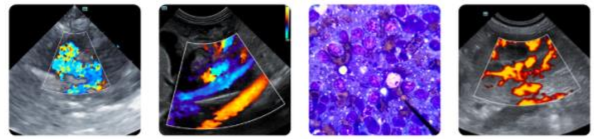


PATIENT
Roscoe Klann

SPECIES
Canine

BREED
Hound

SEX
Neutered Male

AGE
12 Years

WEIGHT
25.4 kg

INTERPRETED BY
Bradley Harris, DVM, DACVECC, DACVIM (cardiology)

IMAGING PERFORMED BY
Dr. Kuzimski

HOSPITAL NAME
Animal Emergency Hospital Deland

REFERRING VET
Dr. Kuzimski

INVOICE
16425

DATE
06/06/26

PRESENTING CLINICAL SIGNS

Patient was seen on 6/3 for vomiting. he has a history of heart disease - currently on furosemide, vetmedin. history of seizures that have been well controlled (phenobarbital and keppra). patient is still eating but not as well. on 6/3 radiographs were concerning for an abdominal mass and possible pulmonary nodules

Abdomen: Tense on palpation. potbelly appearance with concern for cranial abdominal mass

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic urine. The 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. The ureteral papillae appear normal. There is no evidence of inflammatory, infiltrative, or neoplastic disease.

The kidneys are normal in size and structure, with appropriate corticomedullary definition and cortex to medulla ratio. The cortices are uniform in texture with normal echogenic relationship to liver and spleen. The medullary structure differed distinctly from the cortex and no evidence of pyelectasis is present. The capsules are uniform without significant irregularities noted. The left kidney measures 7.4 cm. The right kidney measures 6.7 cm.

Adrenal Glands

Both adrenal glands are not visualized.

Spleen

The spleen is subjectively enlarged and diffusely mottled with a reticular parenchymal pattern and ill-defined hypoechoic nodular changes. The spleen measures 2.2 cm at the hilus.

Liver

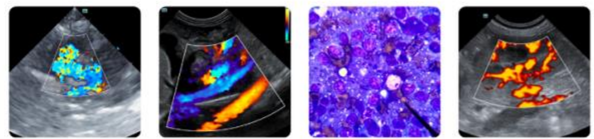
The liver is subjectively normal in size and contour with a diffusely heterogeneous or mottled parenchyma. The vasculature is normal with no evidence of congestion. The gallbladder is non-distended with anechoic bile. The gallbladder wall is mildly thickened and irregular. There is no evidence of intra- 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.

Gastrointestinal

The stomach is moderately dilated with echogenic fluid as well as hyperechoic shadowing material which may represent normal ingesta, however, foreign material cannot be definitively excluded. The pylorus and pyloroduodenal junction are not visualized and a pyloric outflow obstruction cannot be excluded. Small intestine is non-distended with normal wall thickness and maintenance of normal wall layering. The ileocecal colon junction is patent and the colon contains normal shadowing feces.

Pancreas

The pancreas is moderately to severely enlarged and hypoechoic with irregular margins.



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Free Abdomen

There is a moderate amount of hypoechoic mesentery and omental fat. No free peritoneal effusion is noted.

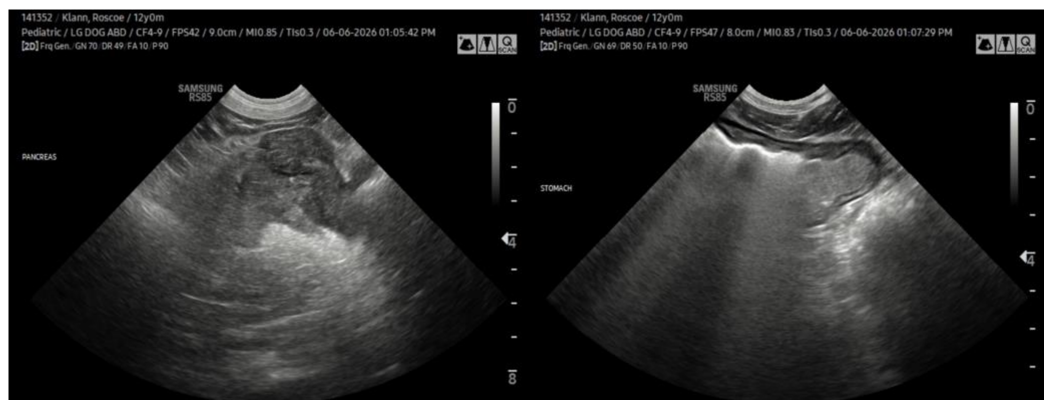
ULTRASONOGRAPHIC FINDINGS

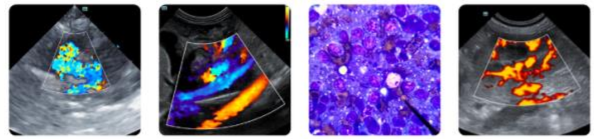
- The spleen is enlarged with a mottled parenchyma and ill-defined hypoechoic nodules. These may represent benign changes such as extramedullary hematopoiesis or lymphoid hyperplasia, however, infiltrative neoplastic disease cannot be excluded.
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory, immune-mediated, metabolic, or endocrine disease. Infiltrative neoplasia or acute hepatitis cannot be ruled out.
- The gallbladder wall appears mildly thickened and irregular. This may be a variation of normal, however, cholangitis or cholangiohepatitis cannot be ruled out.
- The prominent, hypoechoic pancreas with an irregular contour and mixed ill-defined hyper and hypoechoic changes is most consistent with pancreatic remodeling and nodular hyperplasia. This may be secondary to active or acute-on chronic inflammatory disease or pancreatitis.
- The gastric dilation is likely gastric ileus or gastroparesis secondary to the suspected pancreatitis, however, a pyloric outflow obstruction cannot be definitively excluded.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A cPLI is indicated to further evaluate the pancreas for potential inflammation or pancreatitis. 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.

Also consider FNA of the pancreas, however, there is risk that this may worsen inflammation if the changes noted are secondary to pancreatitis. Consider nasogastric intubation with supportive care to help alleviate clinical gastrointestinal signs.





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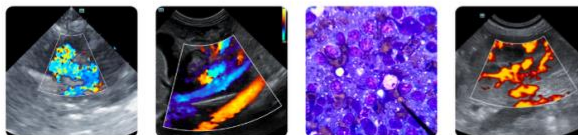

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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