



PATIENT

CORIANDER MOORE

SPECIES

Canine

BREED

Rat Terrier Mix

SEX

MN

AGE

6yr

WEIGHT

11.5kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Hayes

HOSPITAL NAME

Wilvet Salem

REFERRING VET

Hayes

INVOICE

22919

DATE

11-10-25

PRESENTING CLINICAL SIGNS

P started having weight loss, not eating and dribbling urine back in July. O has taken him into the vet multiple times and they did a lot of labwork and radiographs. He was prescribed a course of antibiotics, steroids, gabapentin and appetite stimulant. He got better on them but then declined once he finished it. He was diagnosed in October with pancreatitis and was prescribed more steroids and antibiotics and he improved while taking them. He has not had any medication in 3 days and he is very painful to be picked up, very lethargic, not eating much (only a small amount of sweet potato mash and chicken in 24 hours) and he can't stand on his back legs. No V/D/C/S. He has been on the EN LF and I/D LF dry and canned when he was eating.

Abnormal PE/Chem/CBC/UA Results: 9/8: CBC: HCT 49.54%, WBC 6.96, Lymph 3.77 (54%), Mono 0.08 (L), Plt 124 (L), PCT 0.12% (L) Chem: Alb 2.6, ALP 225 (H), ALT 212 (H), BUN 11, Ca 12.4 (H), Chol 107 (L), Creat 0.8, GGT 12 (H), Tbili 0.2, TP 6.0, Na 164 (H), K 4.9, Cl 119, 9/19: PCV 50% Manual Platelet count- 116K with clumping UA: USG 1.025 (L), pH 6.5 Ca oxalate 6-20/hpf (H) 10/24: CBC: HCT 43.9%, RDW 24.1 (H), MCHC <18.8 (L), Hemoglobin 8.3 (L), WBC 4.94 (L), Neut 1.87 (L), Plt 130 (L) Chem Creat 1.2 (n), BUN 31 (H), Ca 12.3 (H), Na 156, K 4.1, Cl 119, TP 6.2, Alb 2.6, ALT 119(n), ALP 157 (N), CPL 831 (H), iCa 1.79 (H), Parathyroid <0.5 (N) 11/5: ACTH Stim- Normal 11/10: CBC: HCT: 40.6% (N), RDW 22.9 (H), WBC 4.63 (L), Neut 2.13 (L), Eos 0 (L), Plt 71 (L) Manual Platelet Count: 67.5K no clumping BCS: 3/9 MM: Pale and tacky

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no evidence of urine/lumen sediment, mineral, or calculi. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 5.9 cm in length. The right kidney measured 6.5 cm in length.

The area of the iliac trifurcation was free of pathology including no evidence of medial iliac or sublumbar lymphadenopathy or masses.

The residual prostate appeared normal and free of pathology measuring 1.0 cm in diameter.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.39 cm width at the caudal pole The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.55 cm width at the caudal pole.

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



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thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver/Gallbladder

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The liver presented 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 primarily anechoic luminal content. The cystic and common bile ducts were normal.

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Gastrointestinal

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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.

MN

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of mechanical/metabolic ileus, obstruction or foreign material. The duodenum wall measured 0.5 cm width. The jejunum wall measured 0.32 cm width.

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Normal visible colon wall layers were present. The colon was mildly distended in size containing soft to non-formed fecal matter.

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Pancreas

The pancreas was normal in size and contour with heterogeneous parenchyma compared to adjacent non-reactive or inflamed omentum.

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Free Abdomen

No omental masses, overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary

- Sonographically unremarkable GI tract
- Soft to non-formed fecal matter in colon
- Normal urinary bladder and residual prostate
- Hepatopathy, subjective benign
- Normal gallbladder
- Heterogenous remodeled pancreas-possible mild pancreatitis or remodeling owing to previous inflammation

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Overall, no overt evidence of significant abdominal visceral pathology as a definitive cause of the patient's clinical signs and abdominal pain. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended to correlate with the pancreas and assess for non-structural intestinal disease given GI signs and soft/non-formed fecal matter in the colon. No evidence of neoplastic criteria. Assuming normal clotting status and using a 25g needle, hepatic FNA for screening cytology could be considered for further clarification primarily to assess for steroid hepatopathy or inflammation. Three view chest

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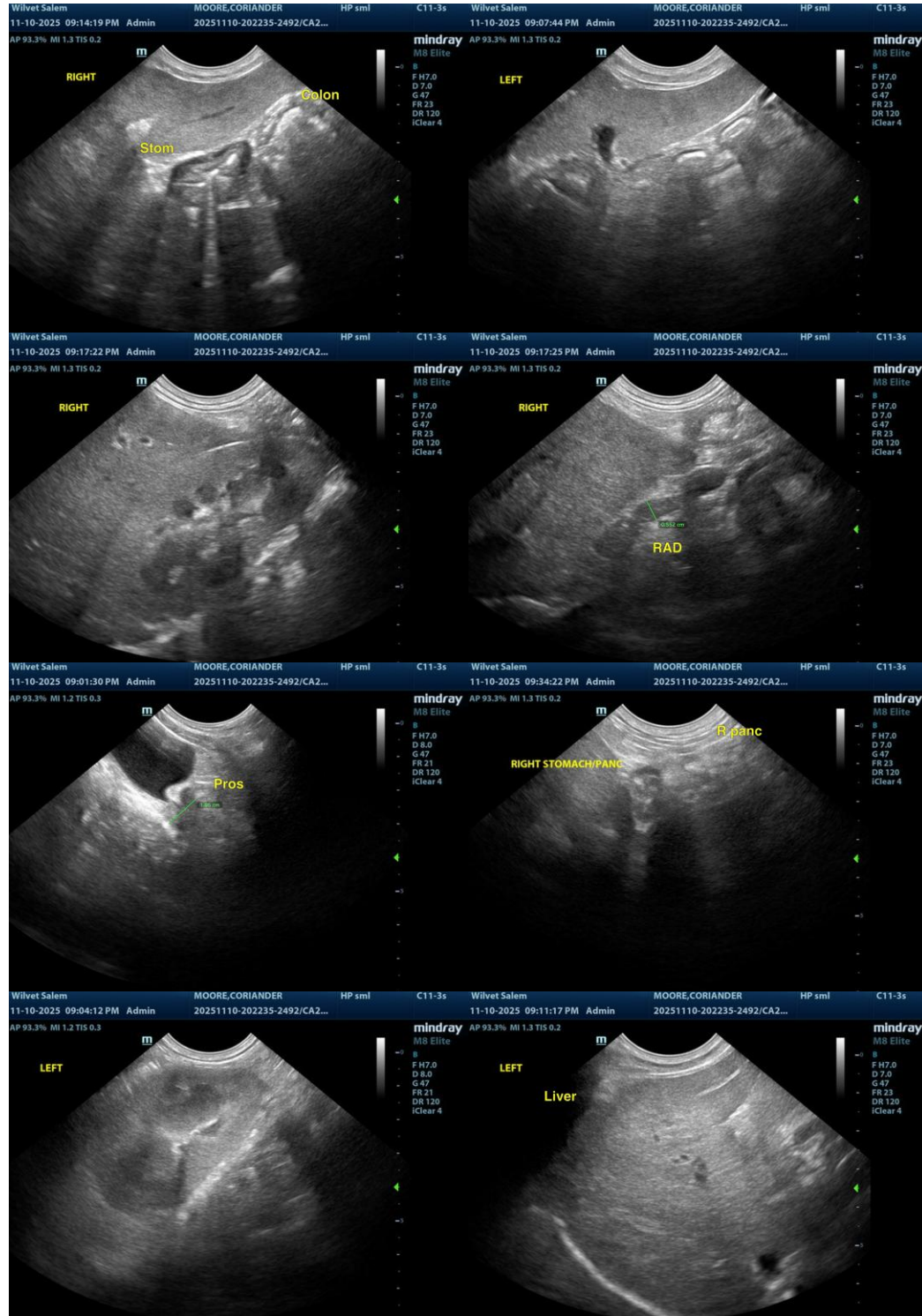
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radiographs are recommended if not done to assess for occult thoracic pathology. A thorough musculoskeletal and neurological examination is suggested if not done.





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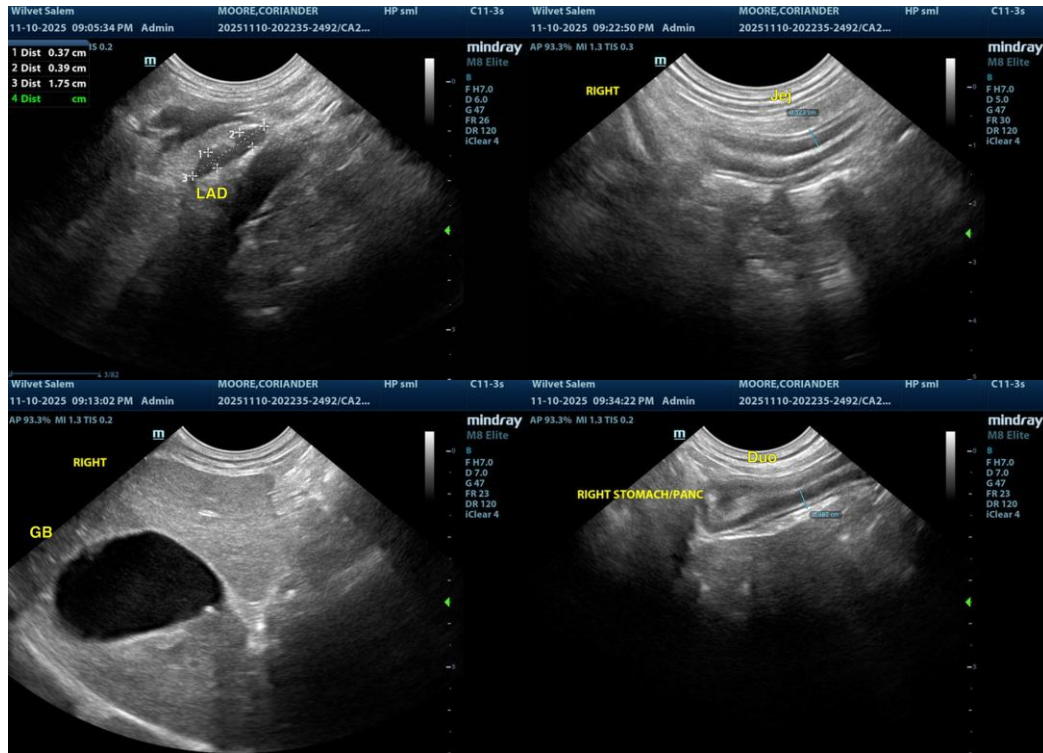
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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.

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