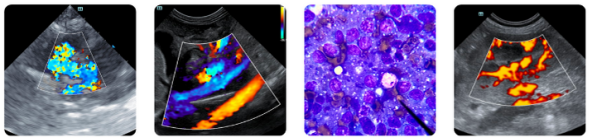


PATIENT

Roxy Gunnels

SPECIES

Canine

BREED

Mixed

SEX

Spayed Female

AGE

14 years

WEIGHT

14.6 kgs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Maria Lara

HOSPITAL NAME

Allure Veterinary Hospital & Urgent Care

REFERRING VET

Dr. Brandy Catton

INVOICE

11702

DATE

4/15/2026

PRESENTING CLINICAL SIGNS

Owner reports Roxie was diagnosed with vestibular disease yesterday (4/14) and still has nystagmus, head tilt, and circling. She is very out of it, has difficulty walking, and has been unusually still/calm. Not eating and not drinking; vomited 2–3 times since yesterday (late last night and early this morning). Concern for dehydration. Urinated just earlier today after well over a day without urination. Previously was drinking a lot of water (reason for initial visit of 4/14). Patient was prescruved: Enrofloxacin (sent home yesterday) — owner unable to administer due to vomiting/refusal. Cerenia (sent home yesterday) — owner unable to administer due to vomiting/refusal. Gabapentin — usually given but has not been given since yesterday due to inability to administer. Rimadyl -- usually given, but has not been given since yesterday due to inability to administer.

Abnormal PE/Chem/CBC/UA Results: WBC 3.34 - 5.05 - 16.76 K/µL L Neutrophils 2.34 - 2.95 - 11.64 K/µL L Lymphocytes 0.64 - 1.05 - 5.10 K/µL L Eosinophils 0.02 - 0.06 - 1.23 K/µL L UA Urine Protein 500 mg/dL Urine Blood / Hemoglobin 250 Ery/µL Hyaline Casts >1 /LPF Non-Hyaline Casts >1 /LPF Cortisol -Resting 4.21 µg/dL.

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 left kidney has a normal shape and size (5.46 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 (5.71 cm). Overall echogenicity is slightly hyperechoic with mildly decreased 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.

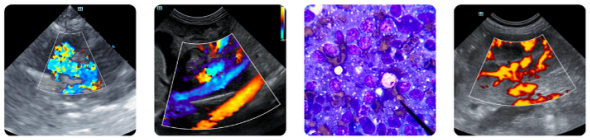
Adrenal Glands

There is a hypoechoic structure visualized in the region of the left adrenal, most consistent with the caudal pole of the left adrenal, which is enlarged measuring 0.86 cm. The cranial pole is not clearly visualized. No evidence of vascular invasion is visualized.

The right adrenal gland is normal in size measuring 0.71 cm at the cranial pole and 0.74 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.

Spleen

The spleen is subjectively normal in size (1.7 cm in width at the level of the hilus) and the echotexture is homogenous. The splenic capsule is smooth with no visible irregularities. Rare discrete focal hyperechoic, perivascular parenchymal abnormalities are present. The appearance of these lesions is



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most consistent with benign splenic myelolipomas. The blood flow through the hilus and splenic parenchyma appears normal.

Liver

The liver is large in size, and normal in echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. There are too numerous to count, ill-defined hypoechoic nodules visualized within the parenchyma.

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 mild fluid. The gastric wall is prominent measuring 0.51 cm with a prominent/thickened muscularis layer. 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 (between 0.3-0.5cm in wall thickness) and the jejunum measured as normal (0.3 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 normal and isoechoic to surrounding mesentery. 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 did not reveal any evidence of effusion, or subjective lymphadenomegaly. 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.

ULTRASONOGRAPHIC FINDINGS

- Age related changes visualized associated with both kidneys.
- Large caudal pole of the left adrenal. Findings could be consistent with hyperplasia and adenoma, other.
- Large heterogenous liver with ill-defined hypoechoic nodules. 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. The nodules observed trend toward a more benign process, but underlying neoplasia cannot be ruled out.

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- 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.
- Prominent gastric wall with a prominent muscularis layer. Findings could be normal for this individual or consistent with mild gastritis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

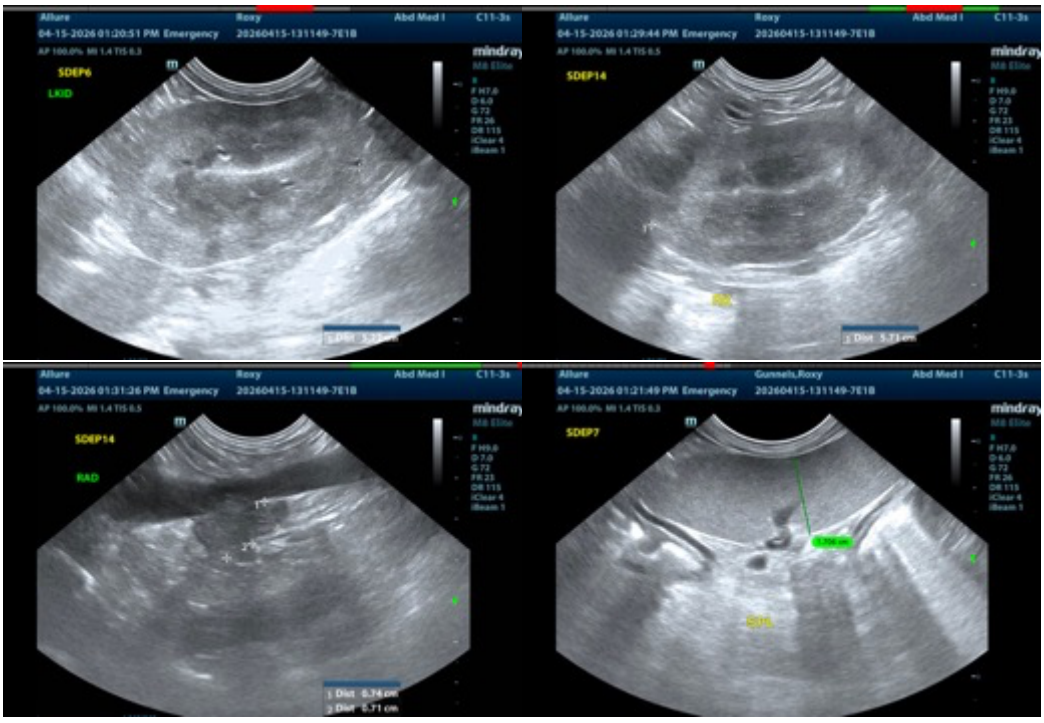
The liver is large and heterogenous with numerous ill-defined hypoechoic nodules. This appearance is most consistent with a vacuolar hepatopathy with regenerative nodules although other differentials are possible. You could consider a fine needle aspirate to further evaluate.

There are age related changes visualized associated with both kidneys. Correlate with a urinalysis for urine concentrating ability and a blood pressure evaluation.

The left adrenal is difficult to visualize in its entirety. There is a structure most consistent with the caudal pole visualized. This is enlarged and could be consistent with a nodule/adenoma, etc. If symptoms consistent with Cushing's disease are present. You could consider adrenal function testing. Recommend close continued monitoring of the adrenal with ultrasound looking for progressive enlargement as an aggressive neoplastic lesion could be a differential (recheck in 2-3 months.)

Recommend aggressive supportive care for this geriatric patient (including possible fluid therapy, subQ? Injectable nausea medications, etc.) in hopes that the vestibular signs will improve over time.

If there are concerns for central vestibular disease, consider consultation with a veterinary neurologist for additional recommendations.



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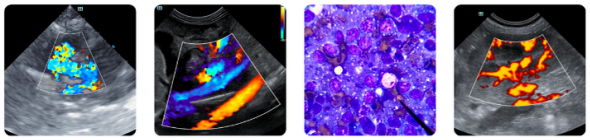

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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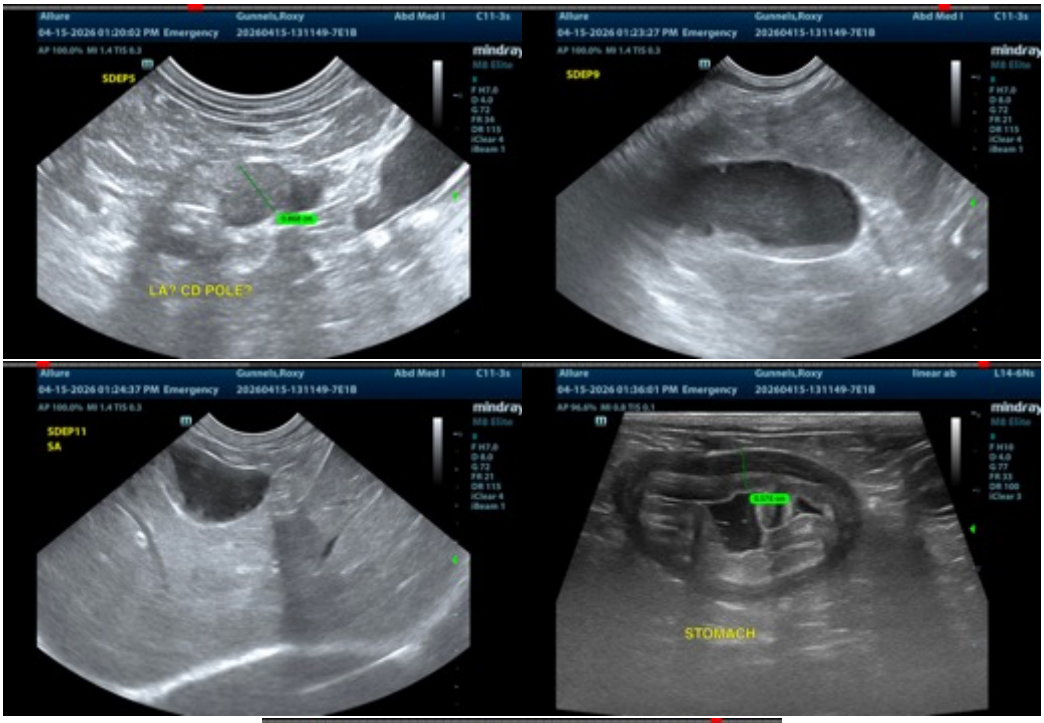

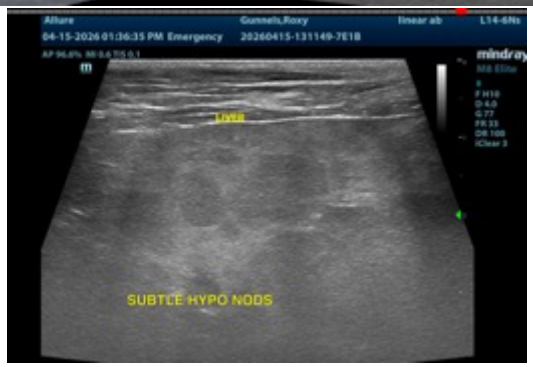

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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