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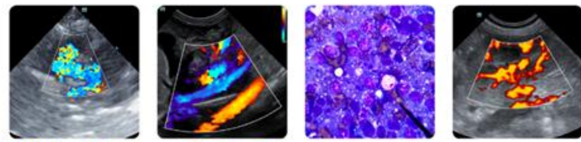


Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT
Bam Bam Burton

SPECIES
Canine

BREED
Terrier

SEX
MN

AGE
11yr

WEIGHT
8kg

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

IMAGING PERFORMED BY
Renee Trionfetti, VMD

HOSPITAL NAME
Blue Pearl Wyomissing

REFERRING VET
Heatherlynn McFarlane, DVM (Internal Med)

INVOICE
23145

DATE
12/08/2025

PRESENTING CLINICAL SIGNS

AUS to further evaluate DKA w/ elevated amylase/lipase and suspected Cushings and progressive azotemia and acidemia. Now also having melena and vomiting coffee ground emesis (similar appearance to the melena). Diagnosed with DM about 1 year ago. LDDST was concerning for Cushings (PDH) and did start on Trilostane but did not tolerate the medications. Over the last few months has had a decreasing appetite. Presented to pDVM on Saturday and BW concerning for DKA. Transferred to the ER where is currently hospitalized and being managed for DKA and progressively worsening azotemia and acidemia. Hosp mgmt: Insulin CRI w/ Dextrose, Cerenia, Sucralfate, Pantoprazole, Buprenorphine. Metronidazole was D/C.

Abnormal PE/Chem/CBC/UA Results: One view chest rad - no obvious nodules 12/6 pDVM - Chem: Glu 536 H, BUN 56 H, Ca 6.8, ALP 1691 H, Amylase Too high to read, Lipase 4000 H, Cl 100 L CBC: WBC 25 K H, Neut 21,500 H w/ suspected bands or toxic/degenerative change, Monos 1,650 ER 12/7 -> 12/8: PCV/TS - 38/6.6 --> 28%/6.0 EPOC - Creat 2.42 H --> 2.45 H, BUN 108 H --> > 120 H, K 3.3, Na 138, pH 7.192 L --> 7.16 L, Bicarb 11.9 --> 9.8 LL, BE (-)16.3 -- (-)18.9 Gluc 200 H Phos 7.3 H (higher than pDVM) --> 3.1 UA: pending

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 mild non-dependent particulate sediment. 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 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. No evidence of pelvic dilation was present. The left kidney measured 6.7 cm in length. The right kidney measured 7.3 cm in length.

The area of the aortic trifurcation was free of pathology.

The residual prostate appeared normal and free of pathology

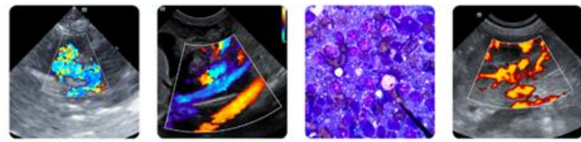
Adrenal Glands

Bilateral mild adrenomegaly was present with symmetrical contour and mild heterogeneous non-mineralized parenchyma. The left adrenal gland measured 0.74 cm width at the caudal pole The right adrenal gland measured 0.70 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 thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver/Gallbladder



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The liver presented increased in size. The parenchyma of the liver was subjectively increased in echogenicity compared to the spleen and renal cortices. The echotexture of the liver parenchyma was uniform with a mild coarse echotexture. The capsule of the liver was symmetrical in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. No visualized masses or nodules were present.

The gallbladder was non-distended in size with thin walls and mild non-organized debris. No evidence of gallbladder/peripheral gallbladder inflammation or wall edema was present. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. Mild gastric distension with primarily anechoic fluid and chyme was present. No evidence of shadowing gastric echo, overt foreign material or mechanical pyloric outflow obstruction.

The intestinal walls demonstrated intact wall layering and maintained 1:3 muscularis / mucosa ratio. The mucosa exhibited mild decreased echogenicity with occasional mucosal speckling. Duodenal corrugation was present. A segmental to diffuse ileus pattern consisting of mild fluid accumulation in the intestinal lumen was present without obstruction or foreign material.

The colon walls presented intact yet prominent wall layering with mild thickened to echogenic submucosa. Soft fecal matter was present in the colon lumen with lumen dilation.

Pancreas

The pancreas was swollen in appearance with symmetrical contour and homogenous mildly hypoechoic parenchyma.

Free Abdomen

Peripancreatic to cranial abdomen mild hyperechoic omentum and minor effusion.

No visualized significant omental lymphadenopathy.

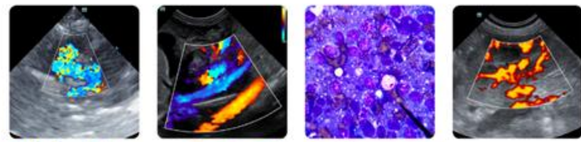
ULTRASONOGRAPHIC FINDINGS

Primary

- Diabetic hepatopathy /hepatic lipidosis pattern
- Non-organized gallbladder debris (non-mucocele)
- Pancreatitis
- Non-specific mild chronic renal changes - possible concurrent diabetic nephropathy
- Bilateral mild adrenomegaly

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Correlation with pending UA and C/S assuming evidence of glucosuria or inflammatory sediment is recommended. DKA protocol with empirical therapy for pancreatitis and gastroprotectants is indicated. If patient is stabilized or if recurrent diabetic dysregulation, recheck adrenal workup may be considered.



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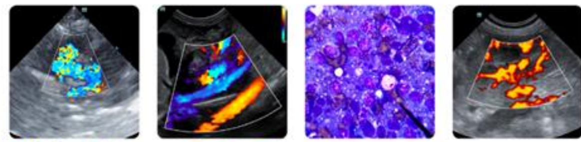

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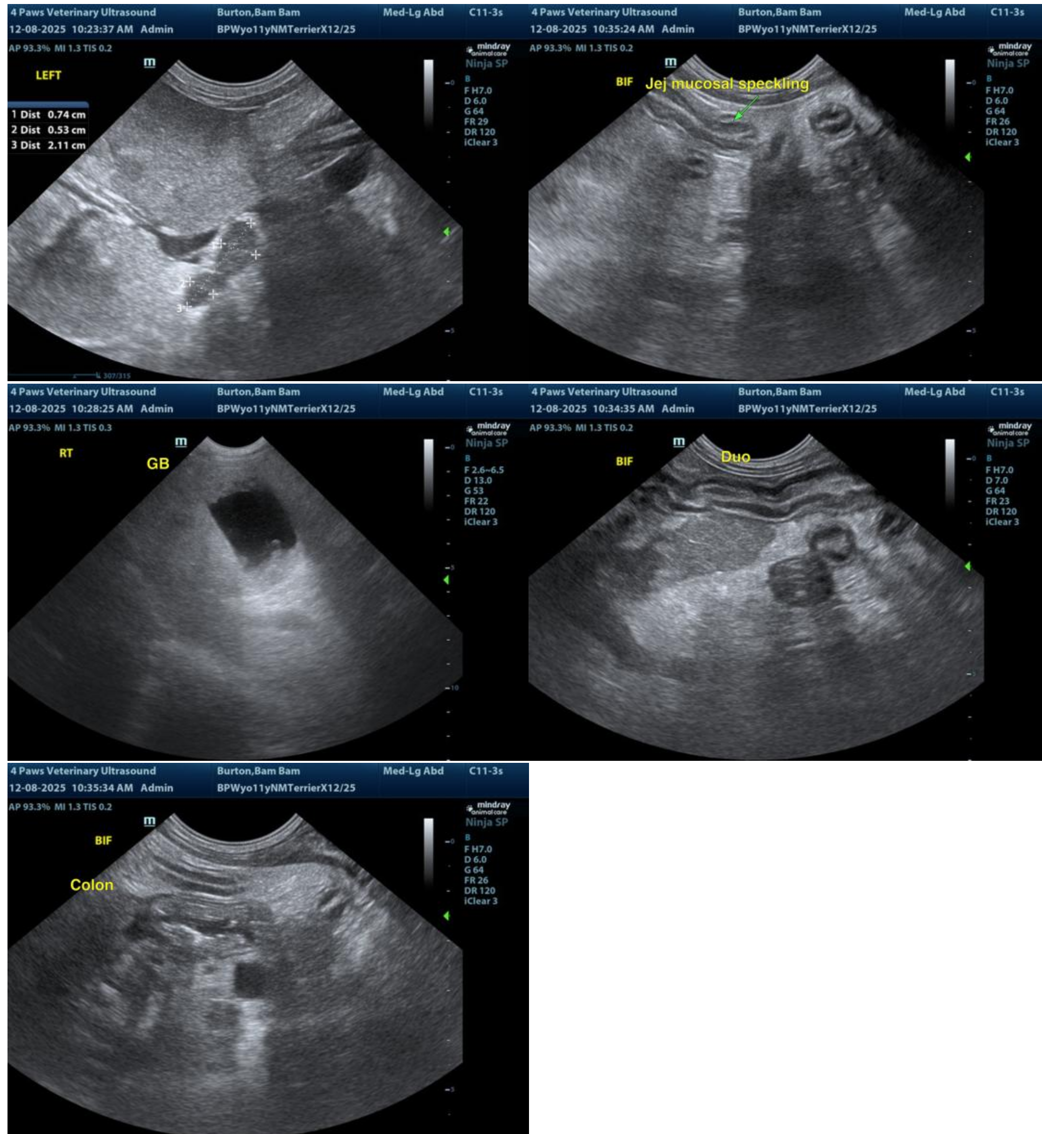

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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