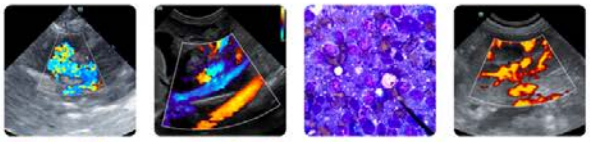


PATIENT

Kahne Kirk

SPECIES

Canine

BREED

Labrador x

SEX

Neutered Male

AGE

8 Years

WEIGHT

25 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Melissa Randolph

HOSPITAL NAME

Shores Veterinary Emergency Center

REFERRING VET

Dr. Logan Law

INVOICE

71968

DATE

11/20/25

PRESENTING CLINICAL SIGNS

Presented for increased thirst, vomiting, pacing. P at rDVM 11/19 for Cushings test. O picked up around 5 pm. P drank a 2 gallon tub of water, went outside, vomited then drank another gallon of water, vomited again. P laying out in the yard which is unusual for him. P wouldn't eat tonight, seemed disoriented, stumbling. History of diabetes and cushings for 9 months, hypothyroid for 2 years. medications are Novolin 22 units BID, Levothyroxine, Vetoryl. *concern for Diabetic ketosis - r/o diabetic ketoacidosis, insulin dysregulation, stress-induced hyperglycemia; Dehydration - r/o diabetes-related polyuria, vomiting, inadequate fluid retention; hyperosmolar syndrome

Abnormal PE/Chem/CBC/UA Results: *PE: multiple subcutaneous masses of various sizes *cbc: wbc 21.83 H, neu 18.75 H, mono 1.90 H, ct 68.5% H, hgb 21.9 Hm rbc 9.36 H *epoc: TCO2 16.8 L *chem: BUN 50.6 H, phos 7.8 H, globulin 4.0 H, glucose > 600 H, cholesterol 367 H, ALT 224 H, ALP 467 H *u/a: ketone 5, protein 1+ 30, glucose 500, pH 5.0, occult blood + 10 hemolyzed, usg 1.040, leukocytes negative; urine sediment: unremarkable *rads: normal abdomen; definitive structural cause for the reported clinical signs is not identified *11/20 4 am: pH 7.343 L, sodium 169 H, k+ 3.3 L, Cl 135 H, lactate 6.19 H, BUN 40 H, creatinine 1.74 H, hct 62% H *11/20 10:30 am: sodium 164 H, Cl 130 H, BUN 24, creatinine 0.90, hct 51%

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 visualized areas of prostate and surrounding tissue appear normal. Unfortunately, the prostate is not fully visualized likely due to its intrapelvic location. Correlate with rectal exam findings.

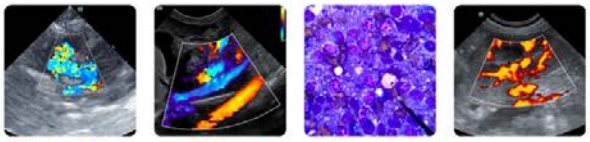
The left kidney has a normal shape and size (7.56 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (6.85 cm). Overall echogenicity is slightly hyperechoic 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 large, measuring 0.92 cm at the cranial pole and 0.94 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 large, measuring 0.63 cm at the cranial pole and 0.85 cm at the caudal pole. 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.



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Spleen

The spleen is subjectively normal in size (1.73 cm), echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. 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. Luminal contents are mild and likely incidental at this time. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains a large amount of gas. 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. Gas artifact interferes with full evaluation of the stomach and some areas of the cranial abdomen.

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. Duodenum wall measures 0.48 cm. Jejunum wall measures 0.32 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 right limb of the pancreas is prominent and hypoechoic as compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is mild mesenteric inflammation in the region.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or significant lymphadenopathy. There is some mid abdominal inflammation in the region of the caudal aspect of the right limb of the pancreas.

ULTRASONOGRAPHIC FINDINGS

- Bilateral adrenomegaly – Findings are most consistent with a current diagnosis of pituitary dependent hyperadrenocorticism.
- Age related changes visualized associated with both kidneys.
- Prominent, hypoechoic right limb of the pancreas with surrounding reactive mesentery – Findings could be consistent with mild pancreatitis.

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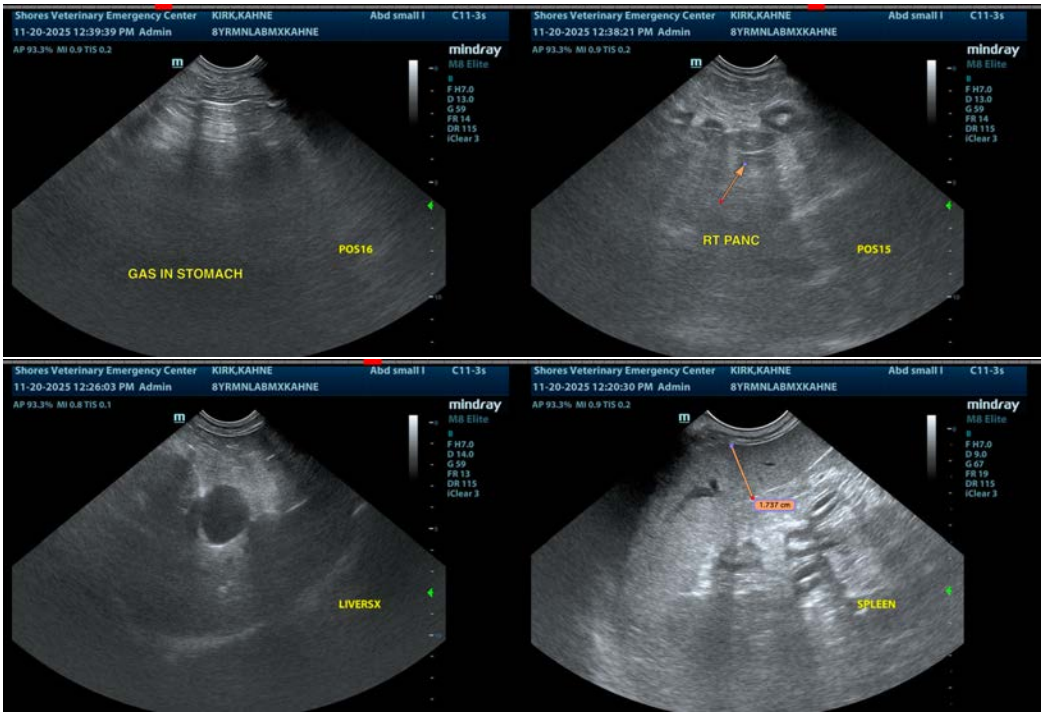
- Heterogeneous liver – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy.

- Moderately distended stomach with significant gas artifact – Findings are most consistent with a panting patient.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Many of the changes described on today's exam would be expected in a patient with diabetes and Cushing's disease (large adrenals, large heterogeneous liver, etc.). There is some mid abdominal inflammation, which could be associated with the caudal aspect of the right limb of the pancreas. An unseen bowel lesion or similar in this region cannot be ruled out. Based on the history provided, hyperosmolar syndrome sounds most likely. Recommend concurrent treatment for pancreatitis with gradual rehydration and normalization of electrolytes. If the patient is not improving as would be expected, consider repeat imaging, looking for the development of new lesions or the progression of today's lesions.



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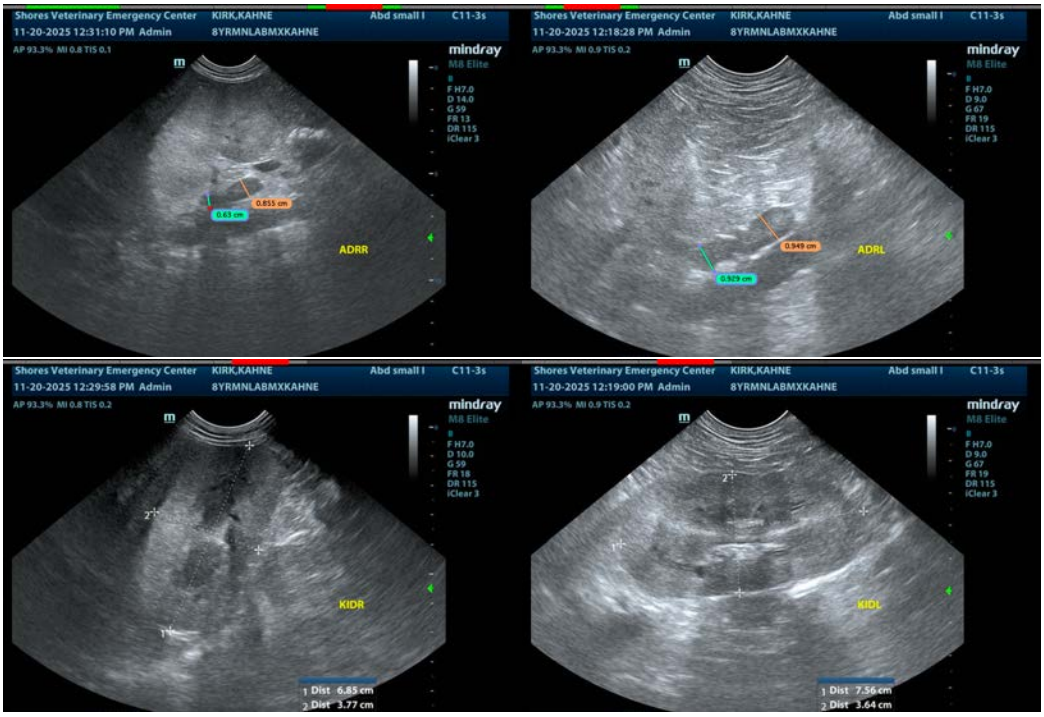

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

info@sonopath.com