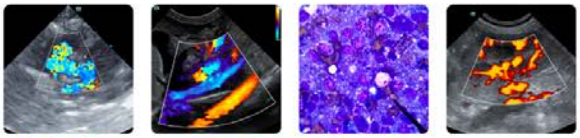

PATIENT

Nic Douglass

SPECIES

Canine

BREED

Yorkie

SEX

Neutered Male

AGE

15 Years

WEIGHT

6.1 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Kathleen Byrnes

HOSPITAL NAME

Shallowford Animal Hospital

REFERRING VET

Dr. Eads

INVOICE

72412

DATE

12/9/25

PRESENTING CLINICAL SIGNS

P presented 8/11/25 for not eating well and not having regular Bm's. Has started having seizures. Given fluids, Cerenia, B12,and lactulose. Returned 12/2/25 for recheck bloodwork. Given Convenia, Metacam, Keppra 12/4- Owner reported P sleepy and lethargic and concern for side effects of Keppra 12/9/25 abdominal US

Abnormal PE/Chem/CBC/UA Results: 8/12/25 BUN 46, Crea 1.9, MG 2.5, Tri 697 Urinalysis 2+ protein, usg 1.040 12/3/25 BUn 41, SDMA 22.7 Urinalysis Protein 3+, usg 1.031, Free Catch Blood 3+ high

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly under distended, but largely adequately distended for assessment with primarily anechoic contents. In the trigone, appearing to extend briefly into the proximal urethra, is an echogenic density measuring approximately 0.60 cm in diameter. No cystoliths are observed.

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

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 3.1 cm. There is an approximately 0.80 cm x 1.0 cm anechoic cyst along the medial aspect of the let kidney. Right kidney measures 3.23 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.63 cm at cranial pole and 0.62 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.53 cm at cranial pole and 0.61 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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). Multifocal well-demarcated hyperechoic homogenous nodules are noted. Splenic vasculature appears normal.

Liver

Liver is relatively normal in size and contour. Parenchyma is mildly heterogenous and coarse with mild likely age-related parenchymal remodeling noted. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic with some echogenic debris noted. Additionally, there is some echogenic

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mineral/sand debris and potentially small, non-visibly shadowing and non-visibly obstructive cholecystoliths. 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 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. Hyperechoic mucosal fogging or speckling is noted. 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. There is some very subtly enhanced hyperechoic mesenteric fat in the cranial abdomen adjacent to the right pancreas and duodenum that could represent an acute inflammatory process.

Free Abdomen

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

There is no apparent pathologic lymphadenopathy noted in these images.

PRIMARY FINDINGS

- The density within the trigone could represent a benign inflammatory lesion, cystitis versus other, although infiltrative neoplasia can't be ruled out without additional information.
- Very mild acute pancreatitis, potentially emerging versus resolving pancreatitis, or an acute on chronic low-grade smoldering flare up of pancreatitis can't be ruled out.
- Very subtle mucosal speckling – Mucosal speckling is often present with inflammatory bowel disease (IBD). It is not specific for type or severity of disease. Mild speckling change can occur as a normal patient variant in the post-prandial state.
- Suspect non-visibly obstructive cholelithiasis.

SECONDARY FINDINGS

- Hyperechoic splenic nodules – most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.
- Age related kidney changes with a cortical cyst in the left kidney.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

While there are a variety of subtle/mild changes described above and some that warrant further workup and potentially intervention, there is not a definitive intraabdominal explanation in these images at this time for patient's reported seizures. Therefore, bile acids could be considered if patient's total bilirubin is not increased.

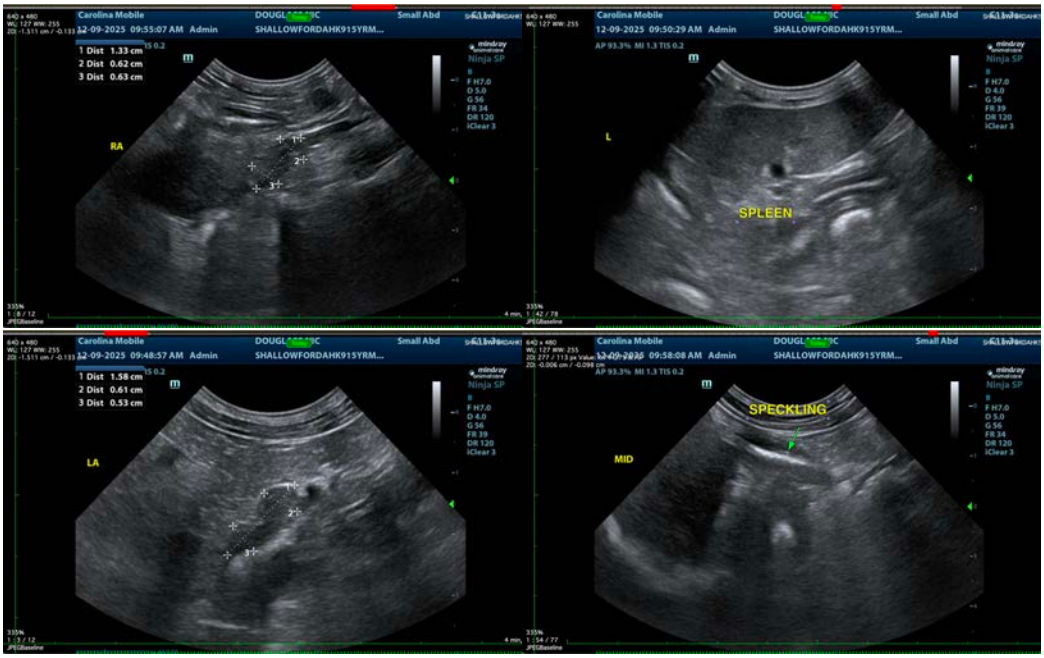
Blood pressure is recommended.

Ultimately, however, consultation with a veterinary neurologist may be warranted for potentially advanced imaging.

In the meantime, urinalysis and urine culture, if indicated based on urinalysis results, are recommended. Submission of urine to look for BRAF gene mutation, which is associated with urinary bladder/prostate cancer, could be considered. Other diagnostic options include traumatic catheterization, fine needle aspirate (with small risk of tumor seeding/trailing) or cystoscopy for further sampling. In the meantime, empirical therapy with a broad-spectrum antibiotic (or ideally an antibiotic based on culture and sensitivity results) as well as an anti-inflammatory (unless otherwise contraindicated based on patient co-morbidities) may begin to help alleviate clinical signs.

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.

While pursuing additional workup, supportive/symptomatic medical management of clinical signs, including medical management of possible early or mild acute pancreatitis is recommended.



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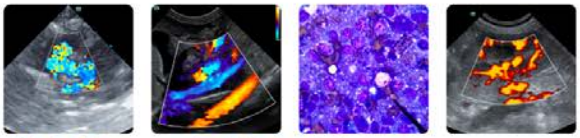

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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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