



**PATIENT**

Ben Kocsis

**SPECIES**

Canine

**BREED**

Mix

**SEX**

Neutered Male

**AGE**

11 Years 2 Months

**WEIGHT**

27 lbs

**INTERPRETED BY**

Dr Brittany Sinclair,  
BVSc(hons),  
DACVECC

**IMAGING PERFORMED BY**

Shari Reffi, CVT

**HOSPITAL NAME**

William Penn  
Veterinary Hospital

**REFERRING VET**

Dr. Mahmoud

**INVOICE**

74731

**DATE**

4/23/26

**PRESENTING CLINICAL SIGNS**

Evaluate adrenal glands (AUS), diabetes, vomiting, diarrhea, organ enlargement. Current Medications: Vetsulin 3U bid; Dorzolamide/Timolol

Abnormal PE/Chem/CBC/UA Results: Hgb012.5; Retics- 142.8; Retic hgb-19.2; Eos- 0.03; MPV-18.2; PLT crit-0.74; Glucose-530; Cl-105; Alb- 4.0; ALP-1,200; Amyl- 1,560; Lipase-3,184

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The kidneys have a smooth capsule and with mild hazing of corticomedullary definition. No evidence of pelvic dilation was present. Hyperechoic striations and cortical mineralizations are noted in the both kidneys. Left kidney measures 5.07 cm. Right kidney measures 5.45 cm.

**Adrenal Glands**

Both adrenal glands were visualized and recognized as having normal shape, size, position and echogenicity for this breed and age. The visible phrenic vasculature was unremarkable. Left measures 2.31 cm in length x 0.56 cm at the caudal pole and 0.52 cm at the cranial pole. Right measures 1.89 cm in length x 0.63 cm at the caudal pole and 0.56 cm at the cranial pole.

**Spleen**

The spleen was normal with age appropriate homogeneous parenchyma and a smooth capsule with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

**Liver**

The liver is enlarged with rounded margins. Parenchyma is diffusely mildly coarse with no specific nodules or masses seen.

Gall bladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally.

**Gastrointestinal**

The stomach contains a small amount of ingesta. It measures at a normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. There were no focal lesions consistent with obstruction or a mass effect observed.

Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.



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**Pancreas**

The area of the pancreas was isoechoic to surrounding tissue with no overt inflammation. Pancreatic tissue was not distinctly visualized which is common.

**Free Abdomen**

Iliac lymph nodes are prominent with normal length to width ratio and normal echogenicity.

No free fluid noted.

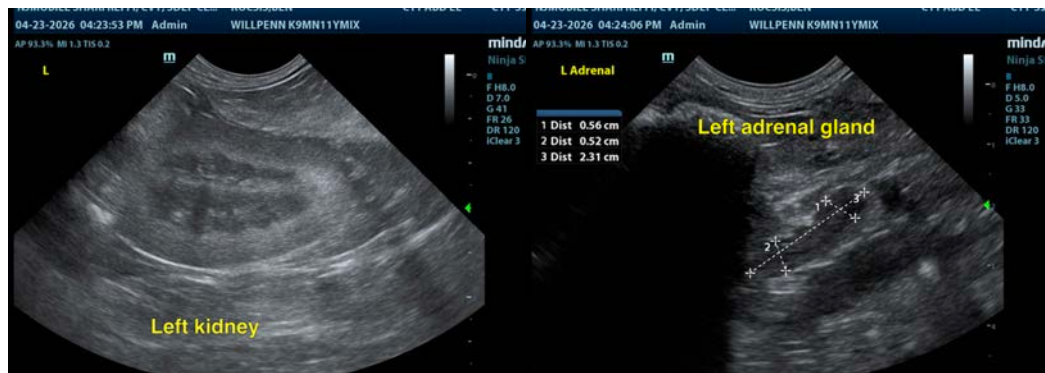
**ULTRASONOGRAPHIC FINDINGS**

- Hepatomegaly with coarse echotexture.
- Aging renal changes.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Liver changes are a common benign age related change, but infiltrative disease (lymphoma, MCT, other) cannot be definitively ruled out. Hyperadrenocorticism is a common cause of these mild changes. No significant disruption of architecture noted to suggest significant pathology. In the face of elevated liver enzymes, fine needle aspirate is recommended to further characterize parenchymal changes, and bile acid profile to assess liver function, especially if any weight loss is noted or for baseline cytological assessment. Ultimately liver biopsy is often required for more definitive diagnosis. Empiric treatments (SAM-E, milk thistle, Vitamin E, ursodiol if bilirubin elevated or gallbladder sludge) could be tried and liver enzymes re-evaluated, especially if liver FNA does not show significant pathology before more invasive liver sampling is pursued.

There is no ultrasonographically evident cause of reported GI signs in this abdominal study. Pancreas and GI tract are within normal limits. Consideration for dietary indiscretion, infectious etiologies (bacterial, viral, parasitic), food sensitivity/allergy or mild inflammatory bowel disease is reasonable. While not sonographically evident, pancreatitis cannot be completely ruled out. Empiric treatment for GI signs including anti-nausea, appetite stimulant and fluid support as clinically indicated is warranted. A diet trial with hydrolyzed protein or select protein diet could be considered if food sensitivity is suspected clinically. If signs are persistent or recurrent, additional diagnostics to be considered include baseline cortisol +/- ACTH stimulation test, GI panel (TLI/PLI/cobalamin/folate), fecal pathogen panel, thyroid testing, bile acid profile, and thoracic radiographs to rule out occult neoplasia, cardiac disease and esophageal disease as potential causes. Ultimately GI biopsy may be required for more definitive diagnosis if the patient is not responsive to medical treatment.





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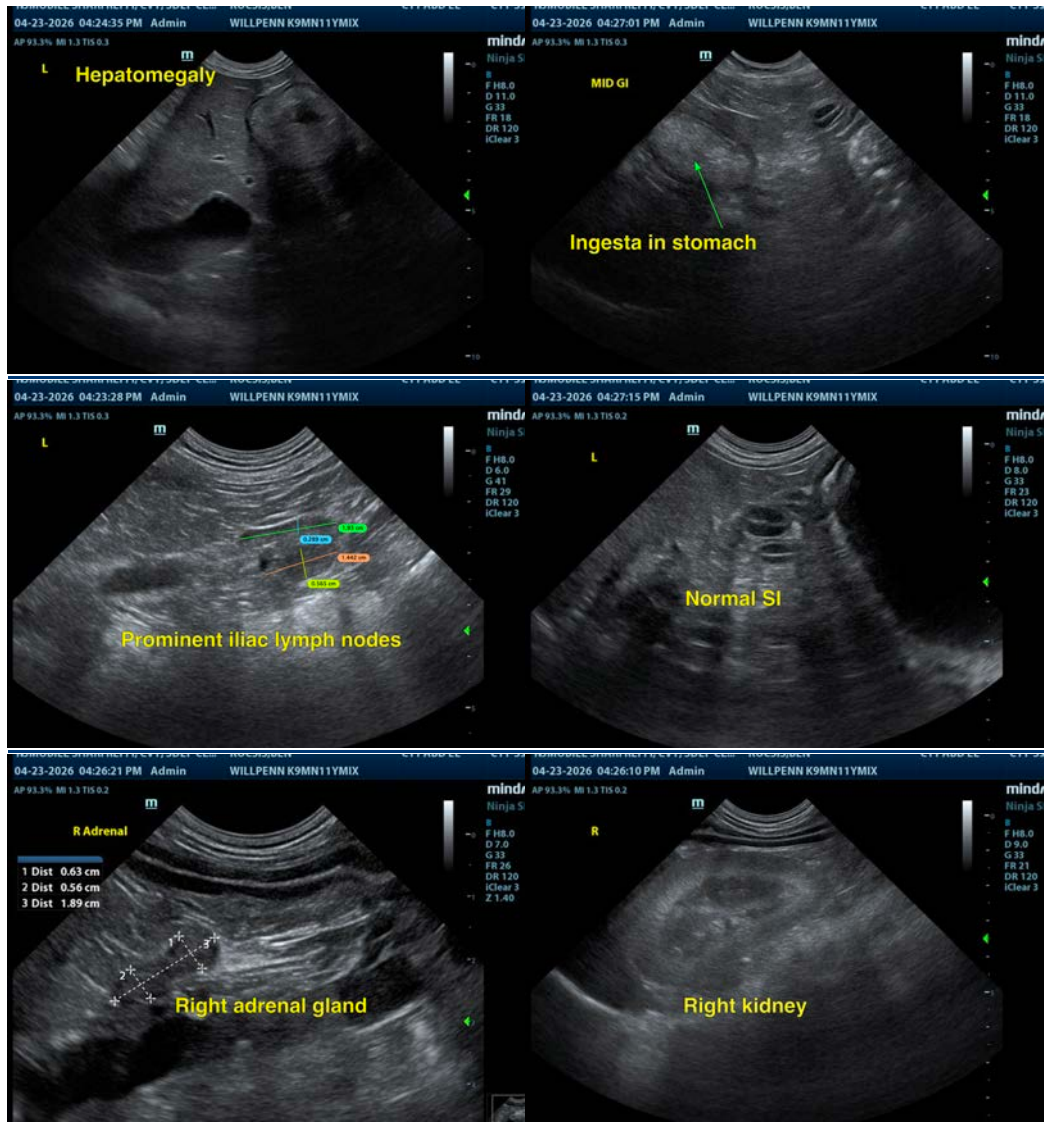
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC

info@SonoPath.com