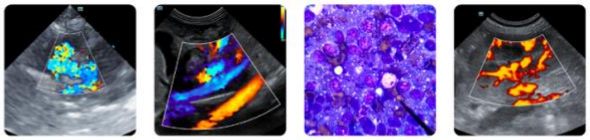


PATIENT

Daisy Long

SPECIES

Canine

BREED

Boxer Mix

SEX

Spayed Female

AGE

11 Years

WEIGHT

30.5 kg

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP

IMAGING PERFORMED BY

Dr. Bennett

HOSPITAL NAME

Wilvet South

REFERRING VET

Dr. Daniel

INVOICE

13193

DATE

01/16/26

PRESENTING CLINICAL SIGNS

Presented 1/15 for several day Hx of V and a possible seizure prior to presentation. Large Mass noted on exam. FNA of mass Dx MCT. Rads of GI tract suggestive of gastroenteritis with no overt evidence of obstruction att. Elevated liver enzymes. Plan to move forward to Dx US and FNA of Liver to further assess for metastasis or other underlying disease. Did regurgitate clear to tan ting-ed fluid. this morning with exam for abdominal palpation. P has not eaten food in 12+ hours and is NPO at this time.

CBC: Lymphocytes 0.75 (L) CHEM/LYTES: Glucose 161 (H), Potassium 2.9 (L), Chloride 103 (L), ALT 142 (H), ALP 1459 (H) Urinalysis: USG 1.030, quiet sediment IMAGYST fecal: negative IMAGYST of mass: Interpretation: Suspect mast cell tumor Radiographs: Report attached FAST scan: 0/4 FAF, enlarged liver with slightly heterogenous echotexture. Fluid filled stomach and small intestines, no overt obstructive pattern seen. Bladder has some hyperechoic debris, no stones visualized. No pleural or pericardial effusion, no overt B-lines.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no sonographic evidence of urine mineral or calculi. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic change were noted.

The area of the aortic trifurcation was free of pathology.

Subnormal right kidney size compared to the left kidney with possible mild underestimation of the right kidney size. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 7.0 cm in length. The right kidney measured 6.1 cm in length.

Adrenal Glands

The left adrenal gland was overtly normal in size, position and shape. The left adrenal gland measured 0.62 cm width at the caudal pole.

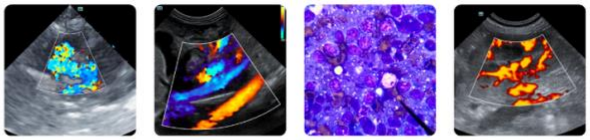
The right adrenal gland was not definitively visualized.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver & Gallbladder

The liver was subjectively mildly enlarged in size. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and mild to variable nonhomogenous



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parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion. No sonographically evident liver mass.

Transdiaphragmatic view revealed a focal mild comet tail lung pattern, which is echogenic sound wave interface with microconsolidations within the caudal lung field. The lung field should not be visualized by sonogram unless pathology is present. Chest radiographs are recommended to rule out alveolar/lung disease such as neoplasia, thromboembolic disease, chronic inflammatory disease with microconsolidation.

The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact visible wall. The stomach exhibited moderate distention with retained primarily anechoic fluid and a mild amount of nonshadowing chyme. No visualized evidence of obstruction to pyloric outflow or obstructive pyloric mural pathology.

The intestinal walls demonstrated intact wall layering and maintained 1:3 muscularis / mucosa ratio. The mucosa exhibited mild decreased echogenicity with occasional mucosal speckling. A generalized mild duodenal and segmental jejunal ileus pattern consisting of mild fluid accumulation in the intestinal lumen was present without obstruction or foreign material.

Normal visible colon wall layers were present with formed fecal matter in lumen.

Pancreas

The right pancreas presented prominent in size with capsule asymmetry and heterogeneous remodeled parenchyma. Mild peripancreatic hyperechoic omentum.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Sonographically normal spleen.
- Mildly enlarged nonhomogenous liver.
- Transdiaphragmatic comet tail artifact.
- Moderate hypomotile stomach with mild duodenal and segmental jejunal ileus.
- Prominent nonhomogenous remodeled right pancreas.
- Mild chronic renal changes.
- Sonographically normal urinary bladder.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The non-specific hepatopathy may indicate vacoular or cholestatic hepatopathy, inflammatory disease, hyperplasia, hepatotoxin or primary versus metastatic hepatic neoplasia.

Further assessment may include (assuming normal clotting status) FNA cytology in conjunction with three view chest radiographs. No definitive evidence of mechanical gastrointestinal obstruction i.e. mass, foreign body, stricture, etc. which may suggest moderate metabolic gastric and mild intestinal ileus. Assessment for cranial abdomen/subxiphoid discomfort on palpation and spec cPL for evidence of chronic pancreatitis as a contributing factor may be considered. A small to non-visualized area of

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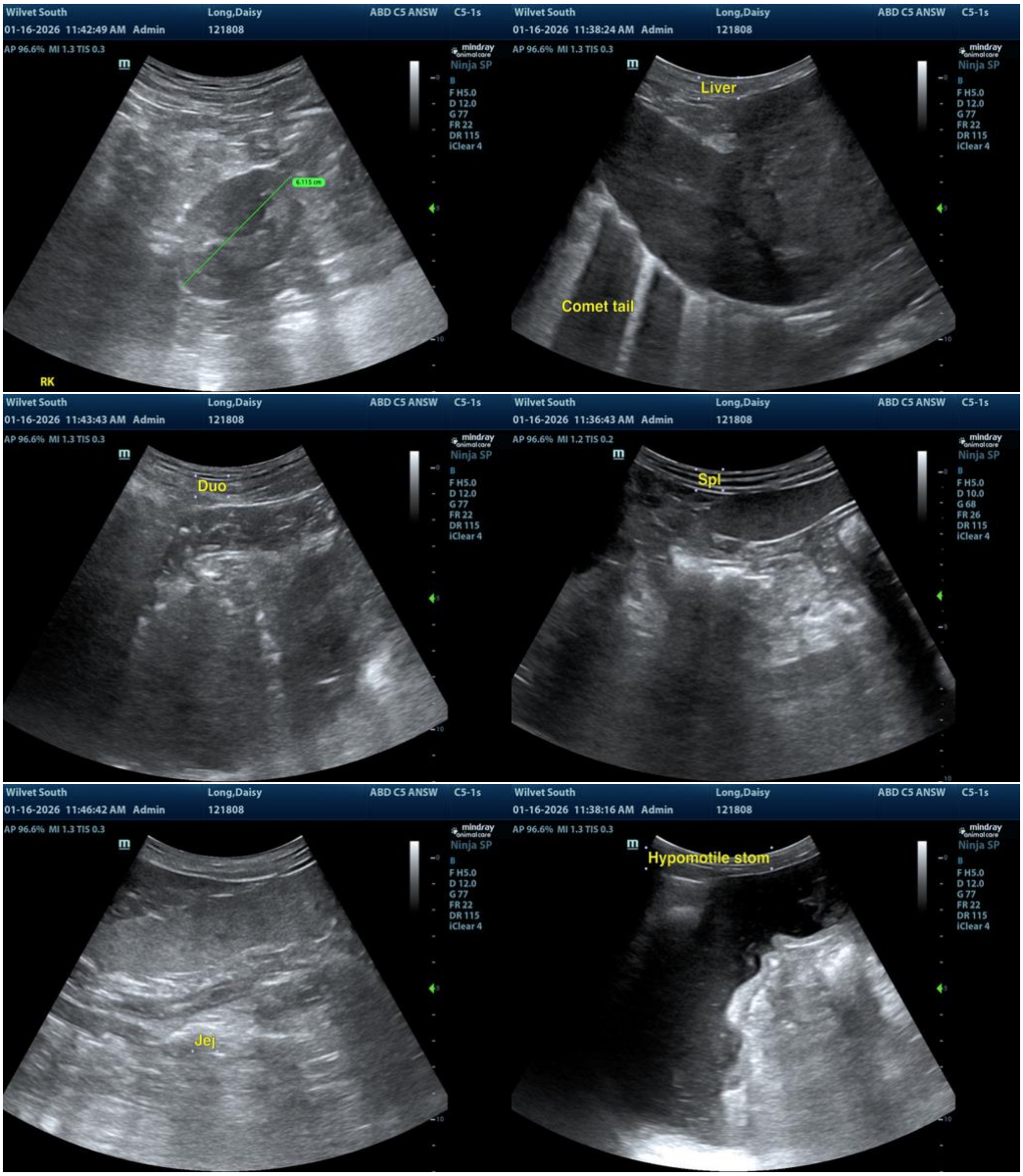
intestinal obstruction potentially obscured by intestinal artifact is thought less likely yet not technically excluded.

Gastrointestinal support with consideration for gastric evacuation with clinical monitoring and sonographic reassessment if recurrent or progressive gastrointestinal ileus is recommended.



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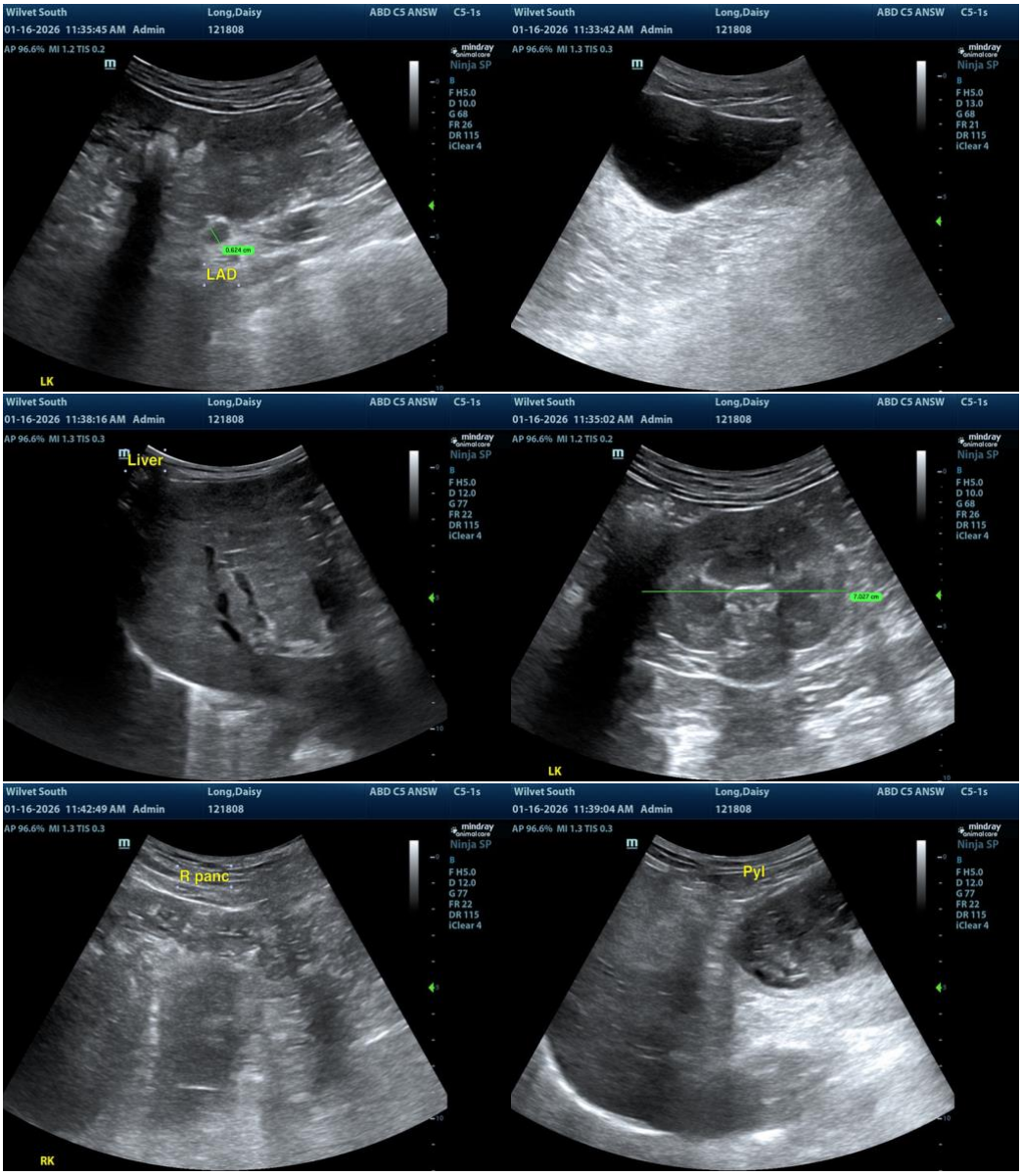

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

info@SonoPath.com