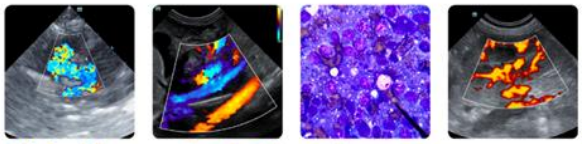


PATIENT

Oscar Stansal

SPECIES

Canine

BREED

Dachshund Mix

SEX

MN

AGE

15

WEIGHT

6.8kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Westcott

HOSPITAL NAME

Dr Alastair Westcott DVM

REFERRING VET

Westcott

INVOICE
23736

DATE
02/01/2026

PRESENTING CLINICAL SIGNS

- evaluation of chronic intermittent vomiting, reported as bilious occurring 3–4 times weekly, most commonly in the early morning, beginning in late December.
- Since onset, there has been profound weight loss (~4 lb)
- marked hyporexia with current intake estimated at ~20% of normal daily calories,
- reduced water intake, and generalized weakness with decreased energy levels

Abnormal PE/Chem/CBC/UA Results: Thin Borderline hydration status Heart murmur Mild NRA Mild elevations ALT/ALP Normal Spec PL Isosthenuria despite reduced drinking levels Normal thoracic rads BP not done

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 no evidence of urine/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.

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 moderate loss of corticomedullary symmetry and definition expected for the age of the patient. Bilateral minor pyelectasia and intermittent cortical cysts were present. The left kidney measured 4.5 cm in length. The right kidney measured 4.8 cm in length.

The area of the aortic trifurcation was free of pathology.

The residual prostate appeared normal and free of pathology.

Adrenal Glands

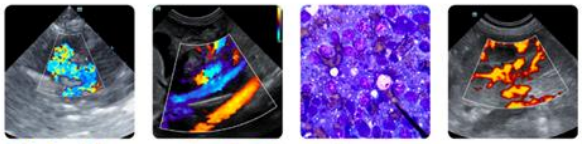
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.38 cm width at the caudal pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.33 cm width 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. A small splenic nodule hypoechoic splenic nodule was present.

Liver/Gallbladder

The liver was subjectively borderline to mildly enlarged. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion. A small area of indistinctly marginated mid to caudal lobar swelling exhibiting similar parenchyma echogenicity and echotexture compared to adjacent liver measuring ~ 2.6 cm in diameter.



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The gallbladder was non-distended in size with thin walls and mild non-organized 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 with no signs of ileus, obstruction 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 mechanical/metabolic ileus, obstruction or foreign material. The duodenum wall measured 0.44 cm width. The jejunum wall measured 0.36 cm width.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The pancreas was mildly prominent in size with mild capsule asymmetry and isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

Free Abdomen

No omental masses, overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary

- Normal empty gastrointestinal tract
- Prominent non-homogenous remodeled pancreas - chronic pancreatitis, remodeling owing to previous inflammation possible
- Mild hepatopathy pattern with parenchymal remodeling and mild mid caudal lobar swelling - vacuolar / cholestatic hepatopathy, inflammation, hyperplasia, possible emerging small caudal hepatoma, emerging to potential low-grade neoplasia possible
- Non-organized gallbladder debris
- Chronic renal changes exhibiting minor pyelectasia and cortical cysts
- Small hypoechoic splenic nodule

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Assuming normal clotting status, hepatic parenchyma and if accessible mild caudal area of lobar swelling FNA cytology warranted for further clarification. Overt hepatic neoplastic criteria was not met yet technically not excluded. Hepatosupportive medications and monitoring would be reasonable.

A GI panel to include PLI/TLI/Cobalamin/Folate and neurological/ musculoskeletal exam to assess for occult pathology as a contributing factor to the weight loss suggested. Gastrointestinal support and empirical therapy for potential chronic pancreatitis despite normal spec cPL would be appropriate.

Potential etiologies for the splenic nodule may include benign processes such as nodular hyperplasia, extramedullary hematopoiesis, hematoma, infection, infarction, or neoplasia. Ultrasound guided FNA of the nodule using 25-gauge needle and assuming normal coagulation parameters may be considered. Otherwise, sonographic monitoring of the splenic nodule for any changes in size or appearance with initial recheck in 3-4 weeks would be a more conservative approach.

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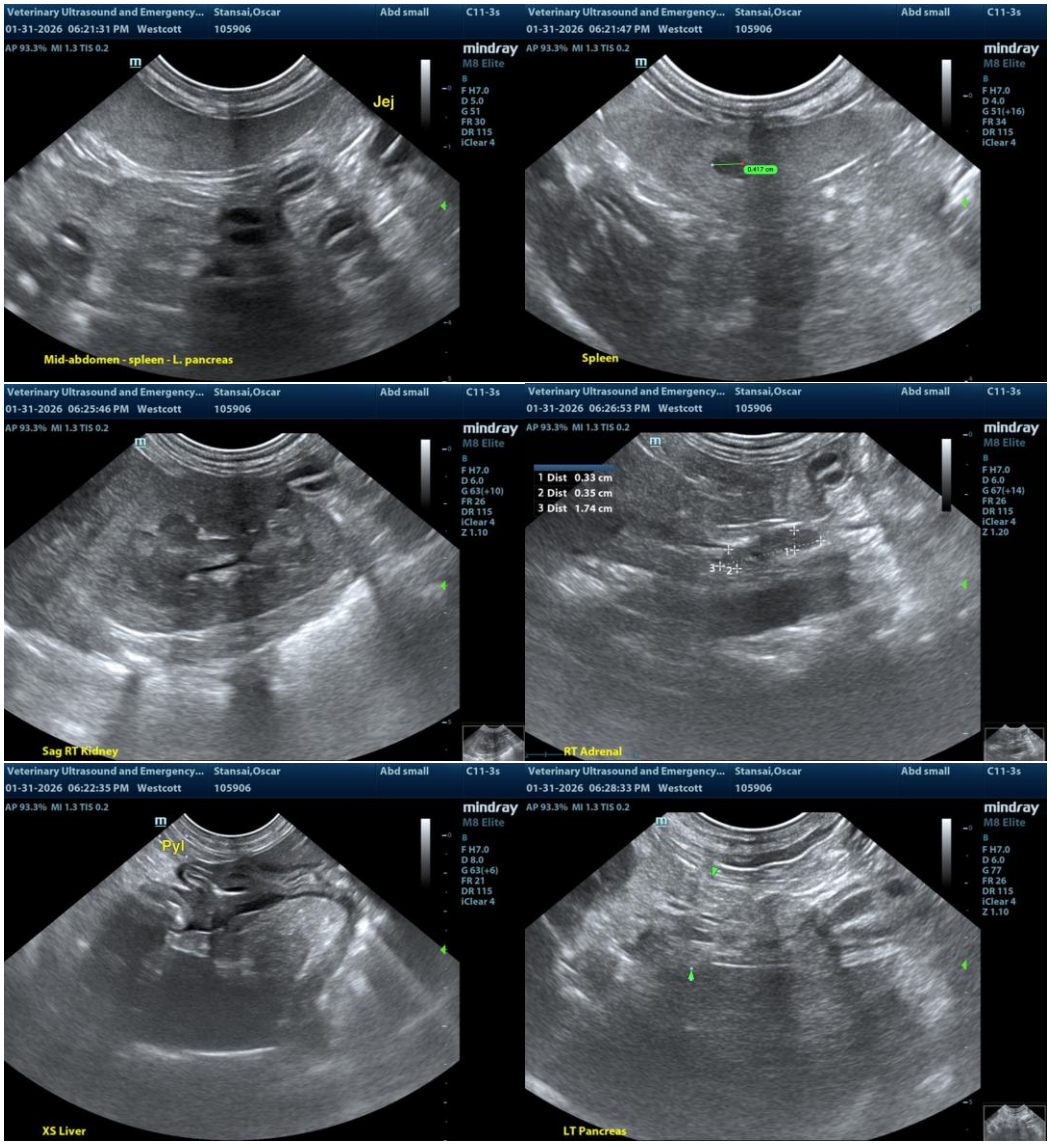
Further renal staging to include urine C/S and protein: creatinine ratio on sterile urine sample may be considered.



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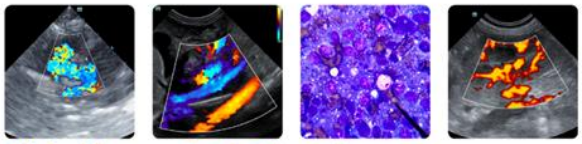

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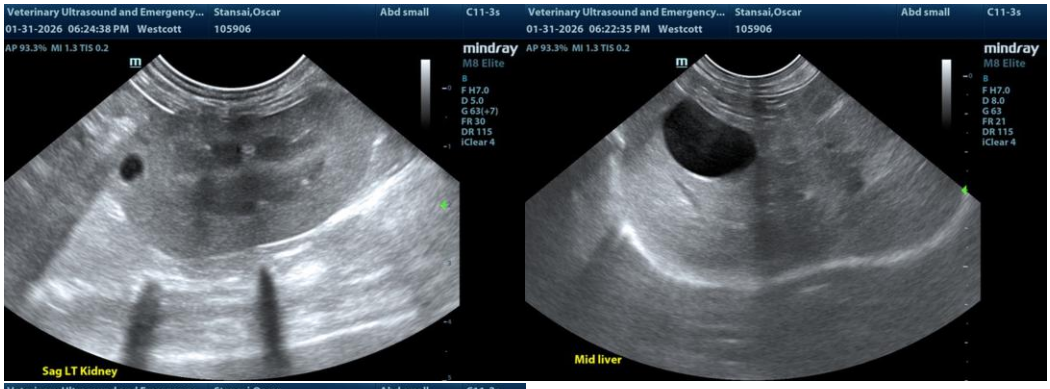

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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