



PATIENT

Quint Bell

SPECIES

Canine

BREED

Rottie

SEX

Male Neutered

AGE

4

WEIGHT

131

INTERPRETED BY

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

IMAGING PERFORMED BY

Jenn

HOSPITAL NAME

Rockaway Animal
Hospital

REFERRING VET

Dr. Maniar

INVOICE

12764

DATE

11/3/25

PRESENTING CLINICAL SIGNS

History: collapsed outside, swollen abd

Abnormal PE/Chem/CBC/UA Results: Glu 388 ALT 182 ALP 837 GGT 16 Lipase 687 Proteinuria, hematuria glycosuria

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and cystourethral junction 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 changes were noted.

The residual prostate was not definitively visualized without evidence of pathology.

The area of the aortic trifurcation was free of pathology.

Normal size and margination was present in the left kidney. 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 8.6 cm in length. The right kidney was indistinctly visualized owing to patient size and confirmation with no obvious pathology present.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.65 cm width at the caudal pole. The right adrenal gland was not definitively visualized owing to patient size and confirmation.

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

The liver presented mild to moderately 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, non-organized, echogenic, nonmineralized biliary sludge. The cystic duct and common bile ducts were normal without evidence of dilation.

Gastrointestinal

The visible gastric walls exhibited intact wall layering without mural pathology or hypertrophy. The stomach contained mild, progressively shadowing ingesta without overt evidence of obstruction to pyloric outflow.



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The visualized segments of the small intestine exhibited intact wall layering with normal wall layer ratio and an empty lumen.

The visualized colon presented sonographically normal.

Pancreas

The area of the pancreas presented sonographically normal.

Free Abdomen

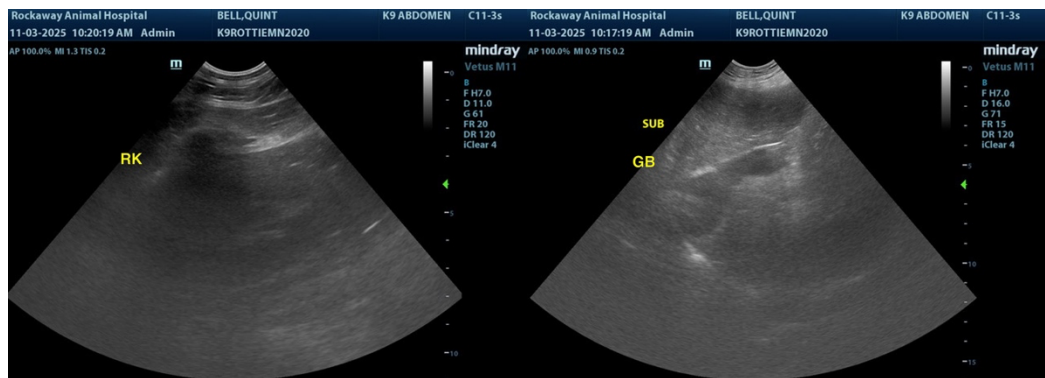
No overt lymphadenopathy or peritoneal effusion was present. No evidence of abdominal masses noted.

ULTRASONOGRAPHIC FINDINGS

- Nonspecific hepatopathy – subjective benign, vacuolar/metabolic hepatopathy, inflammatory disease, non-obstructive cholestasis or other without sonographic evidence of hepatic neoplastic criteria or post hepatic obstruction
- Non-distended gallbladder with mild, non-organized bile sediment
- Normal gastrointestinal tract with mild, progressively shadowing gastric ingesta

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered. Assuming normal clotting status, hepatic FNA cytology could be considered for further clarification. Fructosamine level, if clinical suspicion for diabetes as well as a spec cPL to assess for pancreatitis is recommended. 3-view chest radiographs indicated if not recently done.





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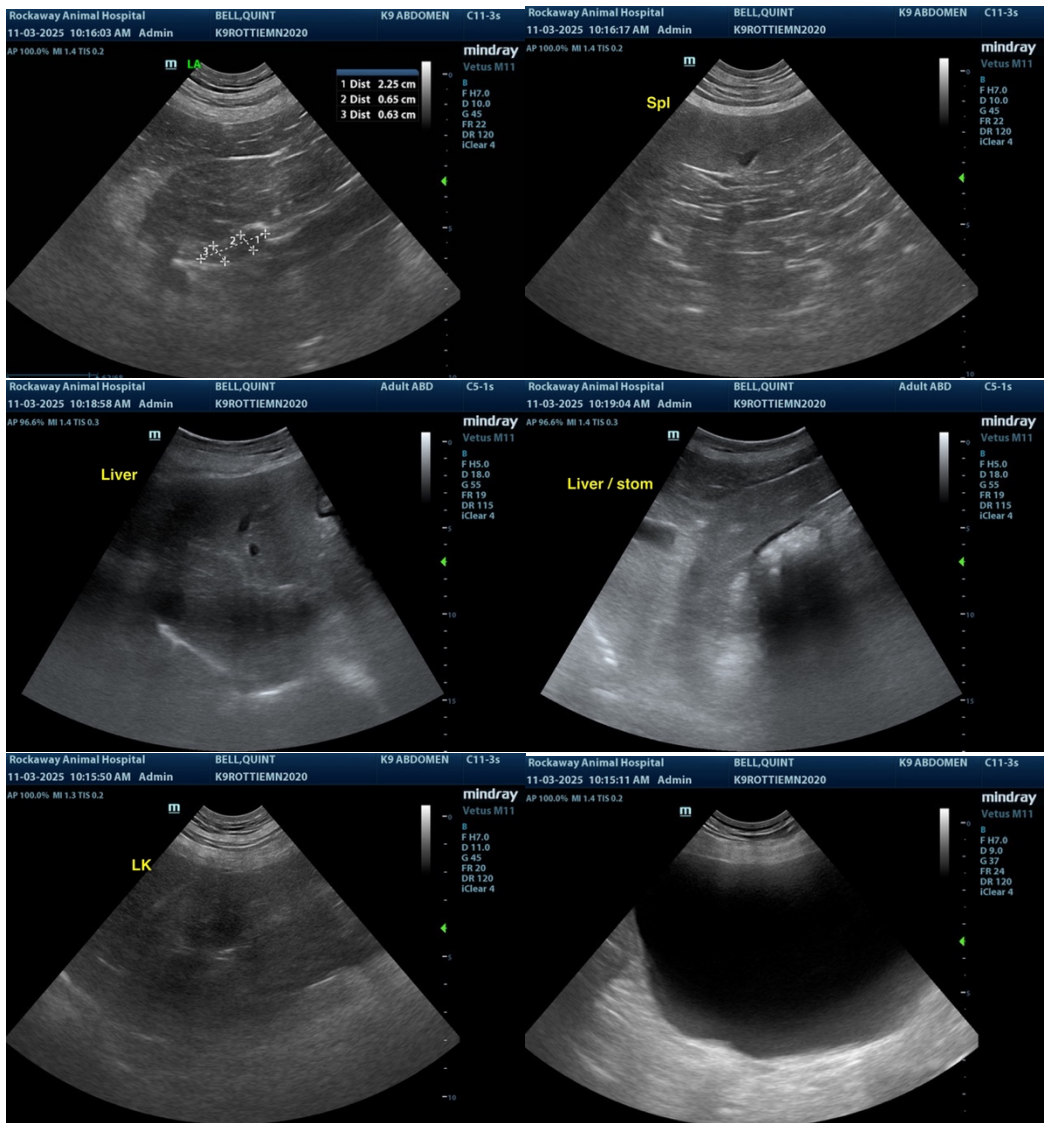
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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