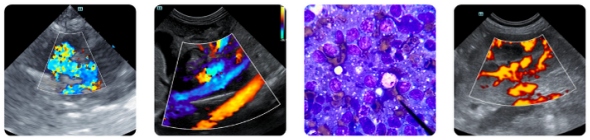


PATIENT

Mieya Mae Badini

SPECIES

Canine

BREED

Dachshund

SEX

Female Spayed

AGE

15y

WEIGHT

12 lbs

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY

Dr. Beth Coe

HOSPITAL NAME

Riverside AC

REFERRING VET

Dr. Beth Coe

INVOICE

13148

DATE

1/28/26

PRESENTING CLINICAL SIGNS

History:

- Seen on urgent basis 1/21/26 - owner reported increased sleeping for one week, inappetence x 2days, anorexia x 24hrs. Shaking more, heavy breathing at night. Bloodwork declined. Rx: NSAID, Gabapentin (hx of IVDD episodes similar presentation).
- 1/23/26: Owner reports patient still seems uncomfortable. Added Robaxin.
- 1/26/26: Anorexia and tachypnea/panting increasing per owner. No v/d reported then. Drinking, but won't eat. Added Clavamox BID, but hard to get into patient with anorexia.
- One episode of vomiting (bile) since seen 1/26/26. Still tachypneic and uncomfortable/quiet today.

Abnormal PE/Chem/CBC/UA Results: 1/21/26: Temp 102.5F/103.1F. RR 72rpm. Heart sounds WNL. P 120bpm. Sits repeatedly when palpating spine. Tense abdomen. 1/26/26: Temp 100.8F. Tachypnea, not panting. Pulse 60bpm, heart sounds WNL. Tense abdominal palpation mid-abd. No pain spinal palp. 1/26/26: CBC - WBC 19K/Neut16K. Rest WRI 1/26/26: Chem - ALKP 288. K 6.4. Rest WRI. Cortisol WNL. No cPL performed. 1/26/26: UAS WNL 1/26/26: Chest rads - alveolar pattern right middle lung. Poss lung mass vs GB debris over diaphragm. Possible bilateral ventral pleural effusion/effaced cardiac silhouette DV projection. 1/28/26: Tachypnea RR 108rpm. Heart sounds normal. Lung sounds NSF. Abdomen tense, but no Murphy's sign scan. Euthermic.

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 uroliths or sediment, mineral or calculi. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

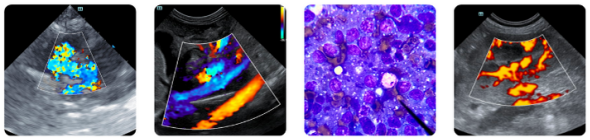
Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and moderate loss of corticomedullary symmetry and definition expected for the age of the patient. The left kidney exhibited moderate pyelectasia without overt left hydro ureter. Pinpoint to focal medullary mineral present in both kidneys. The left kidney measured 4.1 cm in length. The right kidney presented no pyelectasia. The right kidney measured 4.3 cm in length.

Adrenal Glands

The left adrenal gland was normal in size while the right adrenal gland was mildly enlarged in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 0.40 cm width in the caudal pole. The right adrenal gland measured 0.70 cm width in the caudal pole.

Spleen

The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present without evidence of nodular changes. The capsule was smooth and regular without apparent expansion. The splenic



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vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. The parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age-related remodeling with minor potential for inflammatory or neoplastic disease.

Liver

The liver presented subjective mildly enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non distended in size with mild, variably congealed yet not organized, echogenic, nonmineralized biliary sludge. The cystic duct and common bile ducts were normal without evidence of dilation.

Transdiaphragmatic view revealed 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.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. Mild, segmental, non-shadowing chyme without obstructive pattern to the level of the colon.

Normal visible colon wall layers were present with apparent formed feces 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 peritoneal effusion was present.

Other

Brief assessment of the thorax revealed peripheral consolidation and mild air entrapment vs peripheral pulmonary nodule measuring ~1.0 cm in diameter in labeled left dorsal thorax.

ULTRASONOGRAPHIC FINDINGS

- Sonographically normal gastrointestinal tract with minor segmental intestinal chyme
- Mild hepatomegaly
- Non-organized gallbladder debris (non-mucocele)
- Chronic renal changes with left kidney pyelectasia
- Transdiaphragmatic comet tail artifact with left thoracic peripheral consolidation and air entrapment vs pulmonary nodule

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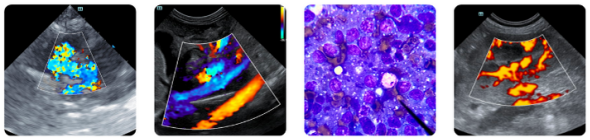

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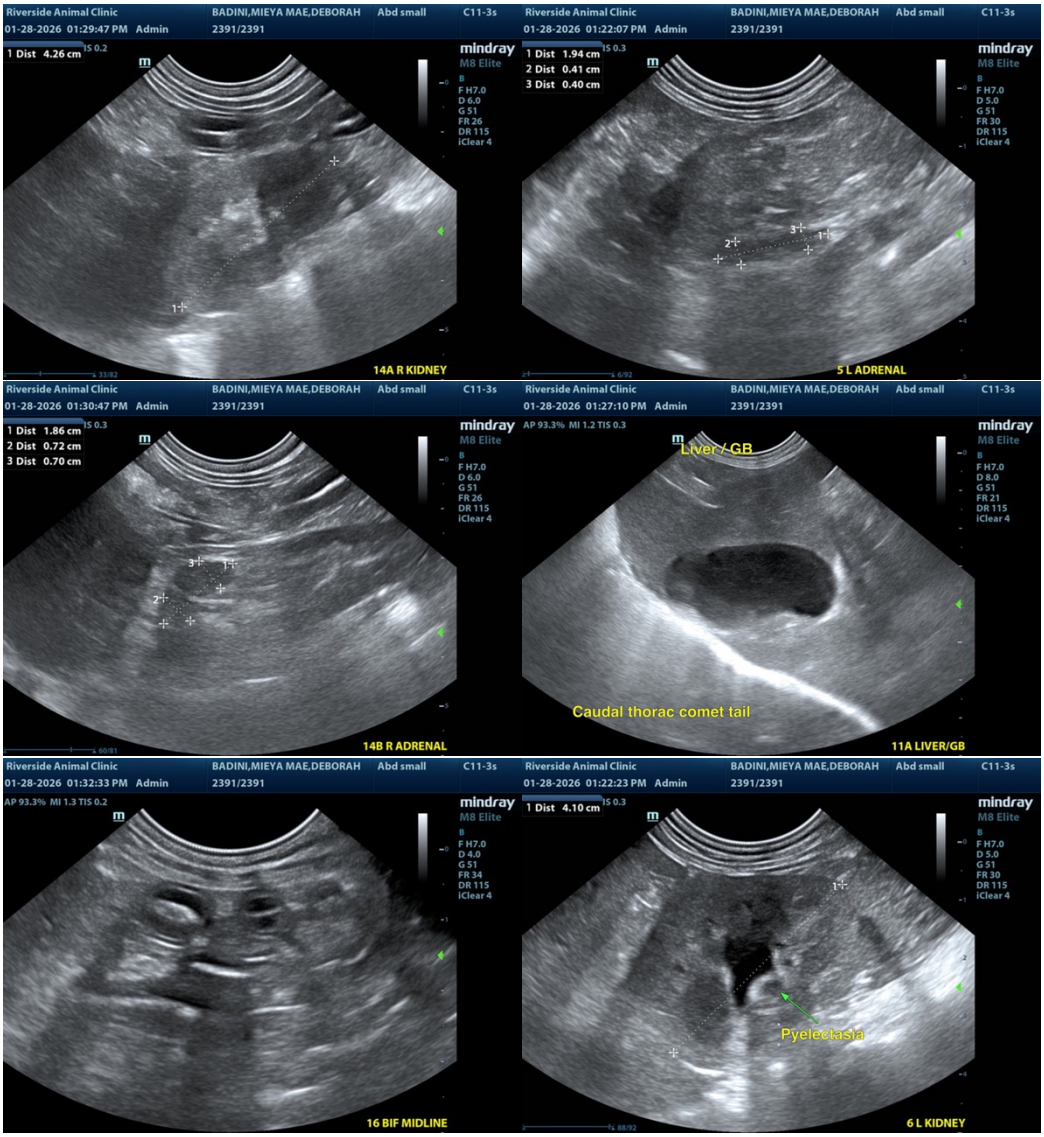
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of significant abdominal visceral pathology, i.e. neoplasia as a definitive cause of the patient's clinical signs. The hepatopathy suggests benign criteria with vacuolar or non-obstructive cholestatic hepatopathy favored in conjunction with elevated ALP. Assuming normal clotting status, screening hepatic FNA cytology and a GI panel to include PLI/TLI/Cobalamin/Folate to assess for occult disease may be considered. Primary intrathoracic or pulmonary pathology may be a primary issue in this patient.



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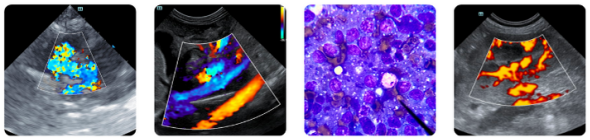

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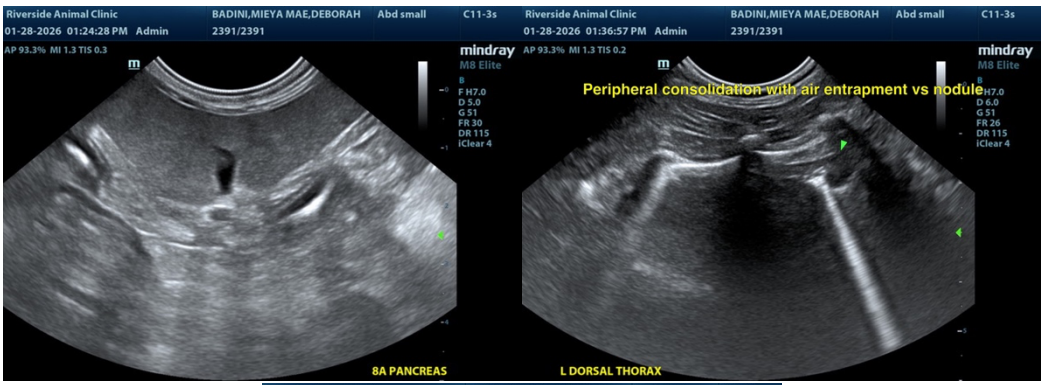

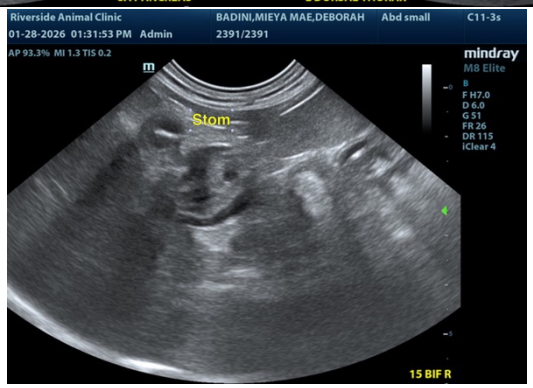

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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