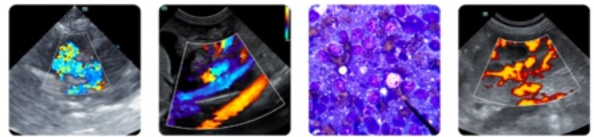


PATIENT
Nugget Maness

SPECIES
Canine

BREED
Labrador Retriever Mix

SEX
Neutered male

AGE
14 years

WEIGHT
47.6 lbs

INTERPRETED BY
Eric Lindquist, DMV DABVP, Cert. IVUSS

IMAGING PERFORMED BY
MEW

HOSPITAL NAME
Weddington AH

REFERRING VET
Dr. Walker

INVOICE
68812

DATE
11/18/25

PRESENTING CLINICAL SIGNS

History: 14 yo MN lab mix presented 11/17 for lethargy, ADR, inappetence of a few days duration. Radiographs did not show any obvious abnormalities. Fecal float NPS. Concerned for pancreatitis vs neoplasia. P has lost 13 lbs over past few months. Currently eating dry food mixed with fresh pet and does eat cat food occasionally. PE unremarkable except for sensitivity on cranial abdominal palpation. Temp was 104.2 yesterday, normal at presentation today. P was given a penicillin shot, cerenia, and subcutaneous fluids yesterday during PE.
Abnormal PE/Chem/CBC/UA Results: CBC: clotted sample/thrombocytopenia (giant platelets present, few small platelet clumps observed), r/o artifact vs real). Normal leukocyte count. Mild neutrophilia - stress Chemistry: mildly elevated ALT (187), moderately elevated ALP (507), moderately elevated PSL (277) - r/o pancreatitis T4: <0.5 U/A: unable to collect

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes were noted. Ureteral papillae were normal.

The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for this age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The kidneys measured approximately 6.0 cm.

Adrenal Glands

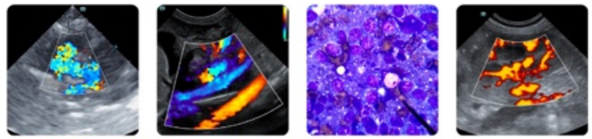
The left **adrenal gland** was mildly enlarged and measured up to 1.2 cm. The right adrenal gland was not visualized.

Spleen

The **spleen** was largely normal with slight irregular contour. The spleen was folded upon itself cranially.

Liver

The **liver** revealed uniform parenchyma with hepatic vein dilation. Heterogenous parenchymal changes were noted in the left cranial liver. This is not quite a mass effect; however, some disorganized tissue was noted. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal. No pathological hepatic lymphadenopathy was evident.



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Gastrointestinal

Examination of the **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.

Pancreas

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

Free Abdomen

Variable free fluid was noted in various pockets throughout the abdomen in the iliac trifurcation. However, no iliac pathology was noted.

Free fluid was noted between the liver lobes and spleen.

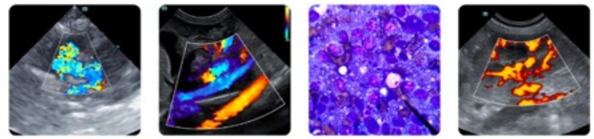
ULTRASONOGRAPHIC FINDINGS

Undefined ascites with heterogenous hepatic changes to sample.

Mild passive congestion liver pattern. Thoracic pathology may be the underlying cause.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Ultrasound-guided abdominocentesis of the pockets of fluid and FNA of the liver changes noted would be recommended. I recommend an echocardiogram to assess for causes of passive congestion such as pericardial effusion or right sided failure. Prognosis is guarded, more diagnostics are necessary.



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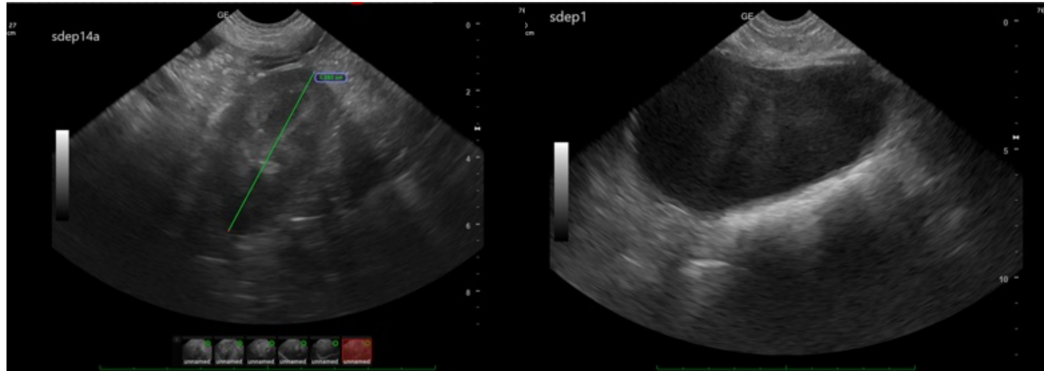

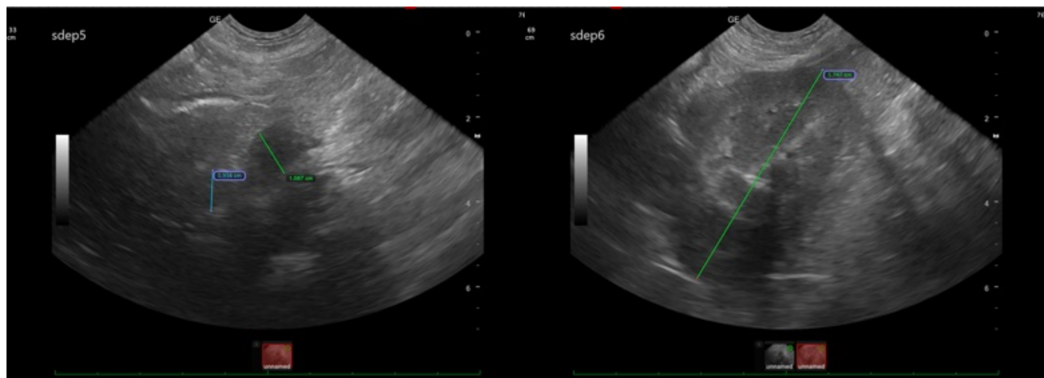

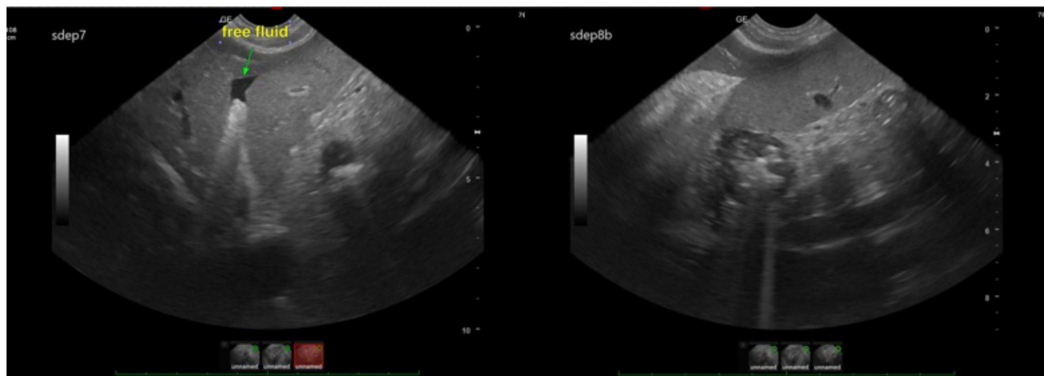

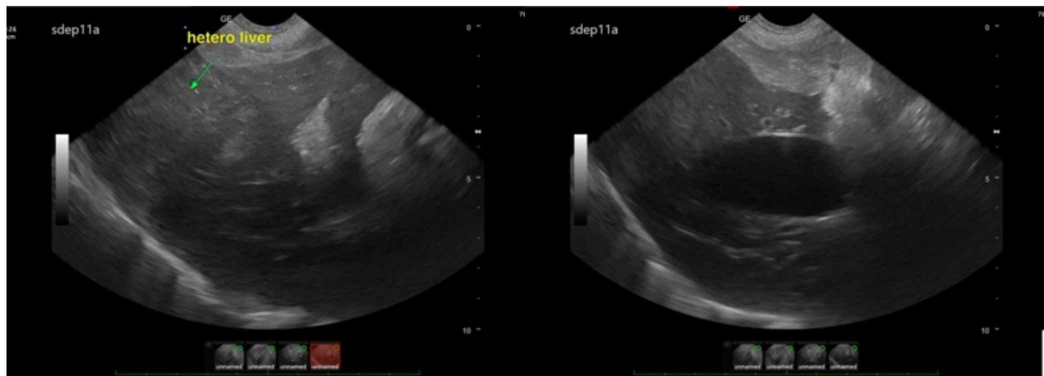

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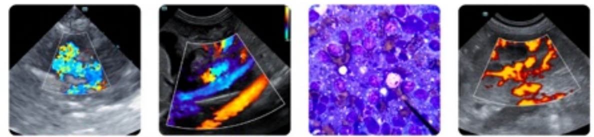

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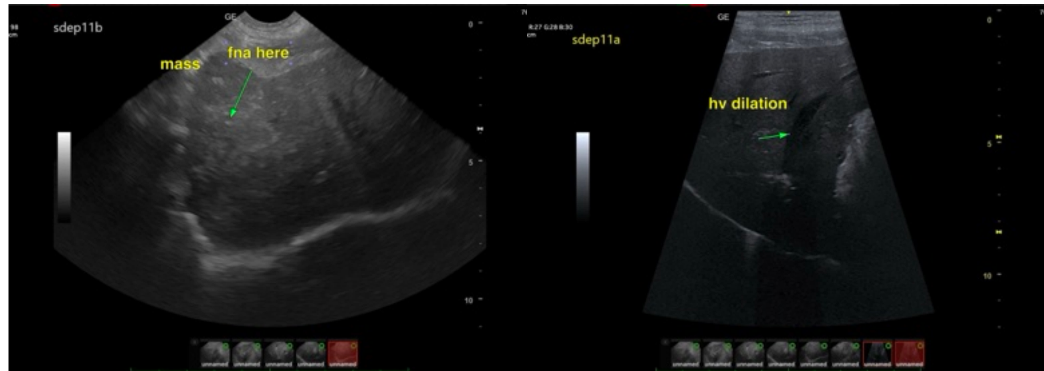

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP (CFM), Cert. IVUSS, CEO of SonoPath.com

info@SonoPath.com