



**PATIENT**

Hank Horton

**SPECIES**

Canine

**BREED**

Labrador X

**SEX**

Neutered Male

**AGE**

13 Years

**WEIGHT**

68 pounds

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Sara Hansen

**HOSPITAL NAME**

Alpine Animal Hospital

**REFERRING VET**

Dr. Wolf

**INVOICE**

12447

**DATE**

11/24/25

**PRESENTING CLINICAL SIGNS**

Clinical Exam Findings: PU/PD (r/o renal disease, metabolic/endocrine (Diabetes Mellitus, hypo/hyperadrenocorticism, hyperthyroidism), UTI/pyelonephritis, hypercalcemia, Diabetes Insipidus, primary polydipsia, other) Suspect OA Moderate muscle atrophy Vomiting Respiratory associated arrhythmia tense abdomen - palpation non-diagnostic Ambulatory x 4, reluctant to extend hind limbs caudally (bilateral) - normal CP's - mild reactivity to spinal palpation in the TL region of the spine.

Abnormal PE/Chem/CBC/UA Results: ABNORMAL Labwork Values TOTAL PROTEIN 5.4 5.5 - 7.5 g/dL LOW ALBUMIN 2.5 2.7 - 3.9 g/dL LOW HGB 12.6 14.6 - 21.7 g/dL LOW HCT 39.8 41.0 - 60.0 % LOW MCH 20.5 22.1 - 26.7 pg LOW MCHC 31.7 32.3 - 38.0 g/dL LOW RETIC HGB 20.7 23.8 - 28.3 pg LOW PLATELET 451 120 - 412 K/uL HIGH MONOCYTE 855 145 - 736 /uL HIGH UA: SPECIFIC GRAVITY 1.007 1.030 - 1.098 LOW Potentially inappropriate concentration. Consider hydration status and, if persistent and inappropriate, renal disease, endocrinopathies, and medications. Recheck UA: SPECIFIC GRAVITY 1.012 1.030 - 1.098 LOW Potentially inappropriate concentration. Consider hydration status and, if persistent and inappropriate, renal disease, endocrinopathies, and medications. PH 8.5 6.0 - 7.5 HIGH Current Medications none

**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. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic change were noted.

No obvious pathology in the area of the residual prostate.

The area of the aortic trifurcation was free of pathology.

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 indistinct corticomodullary border demarcation expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 6.2 cm in length. The right kidney measured 6.3 cm in length.

**Adrenal Glands**

The left adrenal gland was normal in size while the right adrenal gland was borderline enlarged in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 2.5 cm length x 0.63 cm width in the caudal pole. The right adrenal gland measured 2.8 cm length x 0.88 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 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.



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**Liver**

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 mild nonorganized biliary sludge. The cystic duct and common bile ducts were normal without evidence of dilation.

**Gastrointestinal**

The stomach presented with intact borderline prominent wall layering. Gastric body wall measured 0.60 cm width. The stomach was nondistended containing a mild amount of retained echogenic fluid and lumen gas.

The intestinal walls demonstrated generalized intact wall. Borderline thickened duodenum wall exhibiting mild increased duodenal mucosa echogenicity. Segmental generally mild nonobstructive duodenojejunal ileus. The duodenum wall measured 0.69 cm width. The jejunum wall measured 0.47 cm width.

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

**Pancreas**

The pancreas was normal in size with indistinct pancreatic capsule compared to adjacent omentum. Isoechoic mildly heterogeneous remodeled parenchyma. No signs of active inflammation or neoplasia.

**Free Abdomen**

No overt lymphadenopathy or peritoneal effusion was present.

**ULTRASONOGRAPHIC FINDINGS**

- Bilateral chronic renal changes.
- Age-related adrenals with borderline right adrenomegaly.
- Mild hepatomegaly- subjective benign.
- Mild gallbladder debris (non-mucocele).
- Nonspecific gastroenteropathy exhibiting mild thickened intact duodenum wall and nonobstructive gastrointestinal ileus.
- Pancreatic remodeling.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Baseline renal staging to include culture/sensitivity and UPC level if evidence of noninflammatory proteinuria is recommended. The borderline right adrenomegaly is nonspecific with considerations including age related variant, hyperplasia, adenomatous change and with emerging right adrenal tumor thought less likely without overt neoplastic criteria not excluded. Adrenal work up is indicated if clinical signs consistent with Cushing's syndrome as well as monitoring of systemic BP in conjunction with chronic renal changes. Sonographic monitoring of the right adrenal gland for evidence of progressive enlargement with initial recheck in 3-4 weeks would be ideal. Nonspecific gastroenteritis owing to dietary intolerance/indiscretion, infectious disease, enterotoxin, IBD or potential occult to



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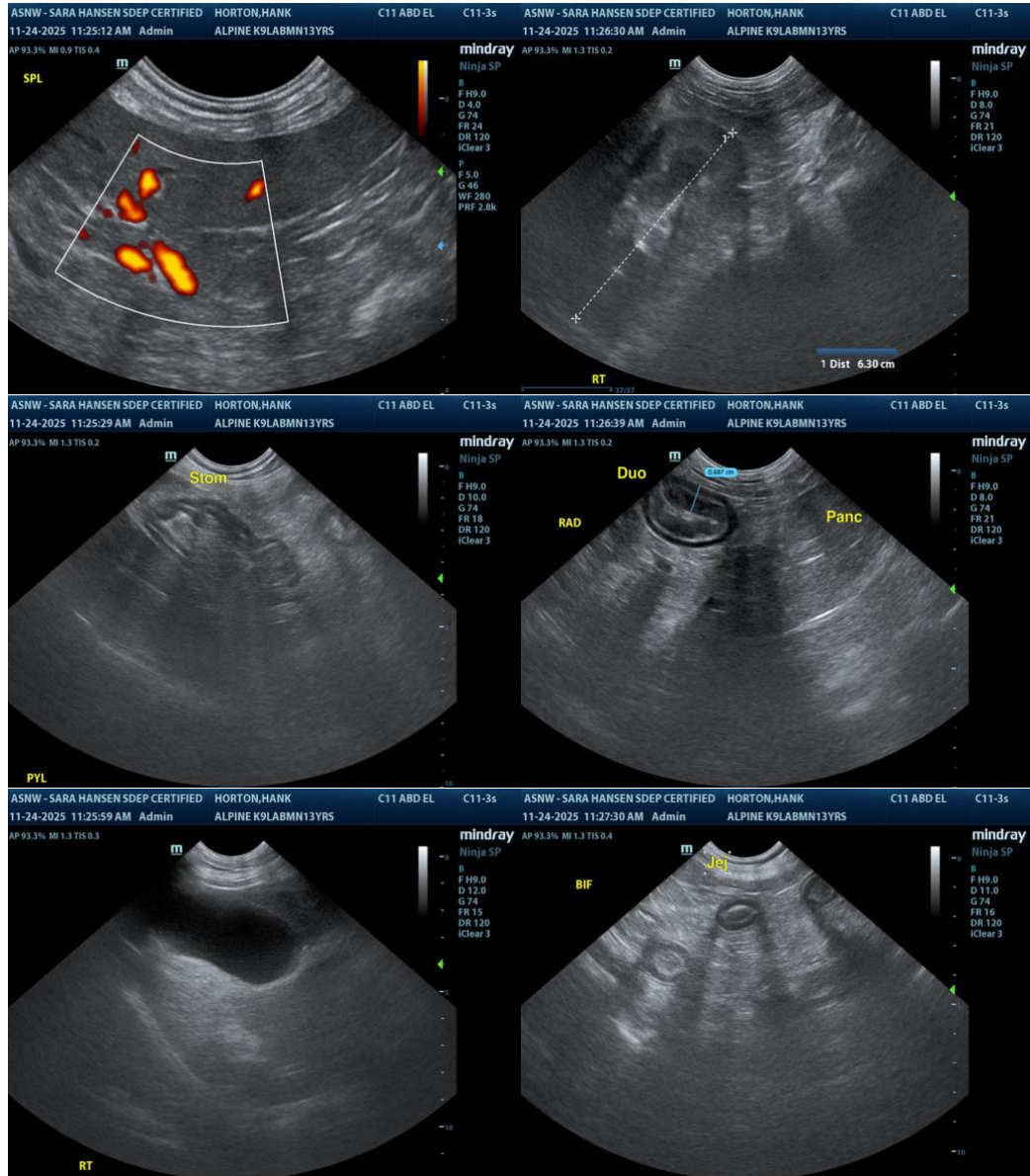
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emerging gastrointestinal neoplasia are all potentials. Gastrointestinal support is indicated initially with clinical monitoring. Concurrent sonographic monitoring of the gastrointestinal tract is indicated if progressive gastrointestinal signs or weight loss. A spec cPL is warranted to assess for mild to chronic pancreatitis.





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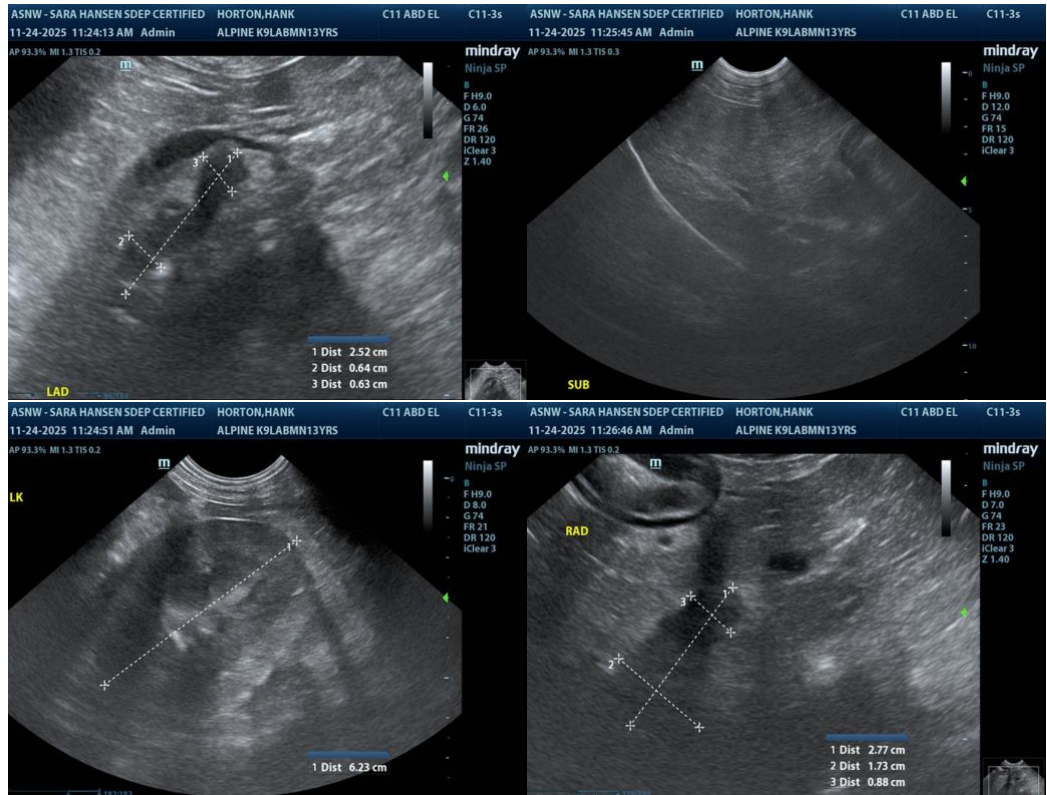
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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