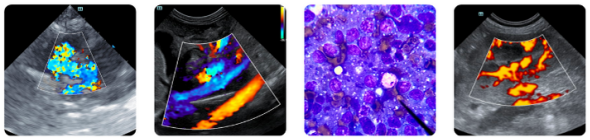

PATIENT

Brigadier Tutela

SPECIES

Canine

BREED

Labrador Retriever

SEX

MN

AGE

12.3 years

WEIGHT

61.3 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Kristen Carpenter

HOSPITAL NAME

Pennridge Animal Hospital

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PRESENTING CLINICAL SIGNS

- Patient was pre-medicated with Gabapentin and Trazodone. Hx of PU/PD starting 11/28/25. UA consistent with UTI, treated with cefpodoxime. On recheck, persistent low USG noted despite resolution of infection. Patient was started on Librela d/t severe OA and limited response to carprofen. Patient re-presented in January 2026 for recurrence of notable pu/pd, weight loss. Uveitis was noted OD on exam. Full b/w performed. Tx with neopolydex OD and cefpodoxime.
- Recheck February 2026, OD uveitis and secondary glaucoma, IOP 53 mm HG. Patient was started on Doxy and Dorzolamide and referred to Ophthalmologist who recommended chest rads and AUS as next step to r/o neoplastic causes.
- Current Medications: doxycycline, carprofen, gabapentin, pred-acetate drops OD, dorzolamide drops OD.

Abnormal PE/Chem/CBC/UA Results: Previous Diagnostics - 11/29/25 UA: USG 1.006 pH 8.5 30-50 WBC/HPF, 15-20 RBC/HPF, marked rods. Screening b/w NSF. Fecal NOS - 12/12/25 UA: USG 1.018, quiet sediment - 1/28/26 Bloodwork: CBC WNL, AST 61 (H), CK 291 (H), Amylase 1,488 (H). T4 1.9, 4dx neg x 4, UA: USG 1.006, quiet sediment - 2/10/26 Thoracic Rads: 3 small nodules in cranial chest, suspicious but not definitive for metastatic changes. Severe elbow OA.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is not fully distended/mildly under distended with primarily anechoic contents and occasional echogenic non-shadowing debris. Apical urinary bladder wall is diffusely thick (0.34 cm). The appearance of the wall may be in part exacerbated by the non-fully distended state of the bladder. 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.

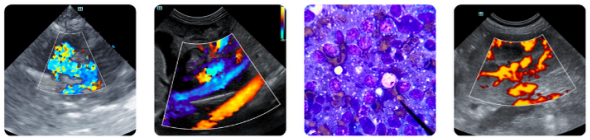
Prostate is normal in size, echotexture, and echogenicity for a neutered male.

The right kidney is normal is size (6.53 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. Both kidneys have multifocal hypoechoic nodules throughout the cortices, most measuring right at 1.0 cm in diameter. Some of the nodules have a “target lesion” appearance, characterized by a slightly hyperechoic center surrounded by a hypoechoic rim.

The left kidney is normal is size (5.57 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. Both kidneys have multifocal hypoechoic nodules throughout the cortices, most measuring right at 1.0 cm in diameter. Some of the nodules have a “target lesion” appearance, characterized by a slightly hyperechoic center surrounded by a hypoechoic rim.

Adrenal Glands

The right adrenal gland is normal in size (1.2 cm at cranial pole and 0.74 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.



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The left adrenal gland is normal in size (0.82 cm at cranial pole and 0.54 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size with normal smooth margins. Parenchyma is normal in echogenicity with a diffusely coarse/heterogenous echotexture. Splenic vasculature appears normal. In additiona to the diffuse subtle change, there is an approximately 1.0 cm x 1.3 cm in size hyper- to anechoic, non-capsular disrupting density mid-spleen.

Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is mottled by multifocal discrete hypoechoic nodules of varying sizes “moth-eaten”. Visible vasculature and biliary tree appear normal without distension or congestion. Some of the nodules have a “target lesion” appearance, characterized by a slightly hyperechoic center surrounded by a hypoechoic rim.

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 gastric wall is difficult to fully assess due to a large amount of reverberation artifact from intraluminal gas. Having said that, in some views of the caudal wall of the stomach, the wall appears hypoechoic and thick measuring 1.4 cm.

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.

PRIMARY FINDINGS

- Multifocal nodules throughout both kidneys, and the liver, as well as the one discrete nodule within the spleen, are concerning for possible infiltrative neoplasia such as round cell neoplasia versus metastatic neoplasia versus other. Especially, given the reported suspicion of pulmonary nodules. Having said that, benign processes including cortical cysts within the kidneys, nodular hyperplasia within the liver, a hematoma, extramedullary hematopoiesis versus other in the spleen, etc. cannot be ruled out without tissue sampling.

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- Similarly, the gastric wall changes could represent the same infiltrative process versus a benign inflammatory gastritis.

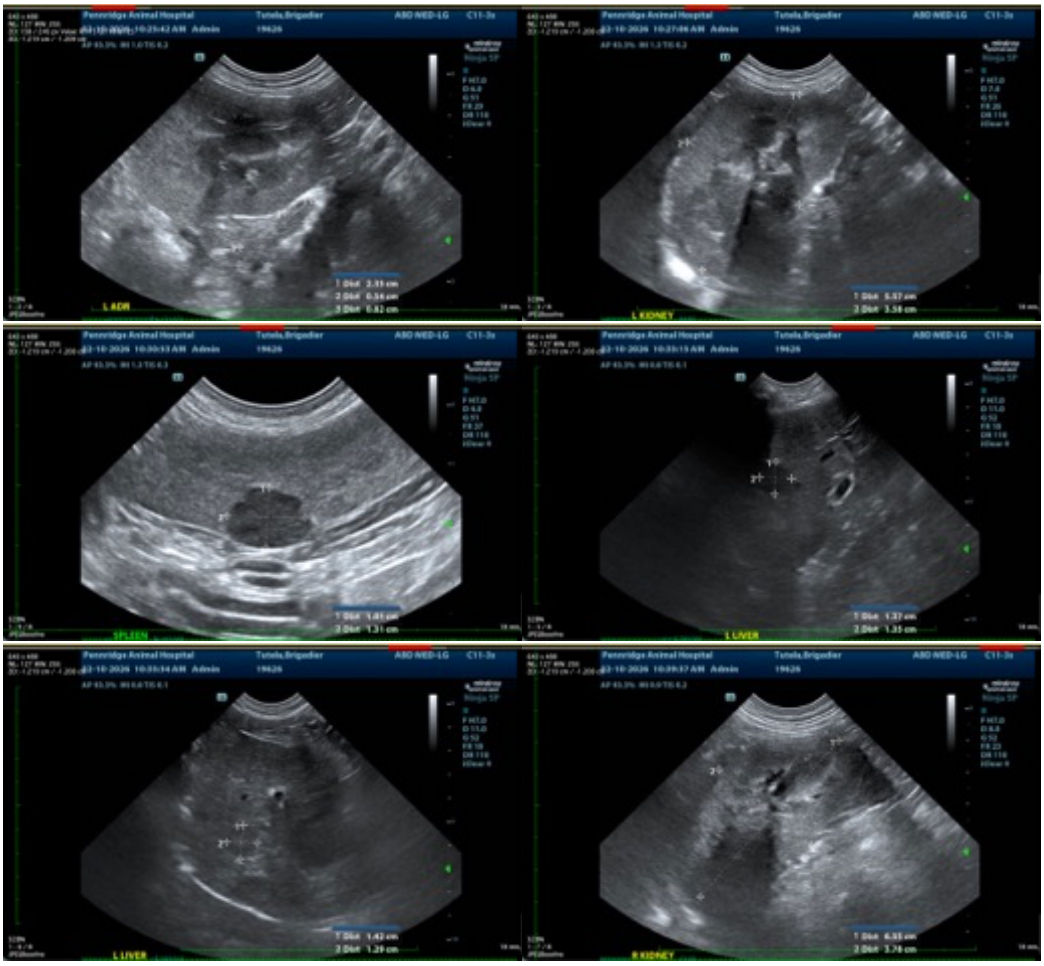
SECONDARY FINDINGS

Possible mild ongoing 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

Fine needle aspirates of the liver, spleen, and kidneys +/- stomach wall are recommended if patient's coagulation status is appropriate.

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



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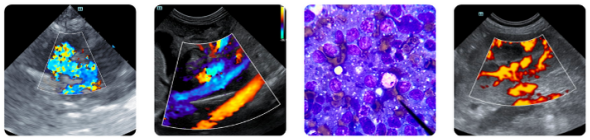

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Educational Teleconsultation Services™

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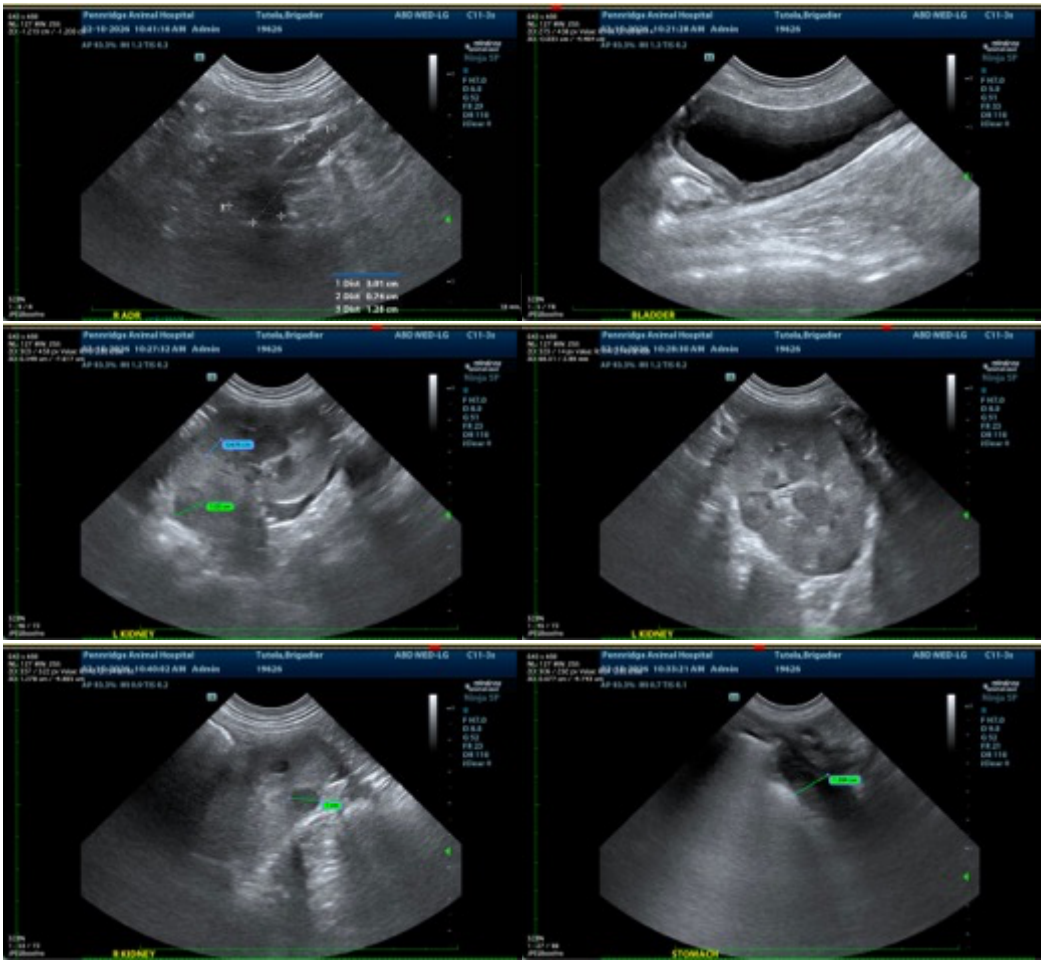

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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