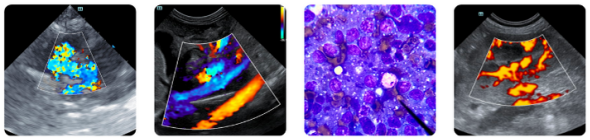


PATIENT

Milo Leppala

SPECIES

Canine

BREED

Pomeranian

SEX

MN

AGE

13 years

WEIGHT

7 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Julia Bakker

HOSPITAL NAME

Orange Blossom Veterinary Imaging

REFERRING VET

Dr. Ashley Sorice

INVOICE

11930

DATE

5/12/2026

PRESENTING CLINICAL SIGNS

Milo hasn't been able to keep solids down for 2-3 days, but able to keep down water and beef broth. He was vomiting intermittingly prior to this and client thought the food was the culprit; switching to Farmer's Dog on Thursday. Yesterday pt appeared weak, and keeps falling down today and walking in circles when he does get up. NO coughing, sneezing, pu/pd. Full body radiographs of chest and abd unremarkable.

Abnormal PE/Chem/CBC/UA Results: Cbc/Chem: Platelets 90 148 - 484 K/µL L - manual count confirms value with no clumps. Glucose 48 70 - 143 mg/dL L BUN 5 7 - 27 mg/dL L Albumin 2.1 2.2 - 3.9 g/dL L ALT 786 10 - 125 U/L H ALP 1,978 23 - 212 U/L H GGT 23 0 - 11 U/L H Bilirubin - Total 2.6 0.0 - 0.9 mg/dL H.

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 (3.76 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. Contains small pinpoint nephroliths. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.79 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

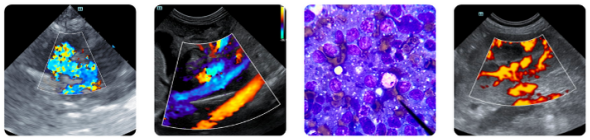
The left adrenal gland is normal in size measuring 0.33 cm at the cranial pole and 0.73 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.52 cm at the cranial pole and 0.66 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 (1.14 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. No focal parenchymal abnormalities are visualized.

Liver



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The liver is subjectively normal in size and irregular in shape. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. There is a somewhat subtle, focal, mottled/slightly hyperechoic mass effect visualized in the left side of the liver measuring 3.34 cm x 2.59 cm.

The gall bladder lumen is moderately distended. The wall of the gall bladder is thickened measuring at 0.25 cm. There is a moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach is moderately dilated with large fluid and irregular shadowing material most consistent with normal ingesta and 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 layering is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum (0.4 cm), jejunum (0.36 cm) and ileum have a uniform diameter with minimal fluid distension. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. 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 large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with mild pancreatitis in both limbs.

Free Abdomen

Evaluation of the peritoneal cavity revealed a small amount of free fluid. There is no evidence of a severe lymphadenopathy. There are occasional prominent lymph nodes. A large hypoechoic lymph node is visualized in the cranial abdomen measuring 0.98 cm x 1.48 cm. The omentum is diffusely hyperechoic.

ULTRASONOGRAPHIC FINDINGS

- Age related changes visualized associated with both kidneys.
- Pancreatic changes most consistent with pancreatic remodeling and chronic active pancreatitis.
- Irregular liver with a heterogenous, rounded area most concerning for a mass effect in the left side. Possible differentials include anatomic variation, adenoma, carcinoma, other.
- Thickened gallbladder wall. Appears to be consistent with edema or cholecystitis. Neoplastic infiltration cannot be ruled out.
- Large, fluid distended stomach. Correlate with the feeding/drinking history. Findings are likely consistent with severe gastric ileus. No evidence of an outflow tract obstruction is visualized but a small partial lesion cannot be ruled out.
- Diffusely thickened small intestine. The mild small intestinal wall changes may be a normal

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variant in this patient or could be consistent with an inflammatory process (e.g., inflammatory bowel disease).

- Prominent cranial abdominal lymph node. Findings are most consistent with a highly reactive or early neoplastic lymph nodes.
- Free abdominal fluid. Recommend fluid analysis and cytology.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The liver appears somewhat irregular in shape with a focal rounded area which is heterogenous, concerning for a poorly defined mass effect on the left side. Consider fine needle aspirate of the mass effect for cytologic evaluation (provided coagulation parameters are normal.)

Both limbs of the pancreas (the left in particular) are prominent and hypoechoic, concerning for active pancreatitis. Correlate with a PLI level and consider empirical treatment for pancreatitis.

The gallbladder has some moderate debris and the wall is thickened. Given the fluid, edema would be a concern, although mild cholecystitis is also possible.

The small intestine appears mildly thickened with intact wall layering. These changes are concerning for significant inflammatory type change. Although early neoplastic change cannot be ruled out. Consider the following:

- Recommend a urinalysis and a urine protein-creatinine ratio to look for evidence of urine protein loss.
- Recommend a GI Panel to Texas A&M for a qualitative PLI/TLI, cobalamin, and folate to further evaluate the pancreatitis and look for evidence of underlying small intestinal disease.

Depending on the nature of the free abdominal fluid, this could be secondary to hepatic disfunction. You can see hypoglycemia secondary to large hepatic mass lesions. Ideally, recommend a contrast CT scan to further evaluate the liver mass effect to better determine if surgical removal is an option/recommended. Consider and insulin glucose ratio when the blood glucose levels are between 40 and 60 looking for any evidence of an insulinoma or insulin secreting tumor.

There's a significant amount of fluid distension of the stomach. Possibly consistent with ileus secondary to pancreatitis or similar. You could consider pro-motility medication and/or a nasogastric tube to empty the stomach and trickle feed until the patient is feeling better.

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

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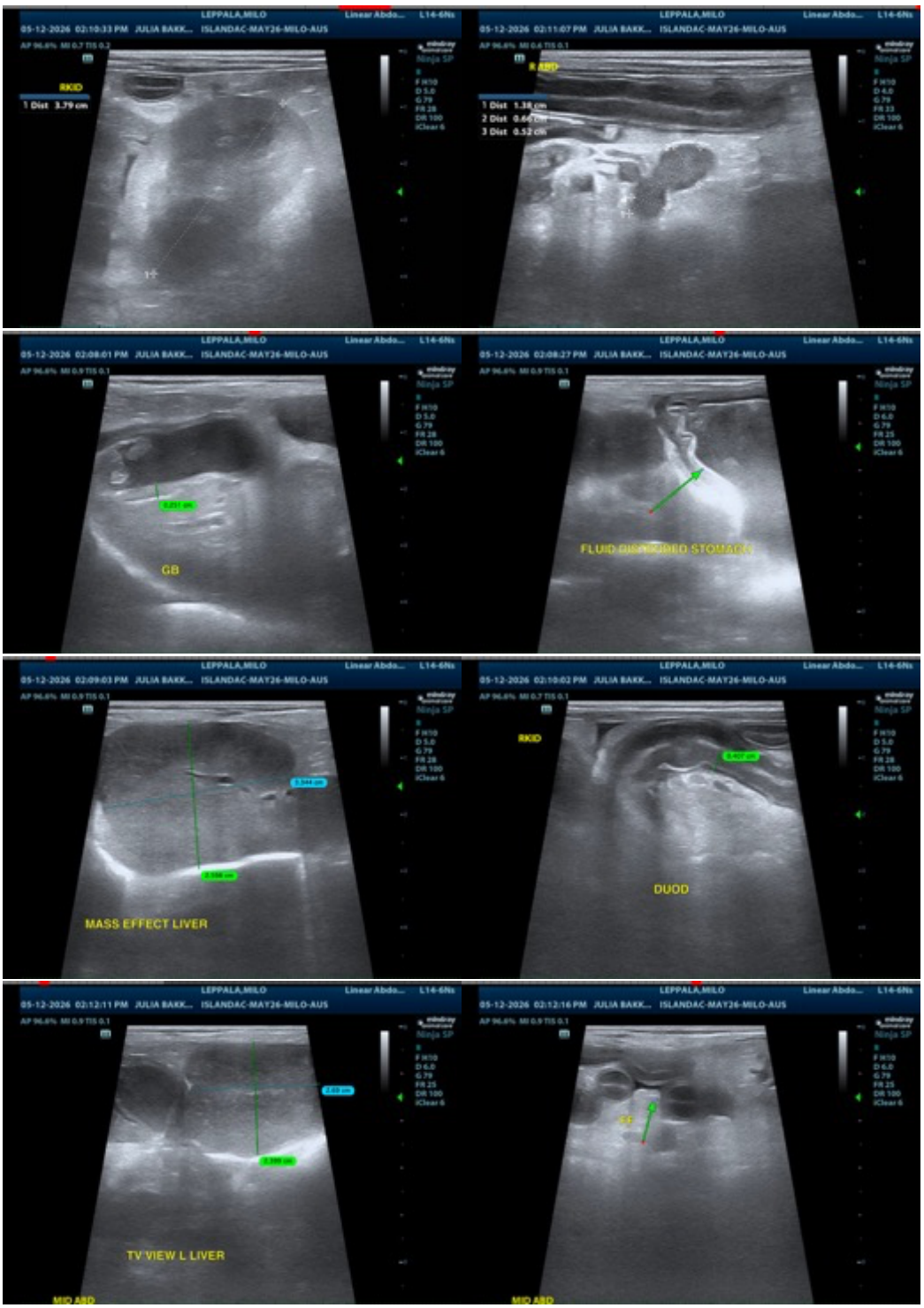

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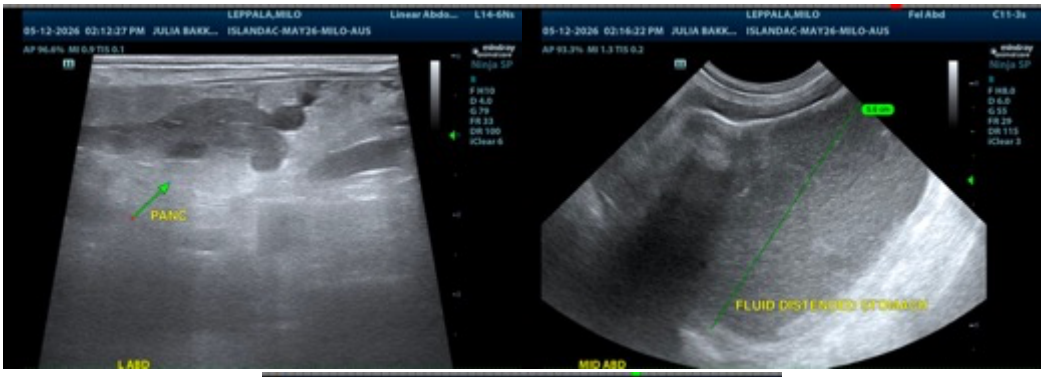

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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