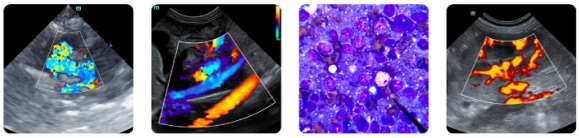

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PATIENT

Radar Debrokert

SPECIES

Canine

BREED

Labrador X

SEX

Neutered Male

AGE

9 years 6 months

WEIGHT

63 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Sara Hansen

HOSPITAL NAME

VCA Westmoreland Animal Hospital

REFERRING VET

Dr. Bugarovich

INVOICE

10684

DATE

11/5/2025

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: tacky mm's, weight loss, picky appetite, intermittent vomiting hx of suspected PLE CKD stage 2 ABNORMAL Labwork Values see records (low albumin) Current Medications Cerenia SID, omeprazole SID.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots, as well as dependent mineral “sand” (crystals) debris. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or discrete definitive cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The area of the prostate is examined without evident prostatic pathology.

The right kidney is small/normal in size (5.7 cm) irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no mineral observed. There is mild to moderate pyelectasia noted bilaterally.

The left kidney is normal in size (6.9 cm) irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no mineral observed. Left kidney measures There is mild to moderate pyelectasia noted bilaterally.

Adrenal Glands

The right adrenal gland is subjectively mildly plump in size (1.2 cm at the cranial pole and 0.8 cm at the caudal pole). Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.58 cm at cranial pole and 0.6 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

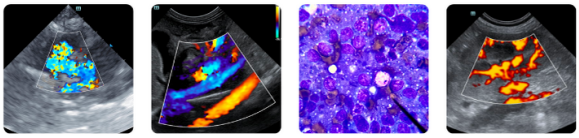
Spleen is subjectively large in size (2.5 cm thick at the hilus) with normal smooth margins. Parenchyma is normal in echogenicity with a diffusely coarse/heterogenous echotexture. No discrete sizable focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

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.

Gastrointestinal



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The stomach is diffusely thick, noted primarily in views of the pylorus, measuring 1.7 cm thick, characterized by mucosal hypertrophy with hyperechoic mucosa and some mucosal remodeling. There is no loss of mural detail, layering remains intact. The lumen of the stomach appears empty.

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 a small amount of free fluid is noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- The gastric wall, again, especially the pyloric wall thickening, could represent irritation secondary to dietary indiscretion or intolerance, infection such as bacterial, viral, other, parasitic or protozoal disease, toxic, other underlying metabolic disease such as pancreatitis, other. Primary infiltrative gastrointestinal disease including causes of protein losing enteropathy, both benign inflammatory as well as infiltrative neoplastic however can't be ruled out. Similarly, microulceration can't be ruled out.

- The trace free fluid is likely secondary to patient's reported hypoalbuminemia, although other pathologic fluid causes are possible.

- Coarse splenomegaly – can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.

- 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.

- Mild to moderate chronic kidney disease changes with bilateral pyelectasia.

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- A moderate amount of echogenic urinary bladder mineral/sand debris. Pinpoint cystoliths can't be definitively ruled out.
- Mild right adrenomegaly could represent normal patient variant, chronic stress, or emerging adrenal disease and should be interpreted in combination with patient's clinical history.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Patient is reported to have hypoalbuminemia but I'm not sure what lab work has been evaluated. If not recently evaluated, a full general metabolic health screen is recommended to include CBC, chemistry panel, electrolytes, and urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

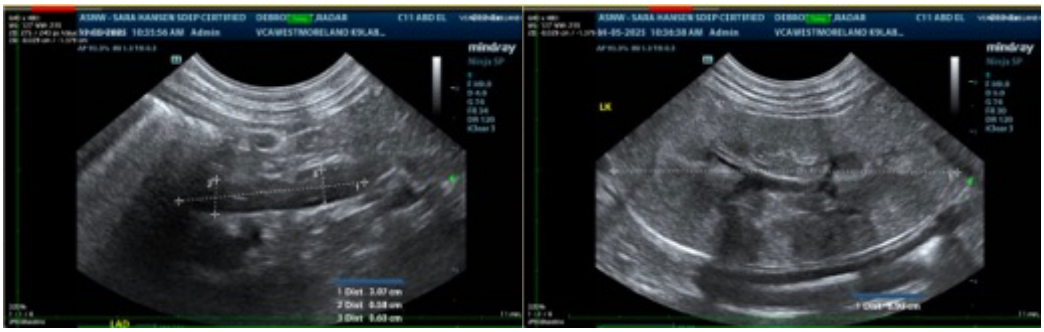
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

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.

Fine needle aspirates of the spleen, as well as potentially the thick pyloric wall could be considered if patient's coagulation status is appropriate.

Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.



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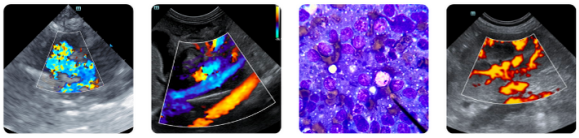

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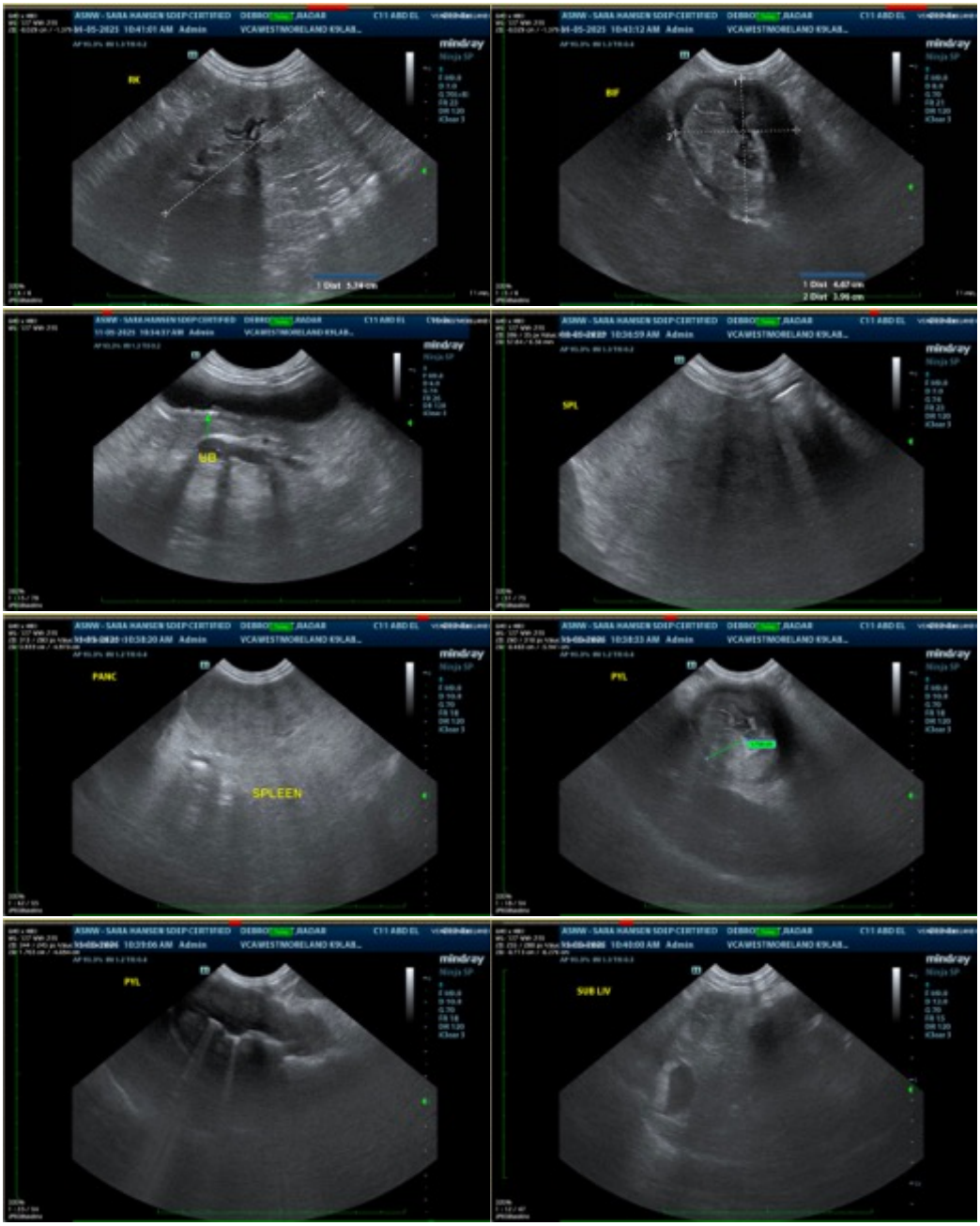

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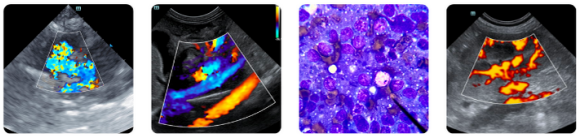

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
info@sonopath.com