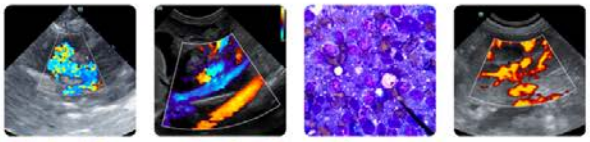

PATIENT

E.B. Mando

SPECIES

Canine

BREED

Tibetan Spaniel

SEX

Neutered Male

AGE

11 Years 5 Months

WEIGHT

18.3

INTERPRETED BY

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

IMAGING PERFORMED BY

Heather

HOSPITAL NAME

Animal Care Clinic of Flanders

REFERRING VET

Dr. Casulli

INVOICE

73923

DATE

3/23/26

PRESENTING CLINICAL SIGNS

Vomiting, weak, not eating well. Very lethargic when came in - owner stated within 15 mins of giving PVPs (gabapentin and trazodone) he was acting very tired. Weak hind legs, decreased muscle, pain lumbar spine. Vetmedin 2.5mg BID , enalapril 15mg BID, sildenafil 1.2 BID prednisone 5mg SID

Abnormal PE/Chem/CBC/UA Results: BUN - 140, CREAT - 4.2, PHOS - 10.8, AMYLASE - 1939, LIPASE >1800, alt - 170, alk phos 1256, HCT - 30.3

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder exhibited normal thickness and tone. Anechoic urine was present in the lumen with mild dependent lumen mineral and non-dependent particulate urine sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes 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 loss of corticomedullary symmetry and definition expected for the age of the patient. Medullary mineral to small renoliths noted in both kidneys. Mild left kidney pyelectasia and intermittent small cortical cysts noted. Left kidney measured 4.3 cm. Right kidney measured 3.8 cm.

Adrenal Glands

The adrenal glands were not definitively visualized.

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

The liver was subjectively normal in size, structure, and contour. Heterogeneous hepatic parenchyma exhibiting variable parenchymal remodeling and coarse echotexture. No distinct masses or nodules visualized. The hepatic and portal vasculature were normal in appearance without signs of congestion.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was primarily empty with lumen gas and minor retained pyloric fluid.

The small intestine presented intact wall layering with overall maintained 1:3 muscularis/mucosa ratio. Segmental duodenal corrugation and discrete hyperechoic duodenojejunal mucosal speckling noted. Generalized empty intestinal lumen without mechanical/metabolic ileus to the level of the colon.

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

Pancreas

The pancreas was mildly prominent in size with mild peripancreatic hyperechoic omentum.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Enlarged, non-homogeneous liver.
- Normal gallbladder.
- Mildly prominent, non-homogeneous parenchyma.
- Chronic renal changes exhibiting medullary mineral/small renoliths.
- Mild left kidney pyelectasia.
- Mild urinary bladder lumen mineral and non-dependent urine sediment.
- Non-specific gastroenteropathy exhibiting mild gastric ileus and segmental duodenojejunal corrugation/discrete mucosal speckling.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Correlation of azotemia with full urinary workup including urinalysis, culture and sensitivity, and baseline UPC level for renal staging is recommended.

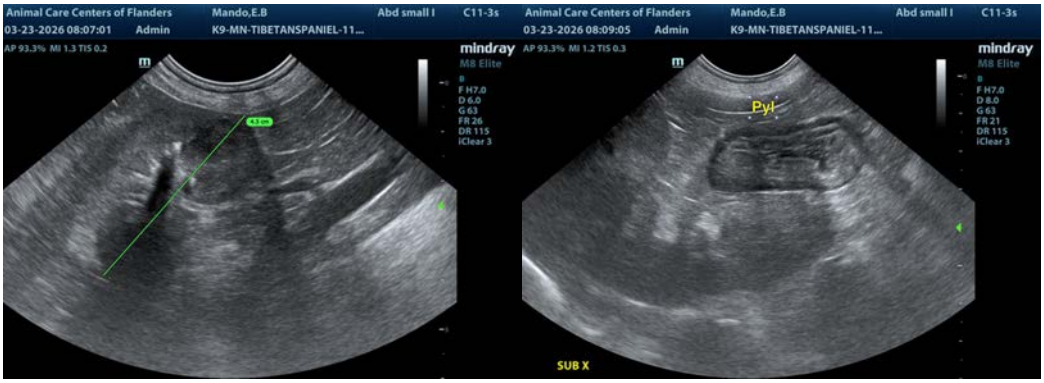
The liver may indicate chronic vacuolar, inflammatory, metabolic, or cholestatic hepatopathy with parenchymal remodeling. Potential for occult hepato-gastrointestinal neoplasia, which is thought less likely but not definitively excluded. Potential suppression of hepatic parenchymal and intestinal mural changes owing to Prednisone possible.

Chronic pancreatitis may be suspected if cranial abdominal/subxiphoid discomfort on palpation. Correlation with a spec cPL and full GI panel to include PLI, TLI, cobalamin and folate is warranted.

Musculoskeletal or neurological disease as a contributing factor is possible.

This patient may be passing small amounts of mineral from the kidneys into the urinary bladder.

Gastrointestinal and renal support with empirical therapy for possible chronic pancreatitis and, and clinical monitoring is recommended.



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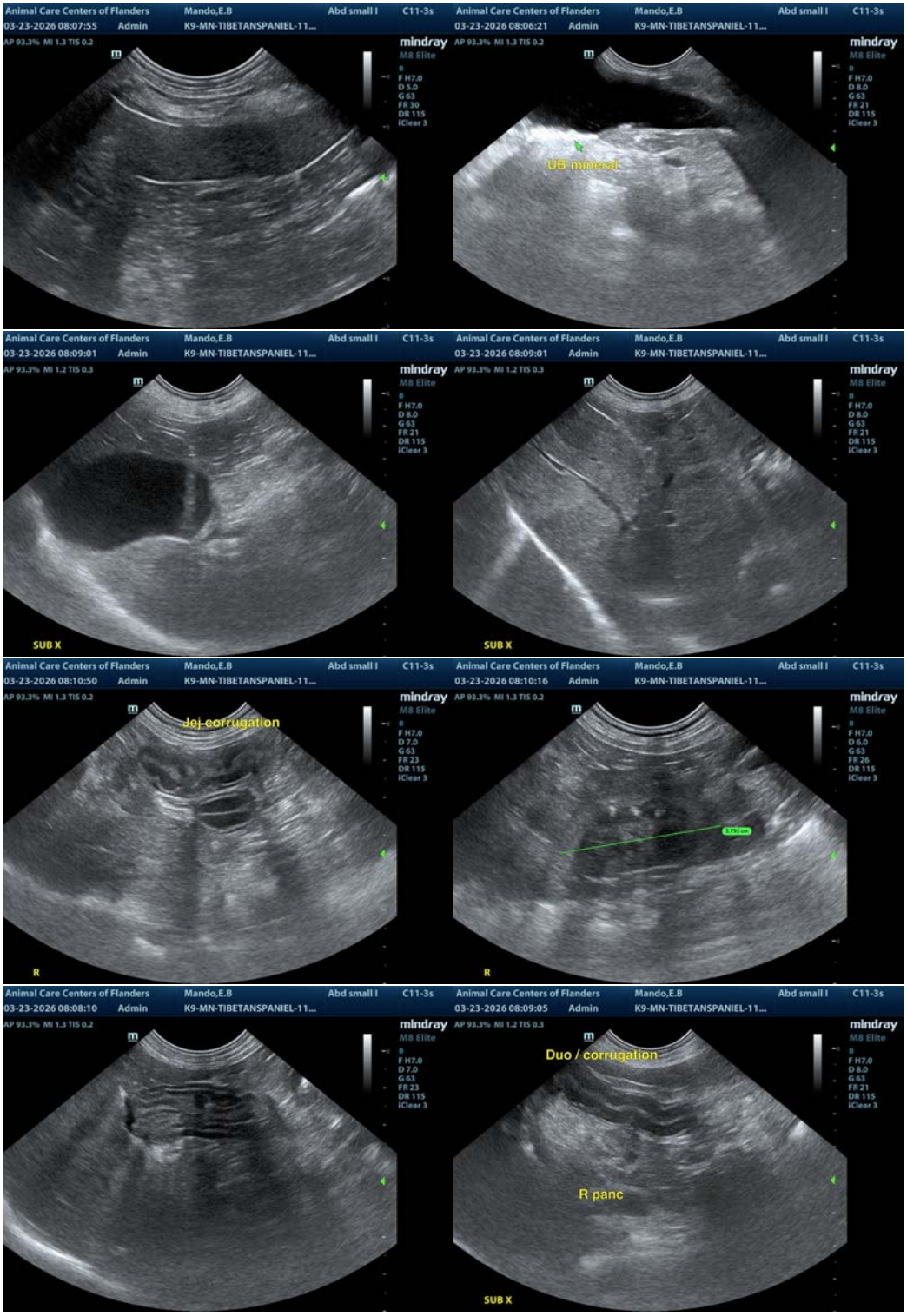

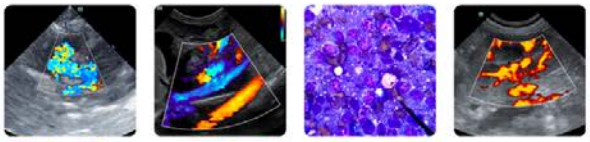

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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