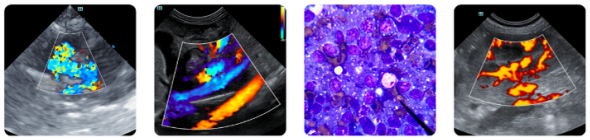


PATIENT

Bandit Clark

SPECIES

Canine

BREED

Cardigan Corgi

SEX

Male

AGE

11 years 7 months

WEIGHT

35.2 lbs

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Dr. Lucas Budden

HOSPITAL NAME

Frontier Veterinary Hospital

REFERRING VET

Dr. Lucas Budden

INVOICE

10743

DATE

11/13/2025

PRESENTING CLINICAL SIGNS

Clinical signs: Chronic ALT elevation, hyporexia History: Chronic ALT elevation since 3 years of age and has been stable. Sibling dog passed away last month and has been hyporexic since then. Ultrasound to assess ALT elevation and cause of hyporexia. Current medications: Butorphanol to facilitate ultrasound.

Abnormal PE/Chem/CBC/UA Results: Physical exam: BCS 8/9, severe dental calculus, new grade 2/6 left systolic HM, moderately tense/reactive to abdominal palpation (more wiggly/reactive when imaging cranial right abdomen) Lab work: UA/culture pending Senior panel 11/7/25 ALT high to 36 BUN high 41 Creatinine high 1.7 SDMA high 18.5 Precision PSL high 170 Hematocrit high 67% Remainder of CBC/Chem normal Thyroid normal 3 Accu Plex all negative Free catch urine USG 1.024 Protein 3+ White blood cell 4-10 RBC 0-1 Squamous epithelia 0-1 Sperm noted Fecal negative.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The prostate is large (4.05 cm x 5.02 cm in the sagittal view), hyperechoic, and mottled. There are numerous, poorly defined hypoechoic cystic lesions. An example of which measures 0.61 cm x 0.86 cm.

The left kidney has a normal shape and size (5.74 cm). The cortex is of increased echogenicity with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (5.94 cm). The cortex is of increased echogenicity with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

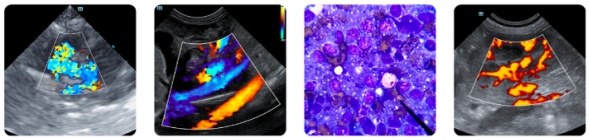
Adrenal Glands

The left adrenal gland is normal in size measuring 0.73 cm at the cranial pole and 0.77 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.65 cm at the caudal pole. The cranial pole is not clearly visualized. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size (1.6 cm) and the echotexture is homogenous. The splenic capsule is smooth with no visible irregularities. The blood flow through the hilus and splenic parenchyma appears normal.



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Liver

The liver is normal in size, and normal in echogenicity with smooth peripheral margins. The parenchyma is mildly heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.7cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. 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. The duodenum measured as normal (0.54 cm in wall thickness) and the jejunum measured as normal (0.36 cm.) Visualized peristalsis appears appropriate. 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.

Pancreas

The pancreas is prominent and hypoechoic in the left limb. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity revealed scant free fluid. There is no lymphadenopathy. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

Other

Both testicles are visualized and appear within normal limits.

ULTRASONOGRAPHIC FINDINGS

- Large, hyperechoic, mottled prostate with small cystic lesions. Findings are most consistent with benign prostatic hypertrophy +/- prostatitis +/- prostatic cysts/abscesses.
- Age related changes visualized associated with both kidneys.
- Pancreatic changes most consistent with chronic pancreatic remodeling +/- chronic pancreatitis.

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- Mildly heterogenous liver. The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, infiltrative neoplasia (less likely) or other hepatopathy.

- Moderate gallbladder debris. The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting but seems unlikely to be causing a current issue. Recommend continued monitoring.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The prostate is large and hyperechoic as would be expected in a mature, intact male dog. Correlate these findings with a urinalysis and culture looking for any evidence of active prostatitis. If this is suspected, then recommend neutering and long-term antibiotic treatment based on culture and sensitivity results.

Both kidneys have changes consistent with chronic renal disease. This is reflected bby the azotemia and isosthenuric urine reported. Recommend the aforementioned urine culture, urinalysis and a blood pressure evaluation (+/- urine protein-creatinine ratio.)

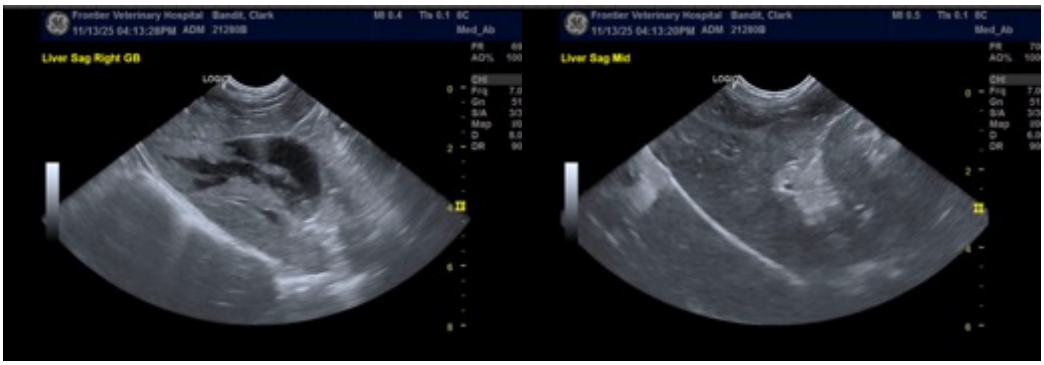
The left limb of the pancreas is visible/mildly mottled. Given the high PSL level, empirical treatment for pancreatitis may be warranted.

No focal lesions are visualized associated with the liver to explain the elevation in ALT reported. Recommend pre- and post-prandial bile acids to assess liver function and consider a biopsy of the liver with samples for histopathology, culture, and copper levels (particularly if liver function is abnormal.)

The gallbladder has a moderate to large amount of debris with no evidence of significant wall thickening or inflammation. Consider chronic ursodiol therapy and continued monitoring of the gallbladder for progression of these lesions.

Although there are several non-specific changes described, keep in mind that underlying gastrointestinal disease cannot be definitively ruled out as sometimes this can produce minimal ultrasonographic changes. If this is a concern, consider a GI Panel to Texas A&M for a qualitative PLI/TLI, cobalamin, and folate looking for supportive evidence of possible gastrointestinal disease which may require further workup.

Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.



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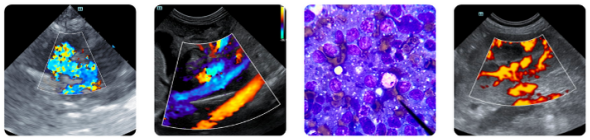

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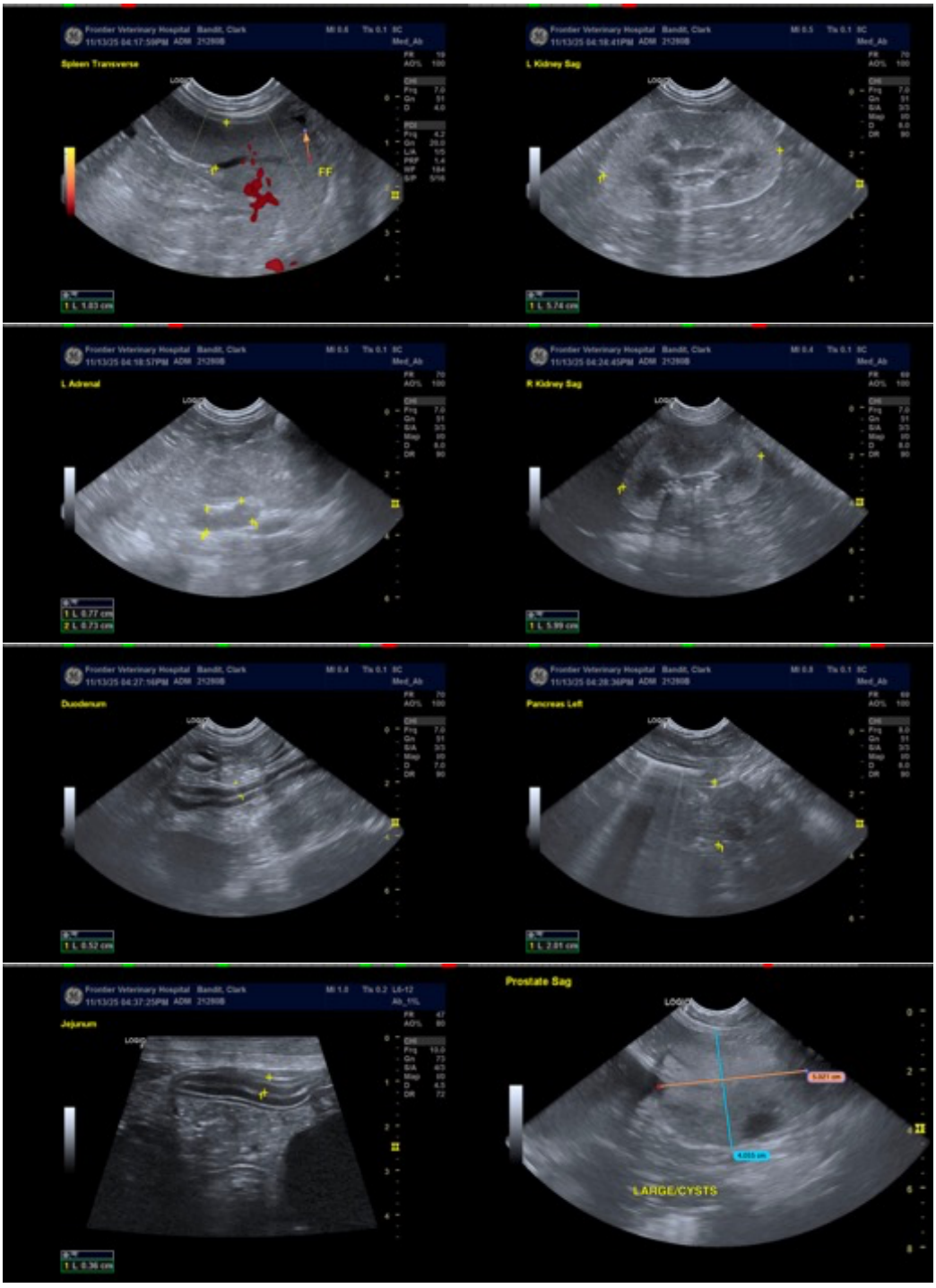

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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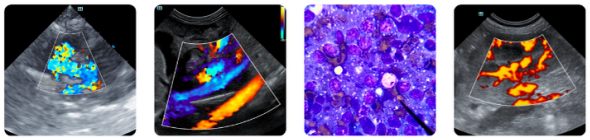

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Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)

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