



PATIENT

Frisco Gallagher

SPECIES

Canine

BREED

Border Collie

SEX

NM

AGE

15 years

WEIGHT

22.8 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Haley Harasimowicz

HOSPITAL NAME

Peak Veterinary
Referral Center

REFERRING VET

Haley Harasimowicz

INVOICE

10305

DATE

11/6/25

PRESENTING CLINICAL SIGNS

Presented to hospital 2 days ago with 2 day history of anorexia, diarrhea and tenesmus. P lives on a dairy farm and frequently eats cow manure and roams in pastures. Previous history of laryngeal paralysis, as well as elevated renal values and liver noted in June/July per owners. Currently on wet food of unknown brand (owner could not remember) and dasuquin daily. Since in hospital over the last 2 days on IVF, buprenorphine, entyce and Unasyn (see below) p has begun eating GI LF canned diet with no vomiting. Diarrhea has persisted.

Abnormal PE/Chem/CBC/UA Results: This morning, p is BAR, normal hydration. Mild cranial abdominal pain persists. Rectal exam showed soft to liquid brown stool. Normothermic. Heart and lung sounds are WNL. CBC - Lymph 0.7 (L) PCV 48%, TS 7.0g/dL Chemistry - BUN 49 (H), Creat 1.7 (H), Glob 3.9 (H), Chol 434 (H), Amyl 1895 (H), all else WNL U/A (cysto) - light yellow, USG 1.008, pH 6, prot 100, sediment: possible cocci present vs amorphous debris on manual review, negative on bacterial confirmation cPL: 121 (WNL) Urine culture not previously performed Abdominal and thoracic rads showed sliding hiatal hernia, hepatomegaly, diffuse bronchointerstitial pattern (with possible emerging patchy interstitial pattern in cranial lung lobes)

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 evidence of urine or 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.

The residual prostate was free of pathology.

No evidence of pathology in the area of the aortic trifurcation.

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 mild loss of corticomedullary symmetry and definition expected for the age of the patient. Mild left kidney pyelectasia was present. Minor areas of medullary mineral were present. The left kidney measured 6.4 cm in length. The right kidney measured 6.2 cm in length.

Adrenal Glands

The bilateral adrenal glands were normal in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 0.8 cm width in the caudal pole. The right adrenal gland measured 0.71 cm width in 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



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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/ Gallbladder

The liver presented hepatomegaly with symmetrical rounded capsule contour and mild nonhomogeneous increased hepatic parenchyma echogenicity. Multiple, variably sized yet nondisruptive, homogeneous to hypoechoic intraparenchymal nodules were present with an example of a larger ventrocaudal intraparenchymal nodule measuring 2.1 cm diameter. The gallbladder was non-distended in size containing primarily anechoic content with mild, congealed yet nonorganized, peripherally adhered gallbladder debris. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty without evidence of retained ingesta, fluid, or foreign material.

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 ileus, obstruction, or foreign material.

Normal visible colon wall layers were present with semi-formed fecal matter.

Pancreas

The right pancreas was normal in size with maintained symmetrical contour and mild nonhomogeneous hypoechoic parenchyma. No evidence of peripancreatic omental inflammation.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Chronic renal changes exhibiting mild medullary mineral and left kidney pyelectasia
- Hepatomegaly exhibiting nonhomogeneous nodular parenchyma - chronic vacuolar hepatopathy, nonspecific hepatitis, hyperplasia, hematopoiesis, neoplasia, all potentials
- Nonorganized primarily peripheral gallbladder debris (non mucocele)
- Sonographically unremarkable empty gastrointestinal tract with semi-formed fecal matter in colon
- Mildly hypoechoic right pancreas without peripancreatic inflammation



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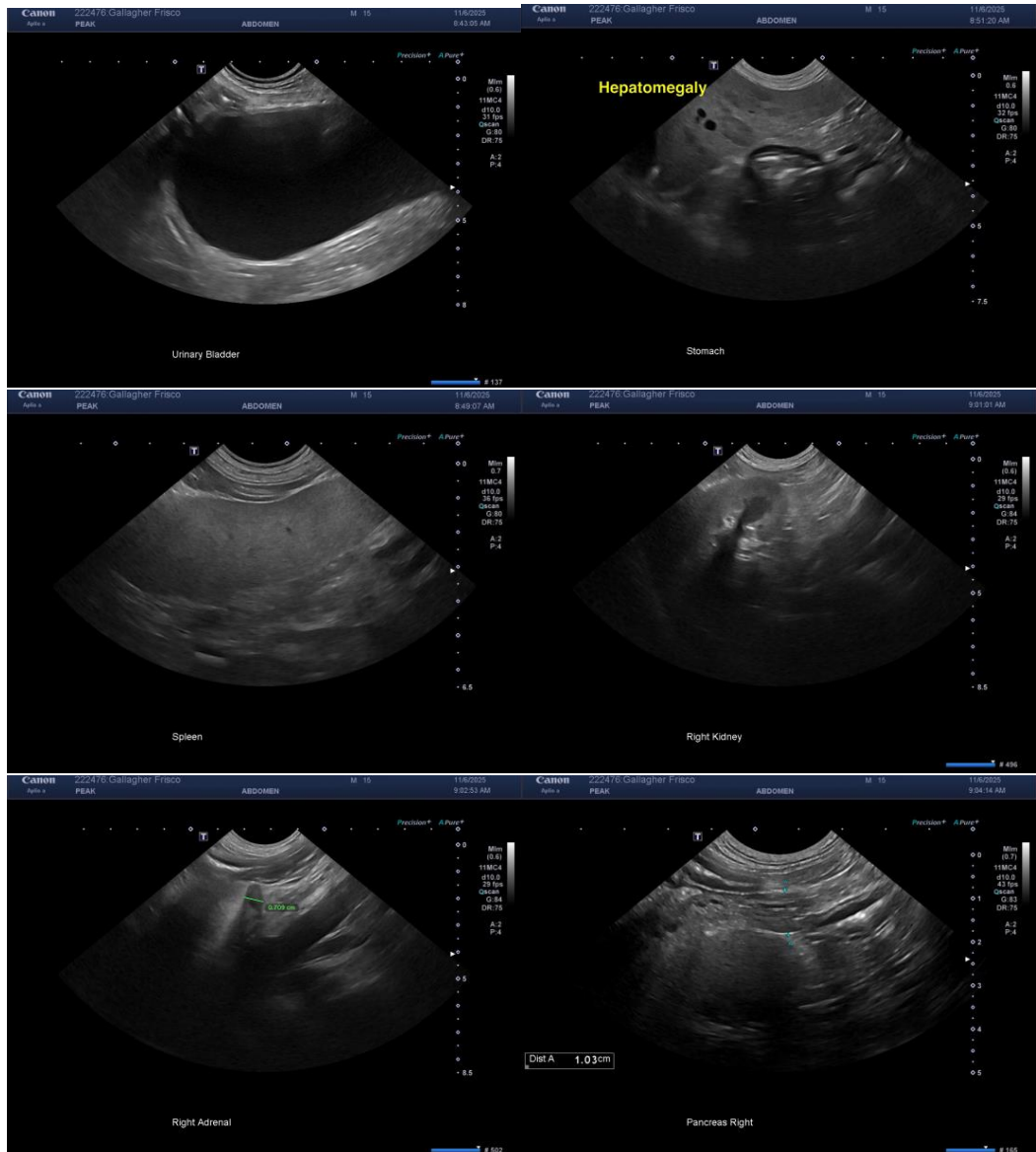
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered. If present, the degree of right limb pancreatic inflammation appears to be mild without surrounding omental reactivity or inflammation.

Assuming normal clotting status and using a 25-gauge needle, hepatic parenchyma and accessible nodule FNA cytology are warranted for further clarification. Gastrointestinal support and empirical therapy for mild pancreatitis with continued clinical monitoring would be reasonable. Sonographic reassessment is indicated if progressive azotemia, arising hepatopathy, or persistent / nonresponsive gastrointestinal signs.





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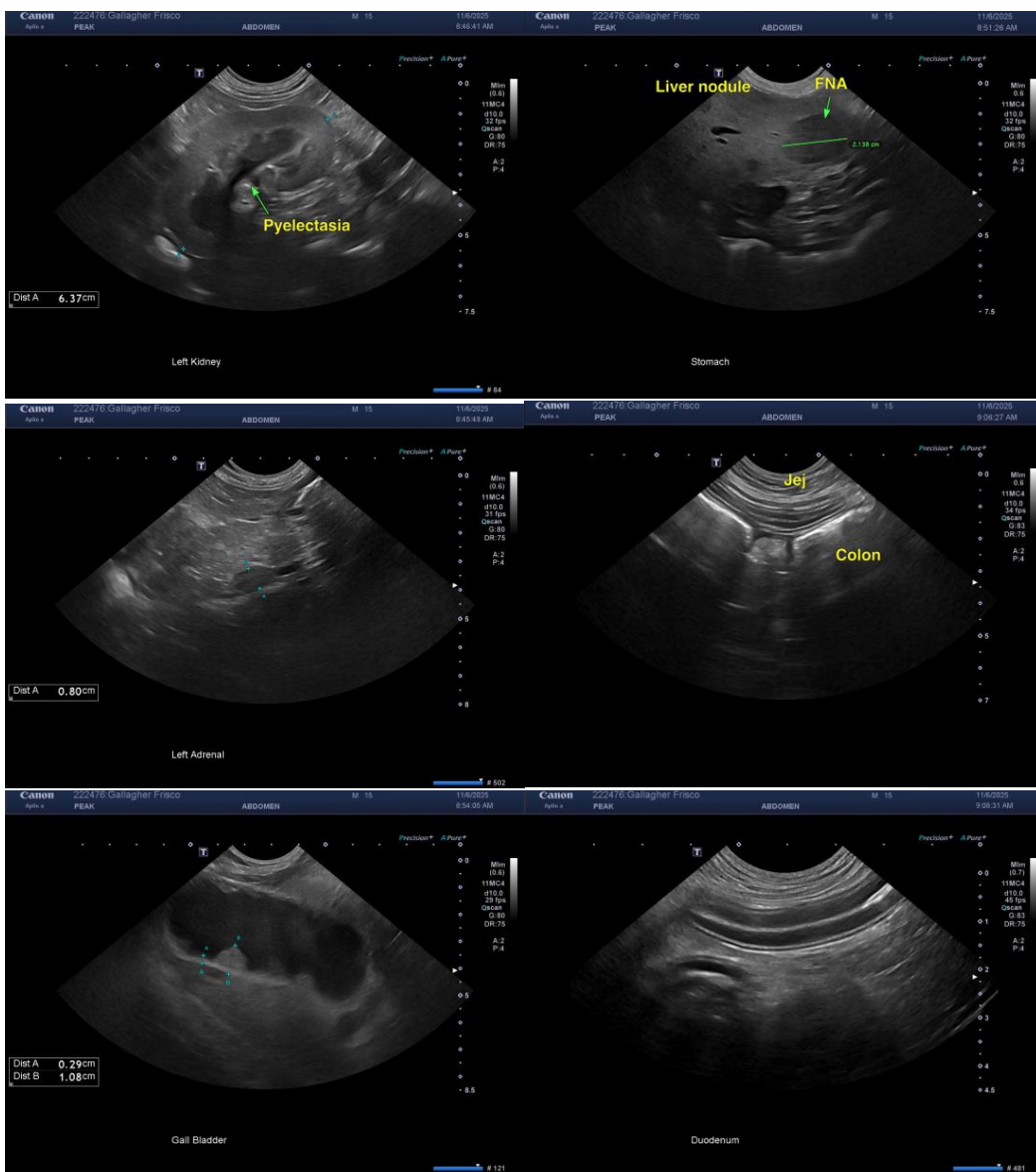
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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