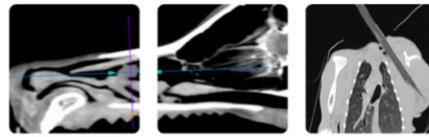

PATIENT
Nico Hardy

SPECIES
Canine

BREED
Pitbull Mix

SEX
Neutered Male

AGE
14 Years

WEIGHT
69.5

INTERPRETED BY
Heike Rudorf, DVM, Dr. med. Vet., DipECVDI DVR

IMAGING PERFORMED BY
ERG

HOSPITAL NAME
DTLAVets

REFERRING VET
Dr. Flores

INVOICE
16456

DATE
05/22/26

PRESENTING CLINICAL SIGNS

Nico presents for new intermittent regurgitation (noted after lying down) and chronic vomiting/grass ingestion. Regurgitation began after starting Dasuquin one month ago; owner discontinued it one week ago with improvement. Yesterday he was hyporexic, vomited twice, refused kibble but tolerated chicken/rice before vomiting again. Vomited water overnight.

History includes MCT, soft tissue sarcoma (grade I, excised), and multiple SQ masses. Diet: Taste of the Wild; recent new bison treats (stopped). On Simparica Trio.

Exam: Appears nauseous, uncomfortable in lateral recumbency. Multiple SQ/skin masses. New suspected bladder mass. QPL elevated (248).

Radiographs: VHS 11, mild dorsal tracheal deviation, small liver, no masses or effusion. Abd US: small liver, mild GB sludge, 8mm splenic hypoechoic nodule, mild renal mineralization, 2.5 × 0.9 cm irregular bladder mass on dorsal wall. GI layering normal; no free fluid; pancreas not visualized; discomfort in R cranial abdomen.

Impression: Regurgitation (improved off Dasuquin), chronic vomiting, small liver, splenic nodule (regen vs neoplastic), bladder mass (TCC vs benign vs clot).

Plan: Cerenia, omeprazole, gabapentin; recommend full imaging review and further GI evaluation.

RADIOGRAPHIC STUDY OF THORAX AND ABDOMEN

R/L lateral and VD, totaling 10 radiographs provided for interpretation.

21.05.2026

RADIOGRAPHIC FINDINGS

The body condition score is 7/9 with smooth, alternating layers of fat and soft tissue opacity.

Lumbar spondylosis is present.

Thorax

The cranial mediastinum is of physiological size and opacity. The trachea diverges slightly from the thoracic vertebrae dips at the carina.

The cardiac silhouette is slightly raised from the sternum by fat. It occupies 75% of the chest height and 3 intercostal spaces (VHS 11). Chamber or outflow tract enlargement is not obvious.

The lung lobes extend to the thoracic boundaries. Pulmonary vessels are visible to the tertiary branches. The bronchial tree is thin walled and tapers towards the periphery.

Abdomen

The abdominal organs are surrounded by fat; diaphragm and abdominal wall are intact.

The liver is located well within the costal arch.

The head of the spleen appears physiological.

The gastric axis runs physiologically and parallel to the ribs. The stomach contains a small amount of air. Distribution and size of the small intestinal loops appear physiological. The desc. colon contains a small amount of unformed fecal matter.

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Both renal shadows have a physiological size and opacity. The bladder contains a small to moderate amount of fluid and the bladder neck is located cranial to the pubic brim. The ventral bladder outline bulges persistently.

A prostatic shadow is not obvious

The sublumbar region appears physiological.

RADIOGRAPHIC DIAGNOSIS

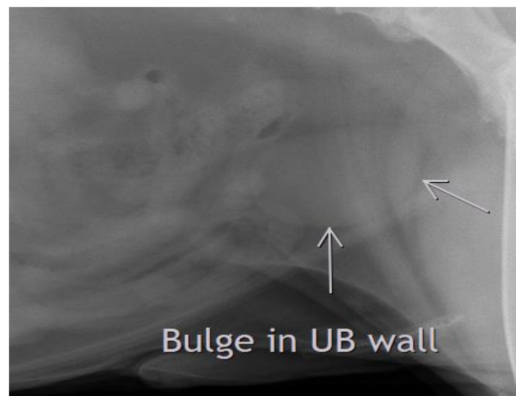
- Mildly altered bladder shape

Incidental finding

- Spondylosis

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Parallelity of gastric axis and ribs indicate a physiological liver size. The slightly altered shape of the bladder could be due to a reduced filling or may be caused by a ventral displacement of the urine in case of a bladder tumor. A VHS of 11 is physiological for the breed. Regurgitation on lying down could be due to incompetence of the lower esophageal sphincter. Occasional hiatal hernias can occur in Pit bulls. Esophagoscopy is recommended to identify a focal inflammation due to the gastric reflux.



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.

Heike Rudorf, DVM, Dr. med. vet., DipECVDI, DVR
info@sonopath.com