



PATIENT

Tsar Lobenstein

SPECIES

Canine

BREED

German Shepherd

SEX

Neutered Male

AGE

9 Years

WEIGHT

81.5 pounds

INTERPRETED BY

R. McKenzie Daniel,
DVM, DABVP

IMAGING PERFORMED BY

Dr. Harold Mike Beard

HOSPITAL NAME

Animal Care Veterinary
Center

REFERRING VET

Dr. Harold Mike Beard

INVOICE

13264

DATE

01/20/26

PRESENTING CLINICAL SIGNS

- History of weight loss and soft stools.

Abnormal PE/Chem/CBC/UA Results: TPP 3.5, Alb 1.6, Calcium 8.0. CBC okay. T4 1.8. IPE negative. UA trace protein. HW negative.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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

Normal size and margination was present in the kidneys. 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 7.4 cm in length. The right kidney measured 6.6 cm in length.

Adrenal Glands

The left adrenal gland was overtly normal in size, position and shape. The left adrenal gland measured 0.57 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 normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was non distended in size with mild nonorganized biliary sludge. The cystic duct and common bile ducts were normal without evidence of dilation.

Gastrointestinal

The stomach presented intact wall layering. The stomach was nondistended containing minor anechoic fluid.

Intestinal wall layering was maintained with overall maintained wall layer ratio. Borderline prominent duodenal walls secondary to subjective prominent mucosa. Discrete to indistinct duodenojejunal



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mucosa hyperechoic speckling to striations. Mild segmental nonobstructive duodenojejunal ileus present. There was no evidence of an obstructive pattern or foreign material. The appearance of the small intestine is most consistent with protein losing enteropathy or lymphangiectasia. There was no evidence of infiltrative or neoplastic intestinal disease which is considered unlikely but cannot be ruled out without full thickness or endoscopic biopsies.

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

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

No overt lymphadenopathy or current peritoneal effusion/ascites was present.

ULTRASONOGRAPHIC FINDINGS

- Intact borderline prominent small intestinal wall exhibiting discrete to subtle hyperechoic duodenojejunal mucosal speckling/striations.
- Minor retained gastric fluid.
- Semi formed to soft fecal matter in colon.
- Normal area of the pancreas.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the subnormal albumin level without evidence of hepatic pathology or significant proteinuria, protein losing enteropathy is probable. Considerations may include IBD or other inflammatory disease, lymphangiectasia or potentially infiltrative intestinal disease. Contributing factors such as malassimilation/maldigested disorder, occult parasitism, occult Addison's disease, EPI or other are also possible.

A GI panel to include PLI, TLI, cobalamin and folate, fresh fecal analysis, screening cortisol level +/- UPC to quantify degree of proteinuria may be considered. Dietary modification, cobalamin supplementation (pending assessment of cobalamin level), empirical deworming despite fecal testing (Panacur 50 mg/kg SID for five days with repeat protocol in three weeks), high colony count probiotics such as Provable and as needed gastroprotectants may prove beneficial. Intestinal biopsies may be required for a definitive diagnosis and could be considered if serum albumin is stabilized, greater than 2.0.



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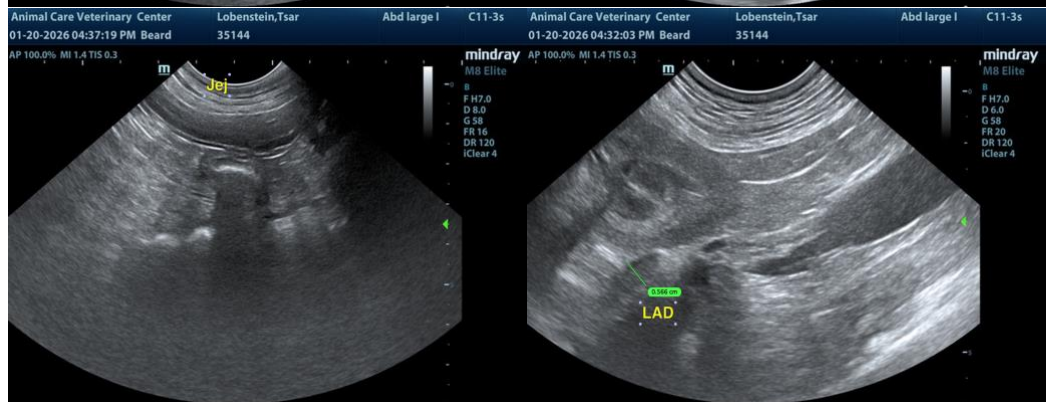
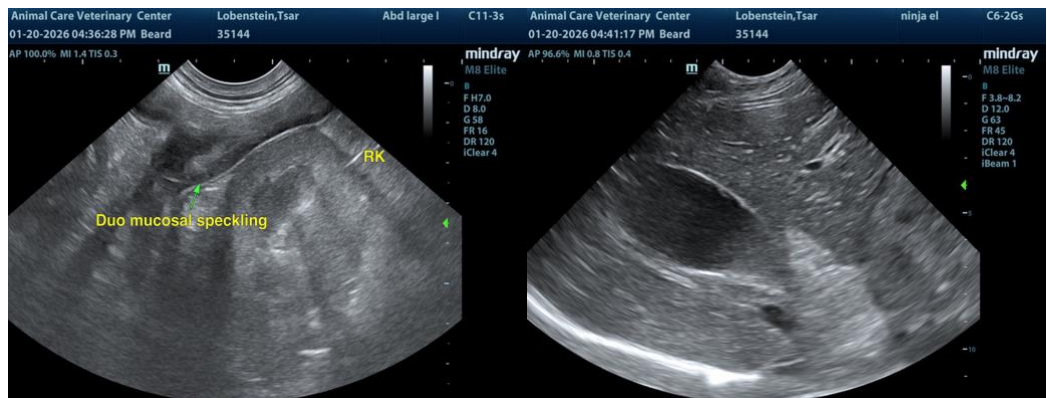
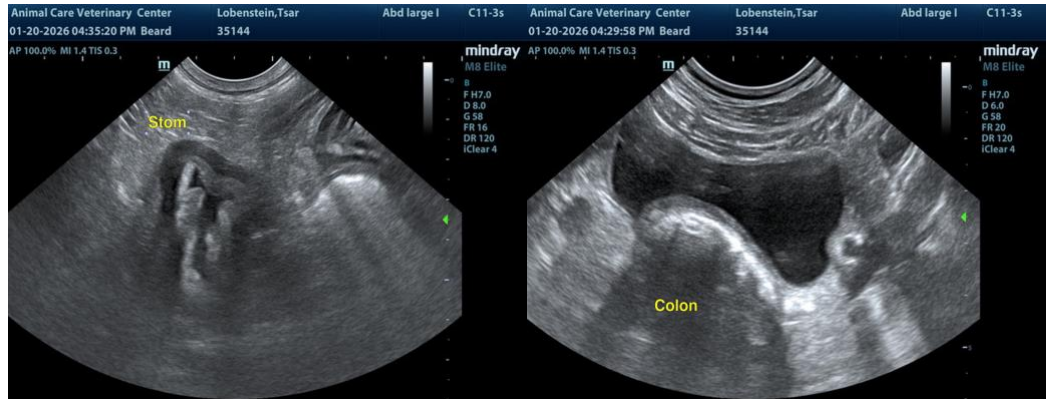
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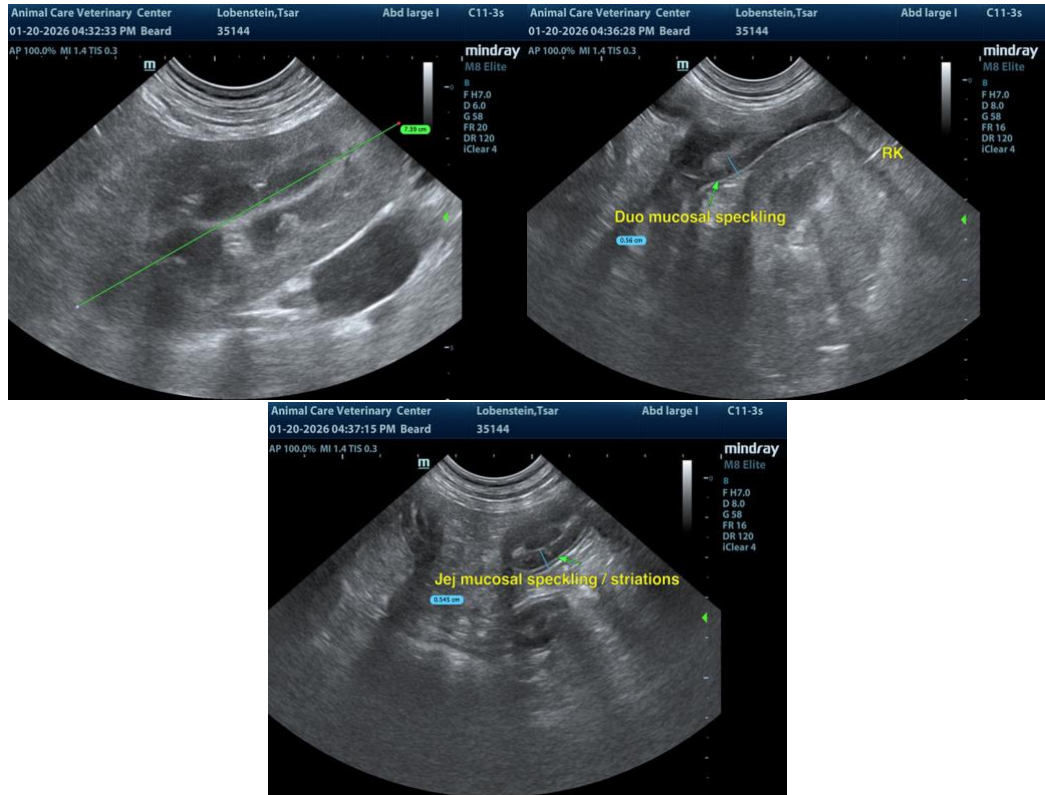
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

info@SonoPath.com