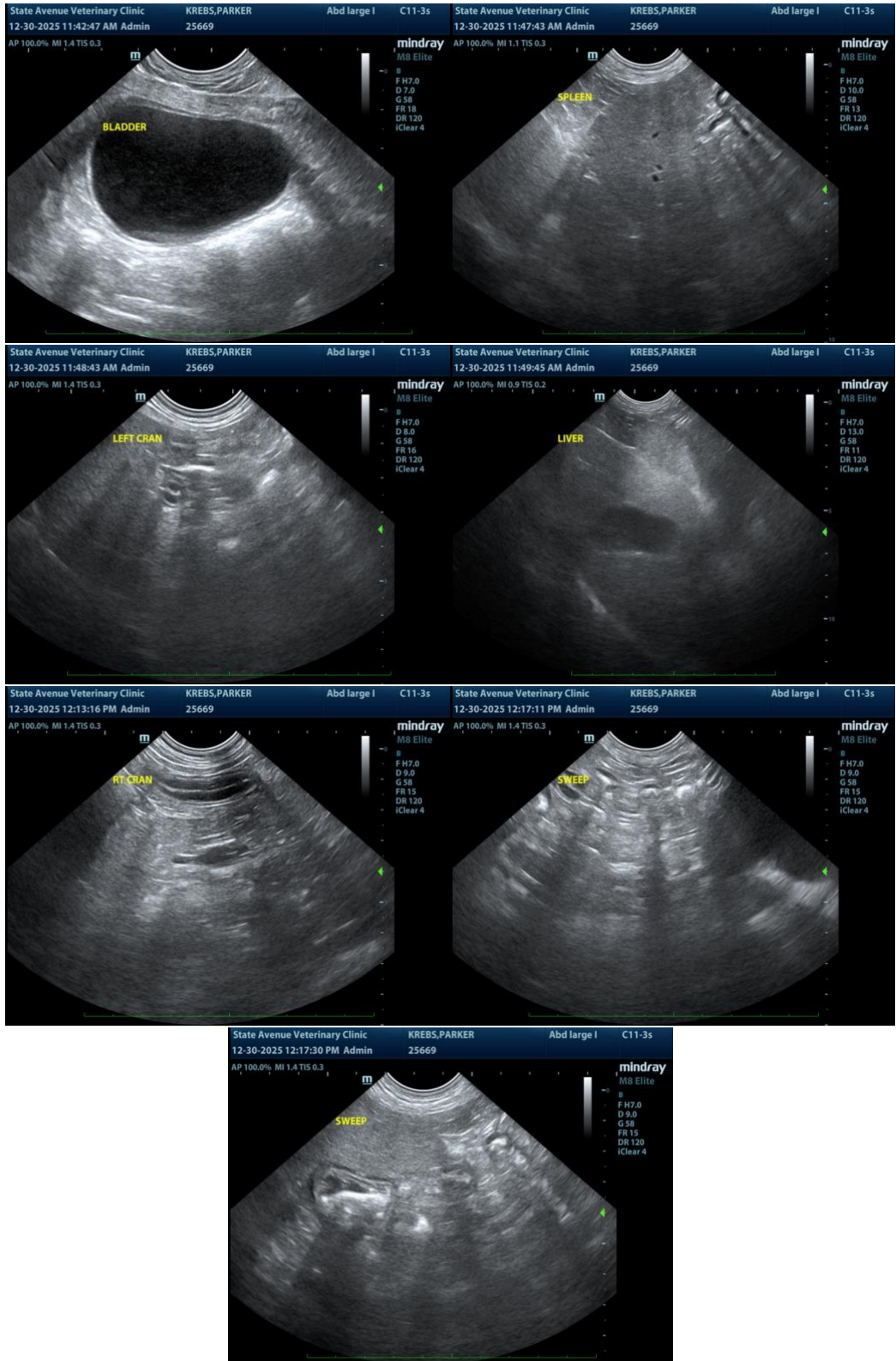
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Bradley Harris, DVM, DACVECC, DACVIM (cardiology)

info@SonoPath.com