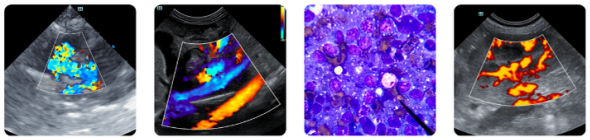

PATIENT

Zeke Mckinney

SPECIES

Canine

BREED

Mixed Breed

SEX

Neutered Male

AGE

11

WEIGHT

68 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Michael Wasserman

HOSPITAL NAME

Morningside Animal Hospital

REFERRING VET

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1/9/2026

PRESENTING CLINICAL SIGNS

Zeke initially presented on 12/19 for evaluation of multiple concerns, including suspected vision loss, vomiting, increased water consumption (polydipsia), muscle spasms, and behavioral changes characterized by wandering and confusion. Zeke re-presented on 12/23 with no clinical improvement. A full diagnostic workup was discussed but not elected at that time. A Librela injection was administered for pain management. Rimadyl 2.2mg/kg PO no more than BID and methocarbamol 500mg 1 tab PO TID/BID on as needed basis.

Abnormal PE/Chem/CBC/UA Results: Wellness BW revealed Creatinine 2.0 10/08/2025. started renal diet, improved on recheck. On 12/19, PCV/TS was 35% / 6.5 g/dL. On 12/23, systolic blood pressure measured by Doppler averaged 172.5 mmHg. Urinalysis obtained via cystocentesis revealed a urine specific gravity of 1.020, with the remainder of the urinalysis within normal limits. Today, CBC HCT calculated 27.89, RBC: 6.2^12/L, ALP 235, ALT 119, BUN 4, NA 143 (normal), K 4.8 (normal), TP 6.3 abaxxis, glob 2.5 abaxxis, ALB 3.8 abaxxis, Baseline cortisol 1ug/dL truforma serum, 0.2ml 250ug/ml cosyntropin given IV, 1 hour post serum truforma cortisol: 13.9ug/dL. urinalysis today: 1.000 S.G. refractometer.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Prostate is normal in size, echotexture, and echogenicity for a neutered male.

The right kidney is normal is size (6.36 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal is size (6.06 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

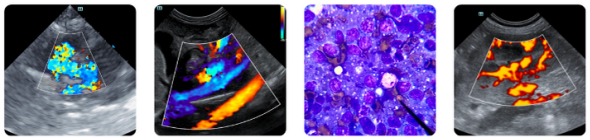
The right adrenal gland is normal in size (0.6 cm at cranial pole and 0.92 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.43 cm at cranial pole and 0.46 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver



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Liver is subjectively enlarged with mildly irregular margins. Parenchyma is diffusely, mildly heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion. In one view there's an area of the mid to left liver that has a slightly more discrete, isoechoic, rounded appearance measuring 4.8 cm x 5.5 cm in size, but in that view is concerning for an emerging mass. However, in multiple numerous other views, the same phenomenon is unable to be repeated.

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

Assessment of heart base images is included when/if a splenic nodule/mass is present (as a complimentary add on). They are also assessed when a specific request is made for assessment of a limited second cavity (heart base and/or thorax) for an additional charge. Images of the heart (and/or) thorax were not assessed for this study. Please contact us if you would like a second cavity.

ULTRASONOGRAPHIC FINDINGS

- Diffusely, mildly heterogenous liver – These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia. An emerging mass lesion in the mid to left caudal liver can't be ruled out but as described above, is not visible in most of the views.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is not a definitive ultrasonographically visible intraabdominal explanation for patient's reported

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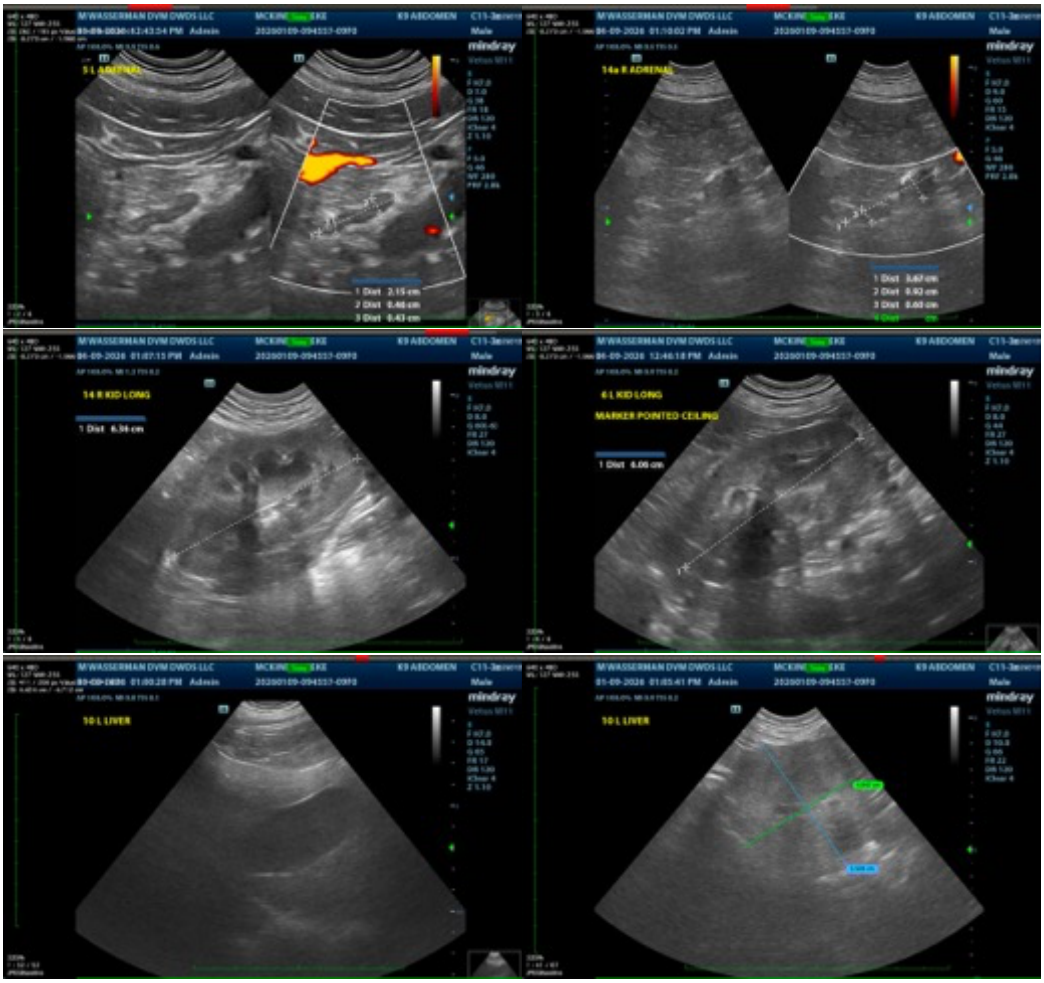
clinical signs and/or laboratory changes present in these images, at this time. Therefore, further evaluation/workup of disease outside the abdomen is recommended. Given the combination of clinical signs: the PU/PD, the neurologic signs, the loss of vision, and possibly mild hypertension, an atypical presentation of hyperadrenocorticism from a pituitary macroadenoma could be considered, as could a stroke type event secondary to protein loss and/or hypertension and/or other underlying primary neurologic disease could be considered. Therefore, full consultation with, or transfer to, if available, a veterinary internist or a veterinary neurologist may be helpful.

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.



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.

Beth Johnson, DVM, DACVIM

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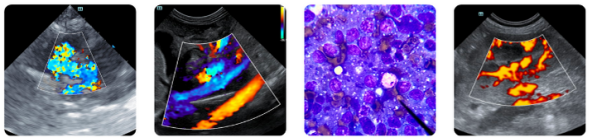

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SonoPath.com info@sonopath.com 1.800.838.4268

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