



PATIENT

Zoe Kardos

SPECIES

Canine

BREED

Cavalier King Charles
Mix

SEX

Spayed Female

AGE

12 Years

WEIGHT

10.45 kg

INTERPRETED BY

Beth Johnson, DVM,
DACVIM (SAIM)

IMAGING PERFORMED BY

Melissa Randolph

HOSPITAL NAME

Shores VEC

REFERRING VET

Dr. Heidi Mostoller

INVOICE

35394

DATE

11/4/25

PRESENTING CLINICAL SIGNS

History: *P's appetite has been declining over the last 3-4 weeks. She has not eaten since Sunday. Lethargic. Around 8 pm, she was shaking/wobbly, O gave karo syrup. Seen 4/2025 for v/ ne; diagnosed with elevated liver values. Diabetic since 2022, Liver issues 2025, Blind. Insulin 9 units Q 12 hours, owner gave 4 units the evening of 11/2. other medications denamarin and ursodiol. admitted for supportive care, buprenorphine, cerenia, ondansetron, unasyn. NG tube was placed. *concern for ileus vs uncontrolled DM diabetes, pancreatitis, other.

Abnormal PE/Chem/CBC/UA Results: *PE: subtle pain, Soft on abdominal palpation, borborygma heard *EPOC: Na 120 (L), Cl- 100(L), Hcoz9.5(L), pH 7.091(L), BUN >120(H) , Cr 3.99(H), glucose >700(H) *Liver panel: ALP 389(H), glucose >600(H) *rads: gas distended stomach; concern for deviation of stomach to left on VD; no obvious effusions; age related pulmonary changes *u/a: colorless, clear, ketone 5, protein trace, glucose 500, pH 5.0, usg 1.022; sediment: RBC<5/hpf, wbc <5/hpf, bacteria none to rare.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. The left kidney measures 5.8 cm. The right kidney measures 5.5 cm.

Adrenal Glands

The adrenal glands are unable to be visualized in these images.

Spleen

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

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is 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. *See Free Abdomen section.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.



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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

Specific pancreatic parenchyma is difficult to fully visualize in these images, however, there is no definitive pancreatic pathology or enhanced tissue consistent with inflammation noted in the area of the pancreas. **See Free Abdomen section.

Free Abdomen

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

There is no apparent pathologic lymphadenopathy noted in these images.

In the cranial abdomen, there is an approximately 3.2 cm x 1.6 cm in size anechoic/cystic density, that appears to originate from the liver. Having said that, pancreatic involvement, while thought less likely, can't be definitively ruled out.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Moderate gallbladder debris- Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.
- 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.
- Suspect incidental benign hepatic cysts. Having said that, pancreatic cysts can't be ruled out. Similarly, other lesions, including hematomas, even an abscess, and less likely infiltrative neoplasia can't be ruled out without tissue sampling.

Secondary Findings



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- Age-related kidney changes

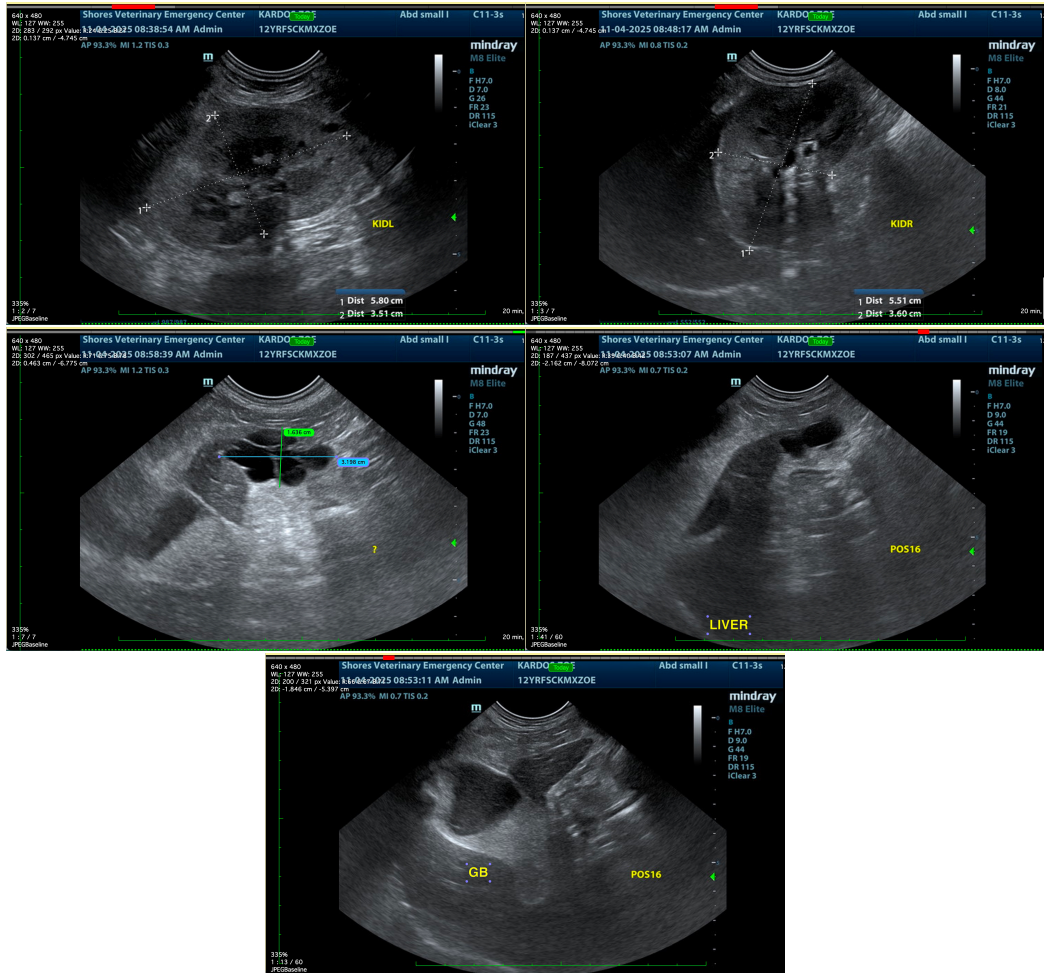
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the patient's history, labwork, etc., a baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

Fine needle aspirates of the cystic structure in the cranial abdomen could be considered if patient's coagulation status is appropriate.

In the meantime, supportive/symptomatic medical management of clinical signs and medical management of patient's ketosis and currently unregulated diabetes, etc., is recommended, as I suspect that's a large contributing component to patient's clinical signs.



The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology



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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

info@sonopath.com