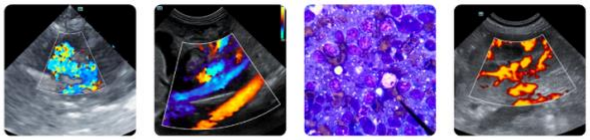


PATIENT
Suki Keillor

SPECIES
Canine

BREED
Shepherd Mix

SEX
Spayed Female

AGE
16 Years 8 Months

WEIGHT
40.7 Pounds

INTERPRETED BY
Beth Johnson, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY
Dr. Lucas Budden

HOSPITAL NAME
Frontier VH

REFERRING VET
Dr. Lucas Budden

INVOICE
36355

DATE
3/23/26

PRESENTING CLINICAL SIGNS

Clinical signs:

- Chronic weight loss.

History:

- Progressive weight loss over time despite normal appetite. Ultrasound to assess for underlying cause. Weight in May of 2025 was 50.8#. Current weight is 40.7#. Recent recurrence of chewing of digit 3 of left hind paw. Similar symptoms August of 2025. X-rays showed potential osteomyelitis vs neoplasia.

Current medications:

- Tramadol
- Rimadyl
- Gabapentin
- Butorphanol/Midazolam sedation to facilitate imaging

Abnormal PE/Chem/CBC/UA Results: Physical exam: BCS 4/9, MCS 2/3, peripheral LNs normal, severe dental calculus, ambulatory but stiff/weak in the back end, digit 3 left hind paw frayed and blunted nail with patch of dermatitis on lateral surface of nail base Lab work: Senior panel 2/17/26 BUN high 51 SDMA high 17.5 PSL high 214 Remainder of CBC/CHEM normal Thyroid normal 1.2 Accuplex all negative Fecal negative USG 1.035 Quiet sediment Chest rads: no obvious mets, final report pending.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

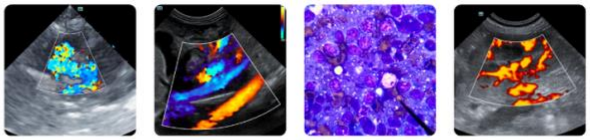
Urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Left kidney is normal in size (5.82 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.

Right kidney is normal in size (5.28 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.

Adrenal Glands

Left adrenal gland is normal in size (0.47 cm at cranial pole and 0.81 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.



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Right adrenal gland is normal in size (1.0 cm at cranial pole and 0.56 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 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. Except for, an approximately 2.0 cm x 2.8 cm homogenous isoechoic density in the mid cranial aspect of the liver. 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

The visible stomach wall is normal in thickness and layering. The stomach is moderately distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. If patient was appropriately fasted, delayed gastric emptying could be considered. Non-shadowing foreign material is considered less likely but cannot be definitively ruled out. If clinical signs are consistent (vomiting, etc.), recommendations include supportive medical care, 24 hours fasting and re-image.

The visible small intestine demonstrates areas of mildly thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen of the small intestine is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction or foreign material noted.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

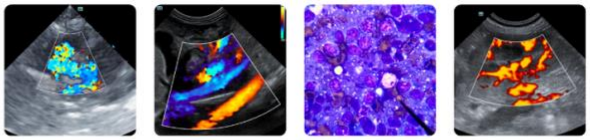
Pancreas

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.



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ULTRASONOGRAPHIC FINDINGS

- Mild/emerging inflammatory bowel disease pattern- Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No loss of layering or distinct characteristics of malignancy are present. Therefore, differentials cannot be further ranked without tissue sampling. This finding may be in part normal patient variant, however, in a senior dog.
- 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.
- Liver nodule- Differentials for a discrete hyperechoic liver nodule includes primarily benign changes such as nodular hyperplasia, fibrosis of an old hematoma, granuloma, myelolipoma, etc.; however, while considered less likely, primary hepatic neoplasia, infiltrative round cell neoplasia and metastatic disease can mimic benign lesions and cannot be definitively ruled out.
- 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not already evaluated, a thorough evaluation of daily caloric intake is recommended to assure an adequate daily caloric intake is occurring vs an inadvertent reduction in calories due to change in diet and/or feeding schedule, competitive eating environment, etc.

Especially in the face of normal or even increased daily caloric intake, further evaluation of digestion and absorption is recommended via a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory for further evaluation of GI and pancreatic function.

A routine fecal/Giardia exam could be considered.

As is reportedly already pending, 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.

If it can safely be reached, a fine needle aspirate of the liver nodule could be considered 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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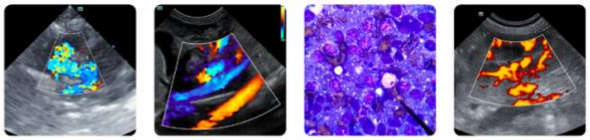

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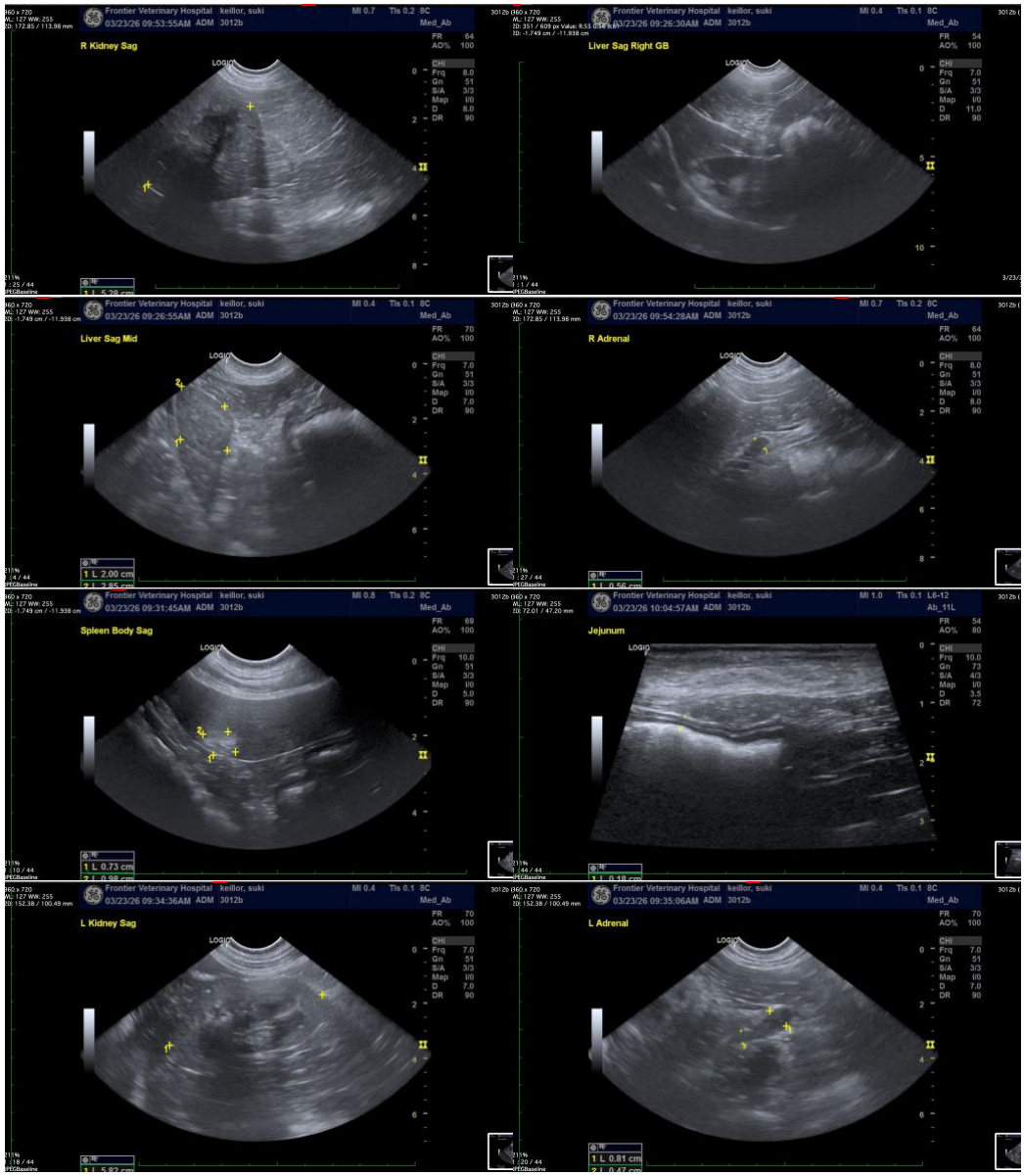

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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