

PATIENT

Nakodah Sommerville

SPECIES

Canine

BREED

Siberian Husky

SEX

Neutered Male

AGE

12 Years

WEIGHT

25.8 kg

INTERPRETED BY

Eric Lindquist, DMV,
DABVP(CFM), Cert.
IVUSS

IMAGING PERFORMED BY

Michelle DeMelo

HOSPITAL NAME

Woodstock Veterinary
Hospital

REFERRING VET

Dr. Rob DeVries

INVOICE

13729

DATE

02/13/26

PRESENTING CLINICAL SIGNS

Kodah is an almost 13-year-old MN Husky. Presented Jan. 8th for dental abscess. Severe dental disease present. History of seizures but none lately. He was always a grazer but ate well normally. Never overweight, no history of GI issues. Preop bloodwork showed that Kodah was diabetic, this was not expected. Dental with extensive extractions on Jan. 15th. Sent home on Metacam, Gabapentin, Clavaseptin continued from the 8th. Recheck mouth post dental on Jan. 22nd, (started on 6 IU caninsulin)-Healing well, temp. normal, patient was eating well on Jan. 22 and still eating well on Jan. 27th at check in. Feb.2nd -decreased appetite, vomiting, diarrhea. O has been offering a variety of food to encourage appetite, with intermittent insulin when eating okay. O has cost concerns, Chem 10 and urine stick revealed normal values (except M1 increase in globulins) and no ketones in urine. Treated as gastroenteritis with Tylosin and Cerenia. Applied Libre disc for glucose monitoring. Feb 5th O started Metacam again concern of pain as cause of decreased appetite, added Sulcrate and famotidine & continued Cerenia. Feb. 10th recheck, wasn't eating well the day before but ate well that am. Mouth appears healing well, Temp normal. O declined diagnostics due to eating well in the am. Feb. 12th owner requested diagnostics due to Inappetence again. Looking for pathology to explain decreased appetite & potential cause of diabetes -Chronic pancreatitis? Concern of possible neoplasia

Abnormal PE/Chem/CBC/UA Results: Feb 12th- Chem10, urine stick NSF, no ketones, glucose 14.99 mmol/L. CPL normal. Owners okayed Abd. US. ran stat due to timing of Friday US.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra to a depth of 1.0 cm 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** were normal in size and contour; however, a minor hyperechoic ring was noted at the corticomedullary junction. This is consistent with diabetic nephropathy. This is likely from glucosuria. However, assessment for proteinuria is also warranted. This is an idiopathic finding, but an expected finding in diabetic patients. The left kidney measured 6.7 cm in length. The right kidney measured 6.1 cm in length.

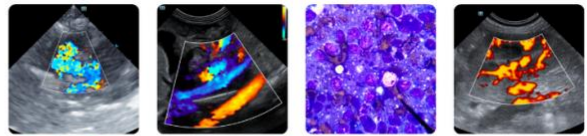
Adrenal Glands

The **left adrenal gland** was visualized and recognized as having normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The left adrenal gland measured 0.68 cm width.

The region of the **right adrenal gland** was imaged with no evident pathology.

Spleen

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes were noted.



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Liver

The **liver** was uniformly swollen. The liver presented coarse architecture with mildly increased portal markings and subtle, mixed echogenic changes. This is consistent with vacuolar hepatopathy and some level of remodeling and history of inflammatory component. There was no overt suspicion of neoplasia. The gallbladder presented with echogenic bile grouping (measured approximately 3.0 cm) and some dependent sand with essentially normal contour. The cystic and common bile ducts were normal. No overt evidence of active inflammatory, infiltrative or regenerative pathology was noted but should be paired with current or past LE elevations regarding any clinical significance to this presentation. The hepatic lymph nodes were unremarkable.

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. Some mild parenchymal remodeling, however, with mild deviation from curvilinear normalcy was observed. Pancreatic duct and capsular irregularities were present consistent with age related changes. If pain upon imaging (+ Murphy sign) was present or if the patient is focally painful in subxiphoid palpation then low-grade smoldering chronic pancreatitis should be suspected.

ULTRASONOGRAPHIC FINDINGS

- Mild hepatic remodeling/hepatopathy.
- Minor diabetic nephropathy.
- Minor gallbladder sand.
- Benign abdomen.

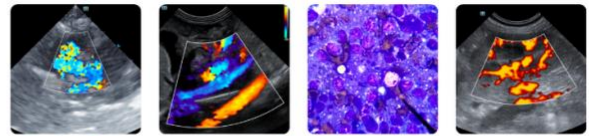
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Ursodiol therapy could be considered empirically yet is highly debatable on effectiveness in this type of presentation.

Potential Causes of Diabetic Dysregulation

This is a suggestive checkoff list when faced with an unregulated diabetic patient:

- UTI
- Dietary indiscretion/intolerance
- Pancreatitis
- Hyperthyroidism/hypothyroidism
- Exogenous steroids (including topical eye meds)
- Cushing's
- Acromegaly
- Owner compliance
- Insulin quality issues
- Antibodies to insulin



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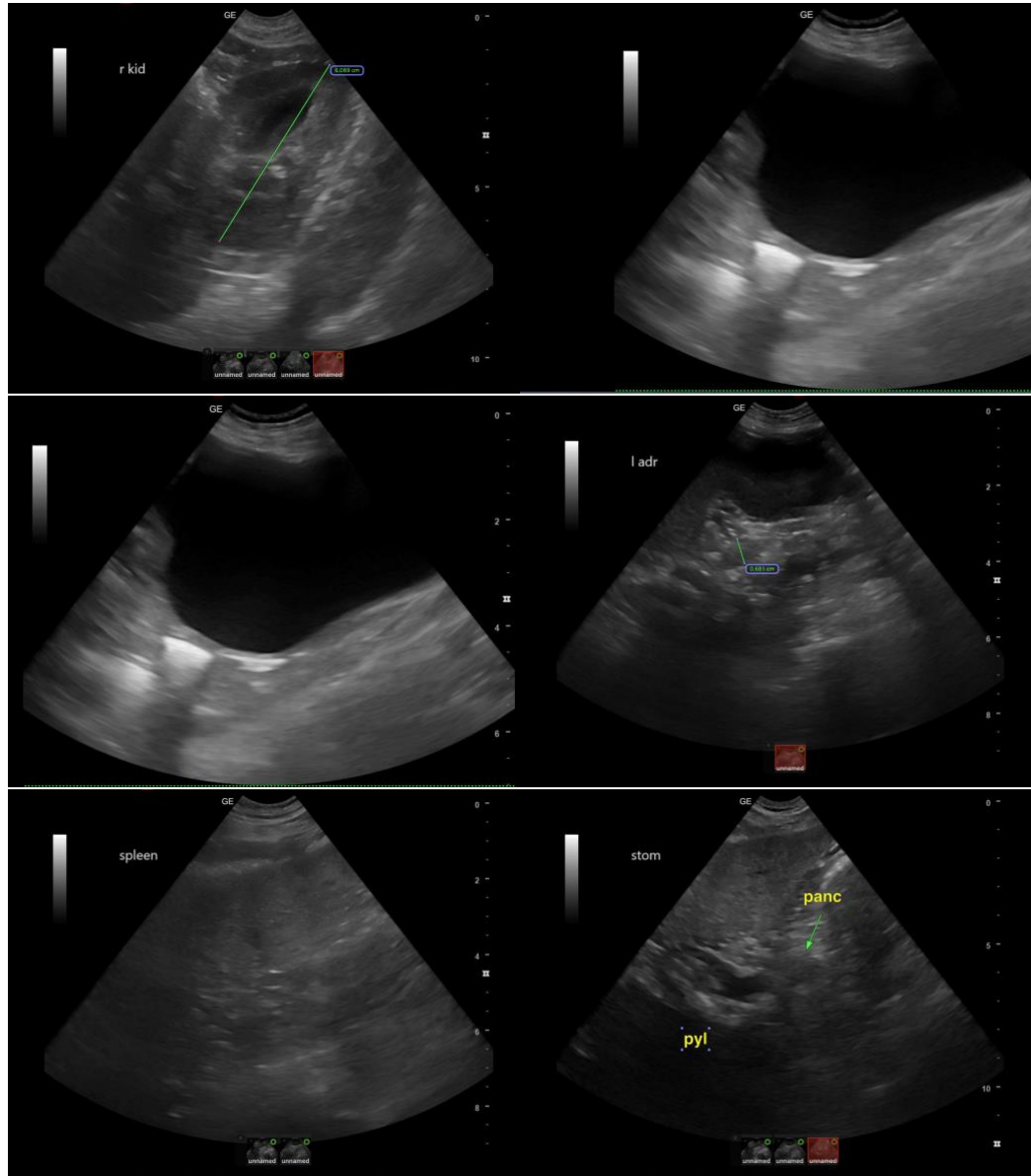
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- Underlying Neoplasia
- Diffuse liver disease

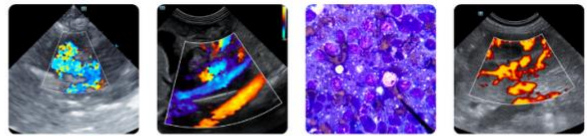


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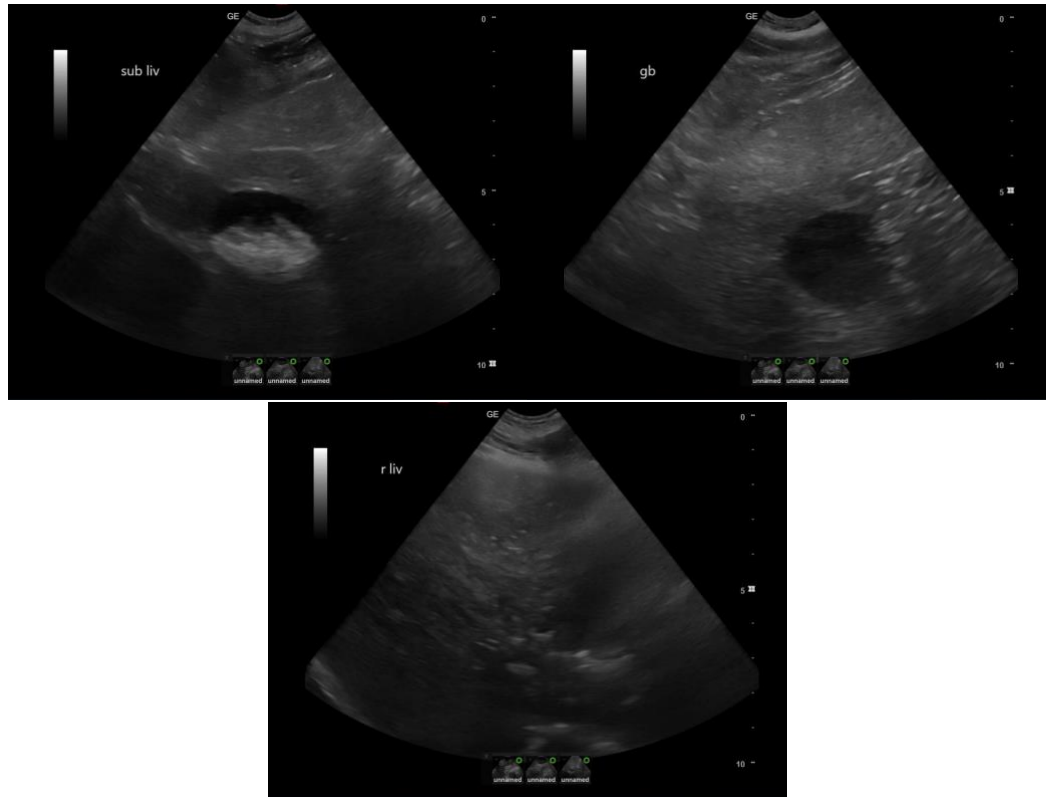
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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,

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