

**DATE**

05/18/26

**PATIENT**

Kipper Koerber

**SPECIES**

Canine

**BREED**

Pomeranian

**SEX**

Neutered Male

**AGE**

04/30/12

**WEIGHT**

11 lbs

**INTERPRETED BY**
 Eric Lindquist, DMV,  
 DABVP(CFM), Cert.  
 IVUSS
**HOSPITAL NAME**
 Chadwell Animal  
 Hospital
**REFERRING VET**

Dr. Mengers

**INVOICE**

16350

**PRESENTING CLINICAL SIGNS**

Patient History: Presented 5/15/26 for soft stool, diarrhea x 1 day, inappetence x 2 months. Hx of Cushing's dz (currently treated w/ Trilostane), grade IV/VI HM, szs, gastritis, hypothyroidism, ITP (2 yrs ago, currently in remission), low grade STS on RF leg (completely excised in 2022, suggestive of a perivascular wall tumor or a peripheral nerve sheath tumor). Stopped pred 1-2 mths ago d/t elevated LEs (much improved but still elevated once pred stopped) and heart dz. On PE, cataracts, bilat MPLs, grade IV/VI HM, mod muscle wasting, anal glands full but rectal exam otherwise normal. O notes has been limping on RF leg for the past 3 yrs but seems worse recently.

Current Medications: Vetmedin 1.25mg - 1.5 tab PO q12h, metronidazole 50mg - 1 tab PO q12h x 7 days (started 5/15), proviable - 1 cap over food q24h x 15 days (started 5/15), maropitant 16mg - 1 tab PO q24h PRN for nausea, trilostane 20mg - 1 cap PO q12h, capromorelin 30mg/ml - 0.5ml PO q24h (switched onto on 5/15 from mirtazipine 15mg 1/4 tab PO q24h), gabapentin 25mg - 2 tab PO q8-12h, cosequin  
 Labwork Results: labwork attached, reported as: 5/5/26 - ACTH Stim: pre 3.57, post 5.38. 4/7/26 - CBC/CHEM/T4 RBC 6.65, hct 42.5%, plts 344k, ALP 427 (prev 754 on 2/26/26 - much improved off of pred), T4 2.1.

Date of Previous IntraPet Ultrasound: 12/23/24. See attached.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

Imaging Performed by: Stephanie Warga RDCS, RVT.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN****Urinary System**

The **urinary bladder** revealed a slight calculus measuring 0.23 cm and appears nonobstructive. The bladder itself was unremarkable.

The residual prostate was uniform measuring 0.9 cm.

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 his age patient. Medullary structure differed distinctly from that of the cortex. Dystrophic mineralization was noted and non-obstructive at this time. The left kidney measured 3.61 cm in length. The right kidney measured 4.21 cm in length.

**Adrenal Glands**

The **left adrenal gland** was slight enlarged at the cranial pole measuring 2.0 cm x 0.75 cm width at the cranial pole and 0.51 cm width at the caudal pole.

The **right adrenal gland** was persistently heterogenous yet measurably similar to the prior sonogram measuring 2.1 cm x 0.7 cm width at the caudal pole and 0.63 cm width at the cranial pole.

**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.

### **Liver**

The **liver** images from right and left intercostal as well as subcostal views revealed subjectively normal liver size, contour, and structure. Some minor age-related parenchymal remodeling was noted but likely not clinically significant at this time. Vascular and biliary tracts were of normal volume and no evidence of congestion was noted. 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. Minor striating bile was noted in the gallbladder yet not to the level of mucocele formation with minor over distention.

### **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**

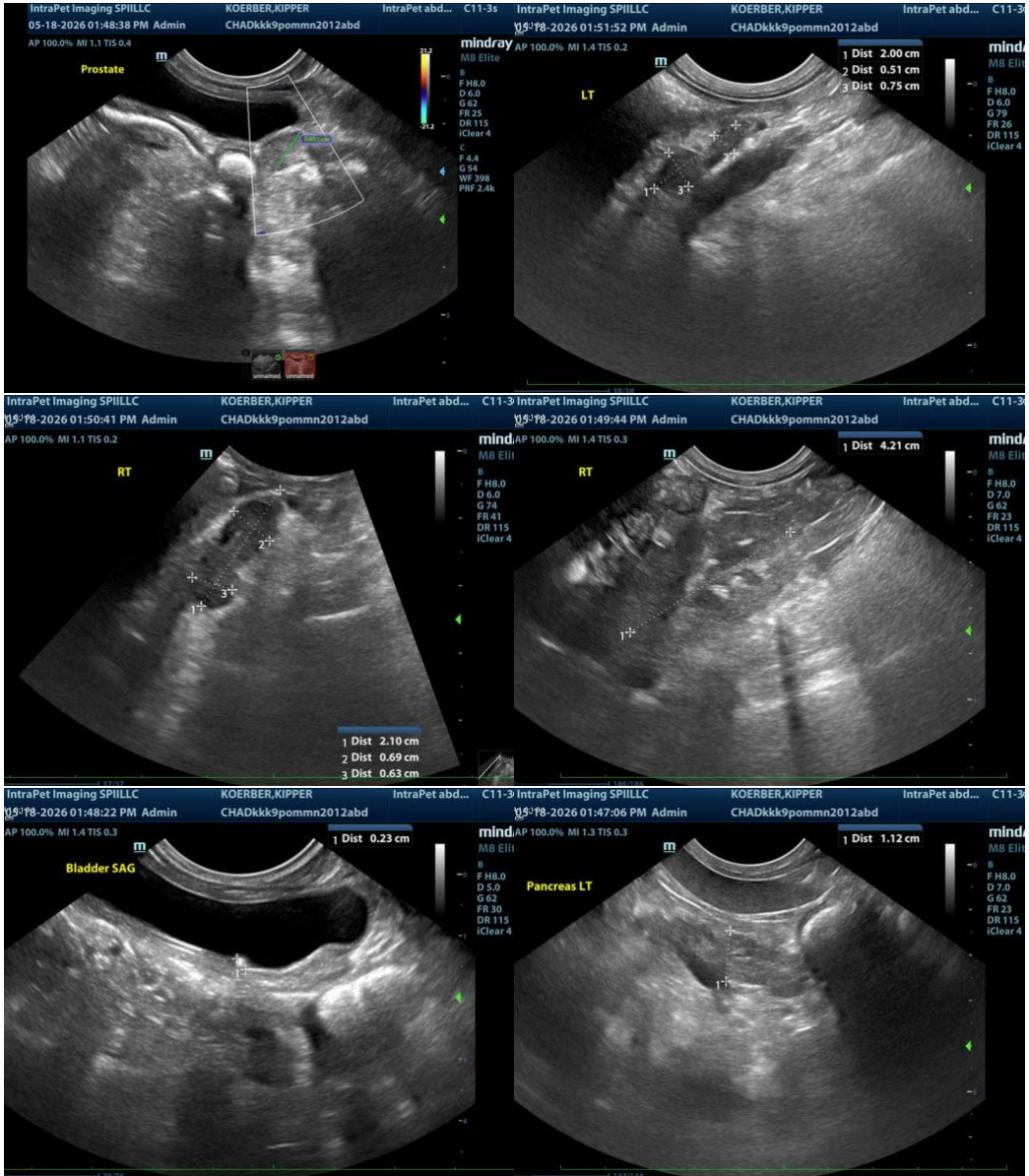
The **pancreas** presented hypoechoic and irregular with enhanced surrounding mesentery and undulating contour measuring 1.12 cm. Both the right and left limbs of the pancreas were enlarged and irregular. Some level of low-grade pancreatitis is possible. Subxiphoid palpation is recommended to assess if there is any pain or discomfort.

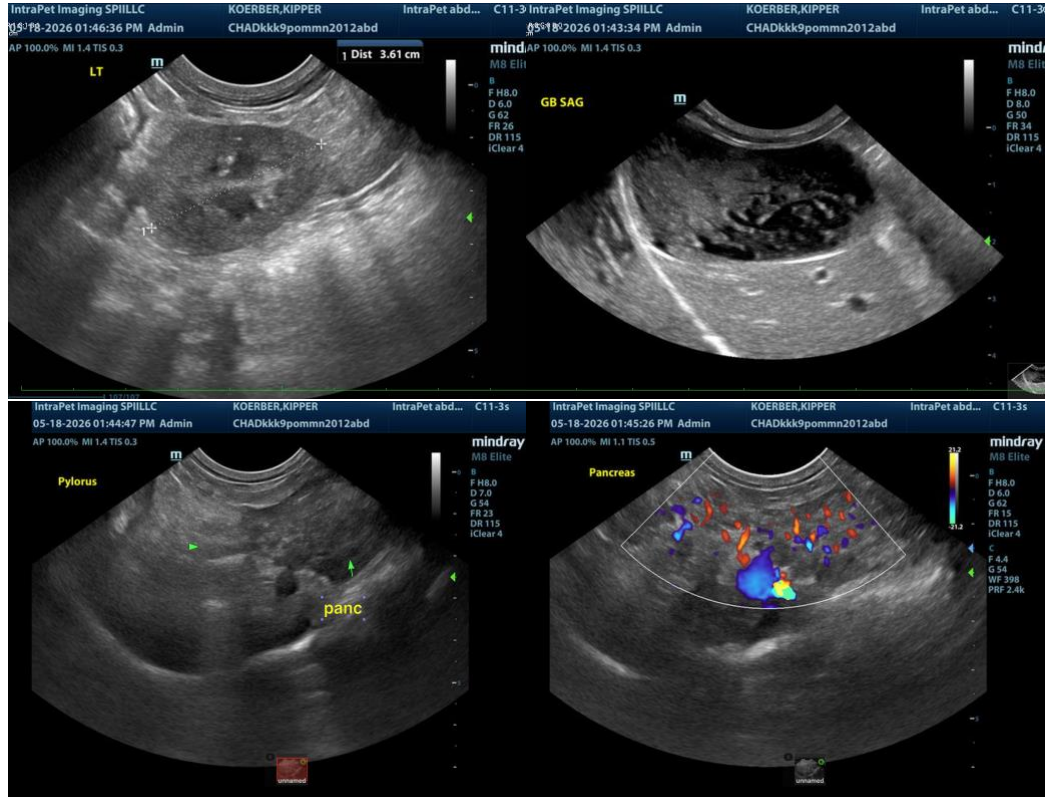
## **ULTRASONOGRAPHIC FINDINGS**

- Chronic pancreatic changes with enhanced vascularity suggests for chronic active inflammation.
- Minor age-related renal changes with mineralization.
- Slight urinary bladder calculus- nonobstructive.
- Heterogenous right adrenal gland.
- Enlarged left adrenal gland.
- Striating gallbladder bile.
- Age-related hepatic remodeling.

## **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Recommend Ursodiol therapy in this patient if any clinical signs consistent with pancreatitis. Recommend outpatient management with diet change and supportive care. Recheck sonogram in six to eight weeks of the pancreas and gallbladder. Broad spectrum antibiotic protocol may be warranted regarding the pancreatic presentation, given the clinical history. No evidence of adrenal mass is noted therefore the cushingoid status is likely owing to pituitary dependent source.





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, Owner, Founder -- SonoPath.com

[info@SonoPath.com](mailto:info@SonoPath.com)