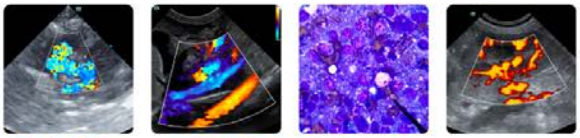


SonoPath www.thefocalzone.com info@thefocalzone.com 289.808.2608

PATIENT

Benji Cottrell

SPECIES

Canine

BREED

Doodle

SEX

Neutered Male

AGE

14 Years

WEIGHT

30.1 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Clarkson Village Animal Hospital

REFERRING VET

Dr. Bloomberg

INVOICE

72637

DATE

12/17/25

PRESENTING CLINICAL SIGNS

Presented 12/11/25 - for eye recheck as discharge is not improving once finished meds Hx of pancreatitis - On Hills Z/D Low Fat pate, Hx of Bilateral laryngeal paralysis - unilateral tie back done 05/2024 Reported decreased appetite + weight loss, loss of 4.7kg since Oct 6th - Dec 11th (~2m) Reported of bleed seen on top of stool, occasional scooting Muscle loss noted on hindlegs - normal gait + proprioception Otherwise NSF/WNL on PE for P Blood and urine sent out Current Medications Metoclopramide 15mg PO BID, Omeprazole 20mg PO BID, Gabapentin 300mg PO SID-TID PRN, Premed Trazadone 150mg PO 2hr prior to appt

Abnormal PE/Chem/CBC/UA Results: Please see attached labs

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with primarily anechoic contents and occasional echogenic non-shadowing debris. Apical urinary bladder wall is diffusely thick (0.93 cm). Mucosa is hyperechoic and irregular. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.

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

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. Left kidney measures 5.92 cm. Right kidney measures 5.37 cm.

Adrenal Glands

Adrenal glands are plump/swollen in size. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. A hyperechoic nodule is noted in the left adrenal gland, adjacent to the caudal pole, measuring 1.4 cm x 2.1 cm in size. Nodule does not disrupt normal shape and/or architecture. Visible surrounding vasculature appears normal. Left measures 0.96 cm at the cranial pole and 1.3 cm at the caudal pole. Right measures 1.6 cm at the cranial pole and 0.78 cm at the caudal pole.

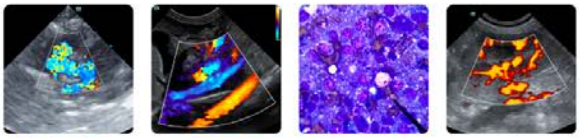
Spleen

The spleen contains an approximately 1.8 cm x 2.1 cm mildly heterogeneous, hypo- to anechoic, non-capsule disrupting mass in the mid spleen, as well as a 2nd similar appearing, similar sized nodule/mass near the cranial aspect of the spleen, resulting in a mild capsular bulge.

Liver

The liver contains an approximately 7.4 cm x 8.1 cm mixed, heterogeneous, partially cavitated mid to left liver mass. The parenchyma surrounding the mass has a diffusely mildly heterogeneous appearance, characterized by ill-defined subtle hypoechoic nodules with an otherwise hyperechoic parenchyma. Visible vasculature and biliary tree are normal without distention or congestion.

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.



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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with a small to moderate amount of echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is 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 is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta/chyme. There is 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

Pancreas is prominent (enlarged) in size and mildly irregular in shape with a slightly undulating contour. Parenchyma is coarse in echotexture and heterogenous to hypoechoic in echogenicity.

Free Abdomen

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

There is no apparent pathologic lymphadenopathy noted in these images.

The visible heart base (RA) and pericardium are unremarkable without obvious pathology noted in these images at this time. If cardiac function evaluation is desired, a full echocardiogram is recommended.

PRIMARY FINDINGS

- The liver mass could represent infiltrative neoplasia such as sarcoma, primary hepatocellular carcinoma, a metastatic lesion, round cell neoplasia, other, as well as a benign process such as cyst, hematoma, extramedullary hematopoiesis, etc., and can't be differentiated without tissue sampling.
- Similarly, similar benign and/or infiltrative neoplastic differentials are possible for the splenic nodules/masses.
- Chronic low-grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.

SECONDARY FINDINGS

- Bilateral adrenomegaly – In a patient diagnosed with hyperadrenocorticism, this finding is most consistent with adrenal hyperplasia secondary to pituitary dependent hyperadrenocorticism. This finding can also be seen with stress and/or normal patient variant. Interpret in combination with clinical signs of hyperadrenocorticism and/or other adrenal disease.
- Hyperechoic adrenal nodule (caudal pole left adrenal gland) – Differentials include primary adrenal cortical adenoma or adenocarcinoma, pheochromocytoma, myelolipoma, adrenal hyperplasia secondary to pituitary disease or metastatic disease. Ultrasound alone cannot differentiate between functional and non-functional nodules and/or between benign and

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malignant disease. Small nodules without other evidence of abdominal disease (to suggest metastatic disease) and/or clinical signs (to suggest adrenal disease) are most often incidental and should be monitored.

- Age related kidney changes.
- Chronic Cystitis - Urinary bladder wall changes are most consistent with chronic cystitis. Infiltrative neoplasia cannot be ruled out but is considered less likely give the location and diffuse nature of the changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the changes noted above, lab work was not available for review. If not recently evaluated, a full general metabolic health screen is recommended, beginning with CBC/Chem panel, electrolytes, and urinalysis.

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 liver and splenic masses are recommended if patient's coagulation status is appropriate.

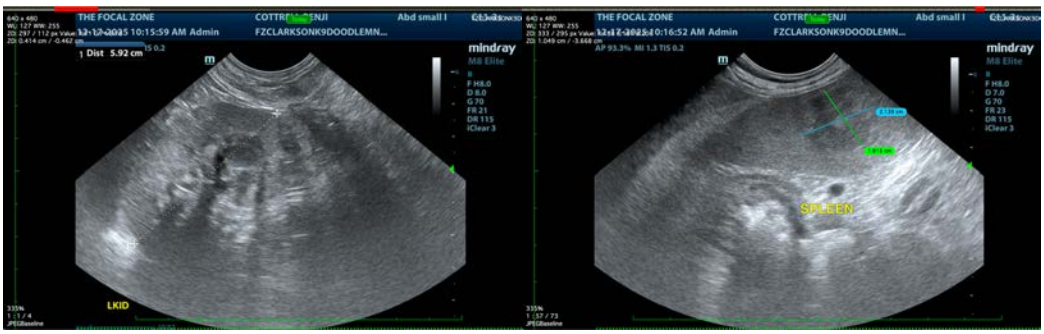
Having said that, however, the masses in those organs of unknown if any relation to patient's reported clinical signs of hematochezia. Therefore, additional gastrointestinal workup may also be warranted, beginning with a routine fecal/giardia exam if not recently evaluated.

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.

Finally, emerging adrenal disease is possible, and hormone testing may eventually be indicated, but is not recommended in the face of concurrent, potentially more serious disease.

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



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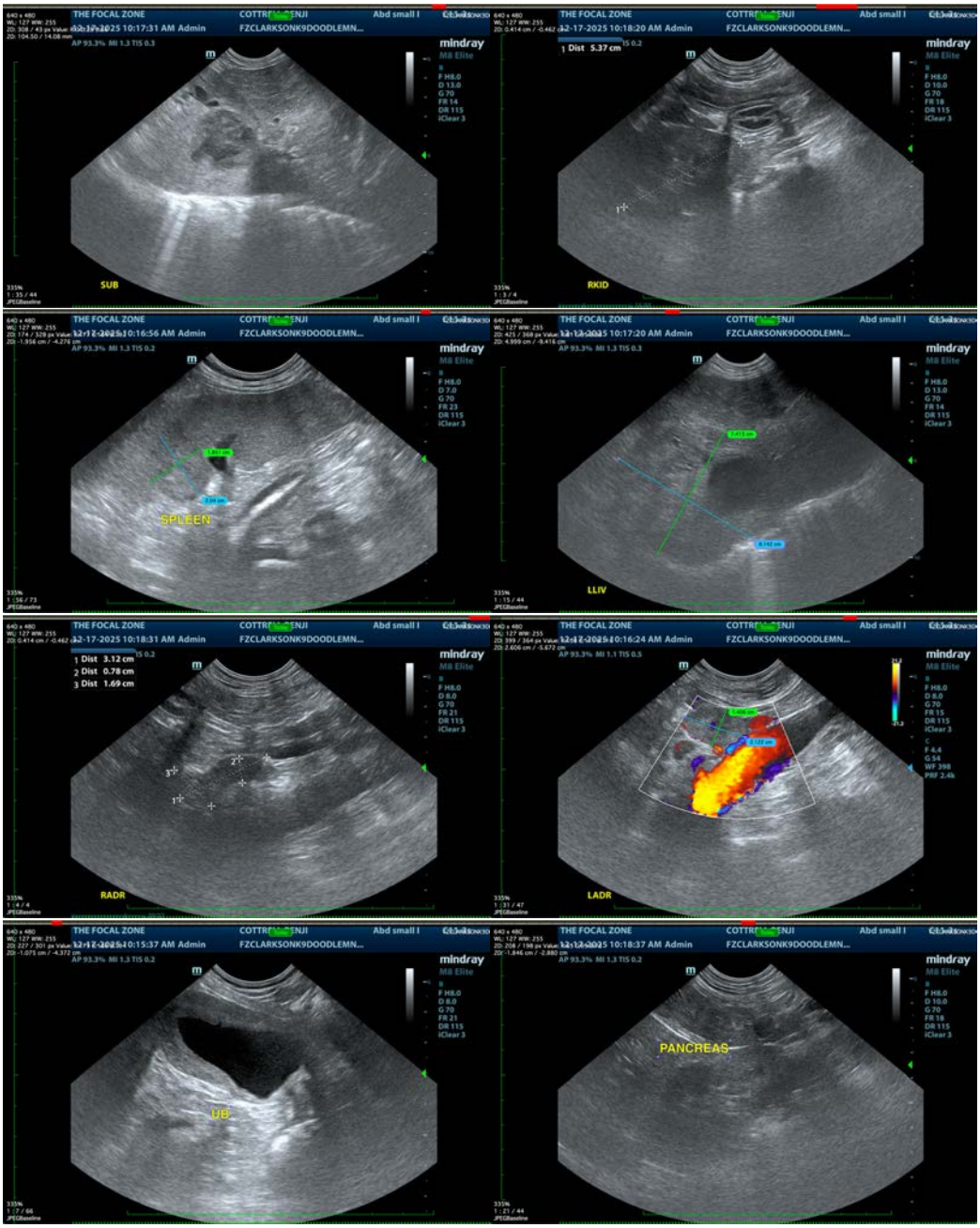

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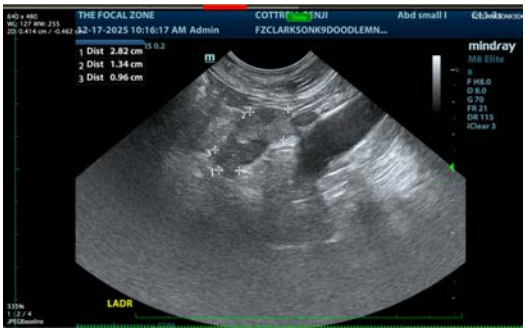

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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