



## PATIENT

Reesie Horozgolou

## SPECIES

Canine

## BREED

Yorkshire Terrier

## SEX

Neutered Male

## AGE

10

## WEIGHT

13.8 lbs

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Dr. John Sampson

## HOSPITAL NAME

Richboro Veterinary  
Hospital

## REFERRING VET

Dr. John Sampson

## INVOICE

71879

## DATE

11/17/25

## PRESENTING CLINICAL SIGNS

Presented 11/15 for labored breathing for 24 hours, and anorexia for 72 hours.

Abnormal PE/Chem/CBC/UA Results: 11/15 - Temp 103. H/L ausculted normally. Painful abdominal palpation, AFAST by rDVM showed enlarged liver and spleen. 1cm firm prostate on exam Blood work showed hct 41, retic 169k, wbc 19k, ALT unreadable, and ALKP 1802 rDVM recd ER - went to ER and had chest rads - unremarkable (per O) and bloodwork confirmed significant elevation in ALT in the thousands (per O) Presented today for AUS and was painful near the gall bladder

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of – cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no 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.

No obvious pathology in the area of the residual prostate. No obvious medial iliac or sublumbar lymphadenopathy or masses.

Normal size and margination were 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 loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. Pinpoint hyperechoic medullary foci noted in both kidneys and intermittent small cortical cysts. The medullary foci may indicate pinpoint areas of microinfarction, fibrosis, or mineralization. Left kidney measured 4.2 cm. Right kidney measured 5.1 cm.

### Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured – cm width at the caudal pole and – cm width at the cranial pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured – cm width at the caudal pole and – cm width at the cranial 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 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 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 thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.



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## Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The stomach was non-distended, containing a mild amount of retained variably echogenic non-shadowing ingesta/chyme.

The intestinal walls demonstrated primarily intact wall layering with segmental indistinct jejunal mural detail and mild segmental non-obstructive intestinal ileus. Propensity for mildly prominent duodenal and segmental jejunal mucosal layer. Duodenum wall measured 0.47 cm. Jejunum wall measured 0.44 cm.

Normal visible colon wall layers were present with soft to non-formed fecal matter.

## Pancreas

The visualized pancreas exhibited normal size and contour with heterogeneous, mildly remodeled to hyperechoic parenchyma compared to adjacent omentum.

## Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

## PRIMARY FINDINGS

- Enlarged, non-homogeneous hypoechoic liver – acute or acute on chronic hepatopathy, non-specific hepatitis (viral, bacterial, Leptospirosis, toxin), vacuolar, reactive, metabolic hepatopathy, cholestasis, non-cardiogenic congestion, occult neoplasia or other.
- Non-distended mildly edematous gallbladder with non-organized luminal debris – not consistent with mature mucocele criteria.
- Chronic pancreatitis pattern with mild parenchymal remodeling/fibrosis.
- Gastroenteropathy exhibiting mild segmental non-obstructive intestinal ileus and soft to non-formed fecal matter in colon.
- Hypoechoic to swollen mesenteric lymphadenopathy – lymphadenitis or primary/metastatic neoplasia, less likely significant reactive hyperplasia.
- Generalized hyperechoic omentum and scant peritoneal effusion.

## SECONDARY FINDINGS

- Bilateral intact mild chronic renal changes.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Multicentric inflammatory versus infectious disease or neoplasia, which may present in similar manner, are considered primary differentials.

Further assessment may include (assuming normal clotting status and using 25-gauge needle) hepatic and accessible lymph node FNA cytology +/- culture and sensitivity and Leptospirosis titers/PCR.

Evidence of gallbladder and chronic pancreatic inflammation is present, yet overt evidence of primary gallbladder or pancreatic disease was not obvious. Correlation with spec cPL or full GI panel to include PLI, TLI, cobalamin and folate in conjunction with recommended sampling considered essential for



**PATIENT**

further clarification may be considered.

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Hospitalization with empirical therapy for acute hepatitis/cholangiohepatitis, gastroenteritis, and chronic pancreatitis, with close clinical and as-needed sonographic monitoring pending additional diagnostics would be reasonable. Guarded prognosis.

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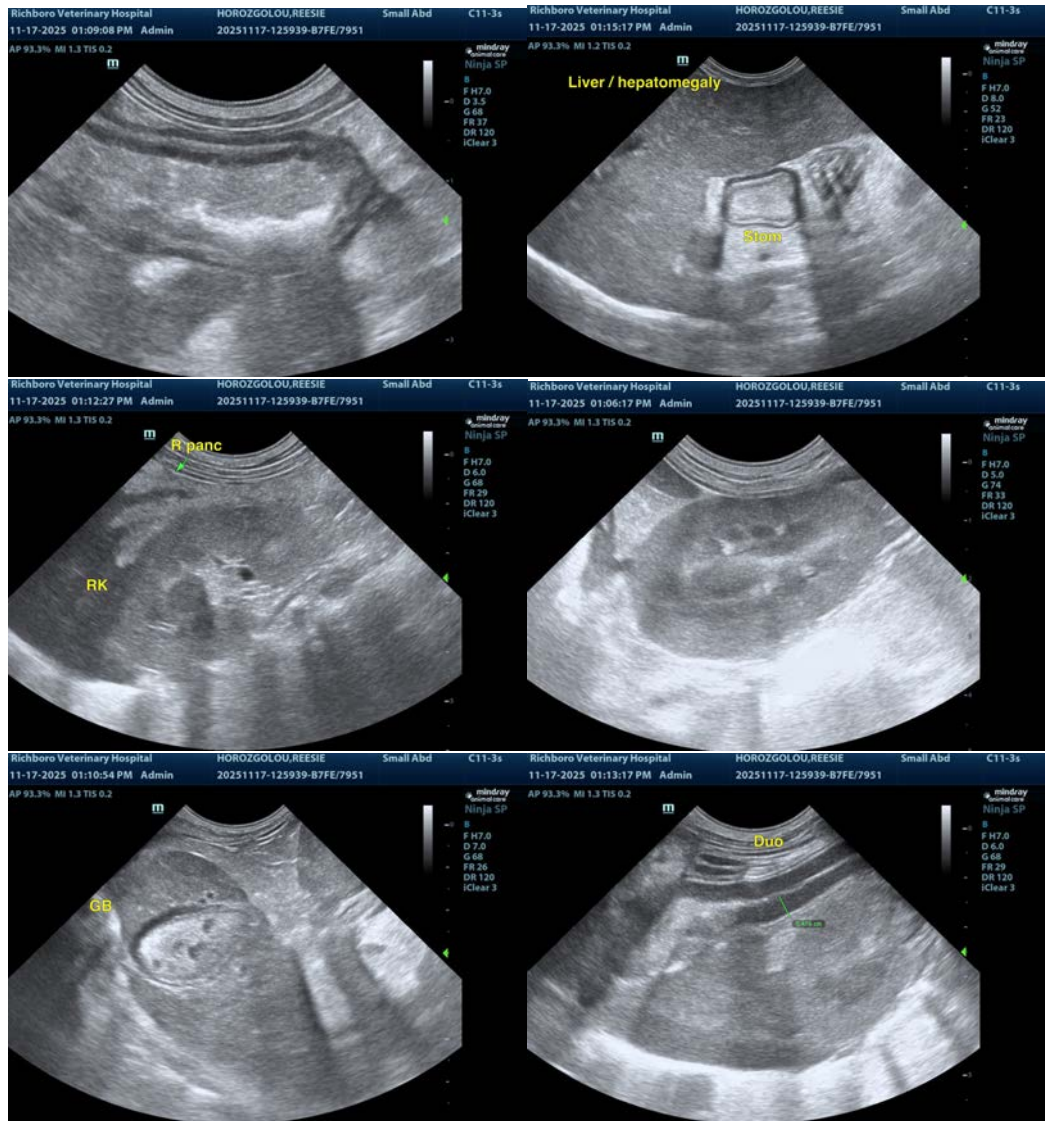
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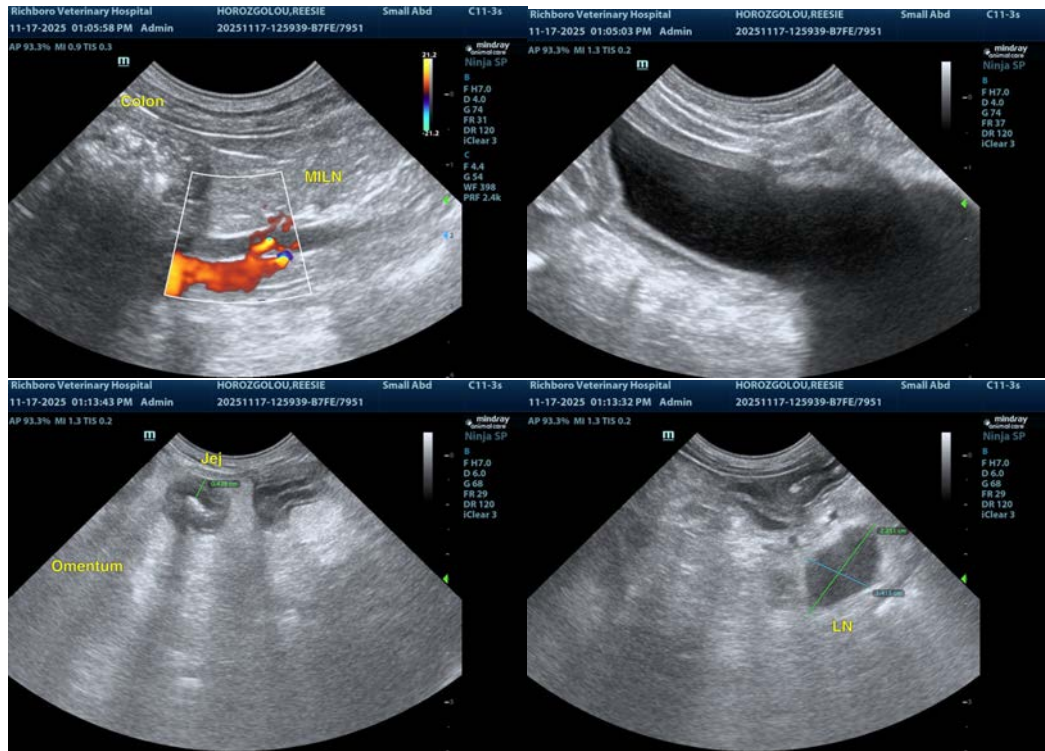
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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