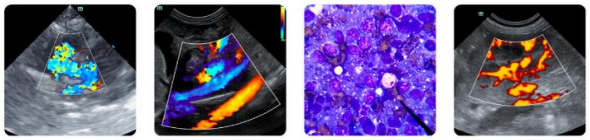


PATIENT

Leo Brindle

SPECIES

Canine

BREED

Shih Tzu

SEX

MN

AGE

14 years, 2 months

WEIGHT

7.9 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Patti Mayfield DVM

HOSPITAL NAME

Sunriver Veterinary Clinic

REFERRING VET

Emily Kent DVM

INVOICE

10800

DATE

4/14/26

PRESENTING CLINICAL SIGNS

History: - Patient presented for a 2-3 week hx of hyporexia and increased sleeping (no lethargy reported).

- No v/d/s/c. - No reported weight loss. - Mild regenerative microcytic, hypochromic anemia; however, this has not changed dramatically from the last labwork in Aug 2024. WBC counts are normal. PLTs are elevated, which could be due to an inflammatory response or even stress.

- Chemistry shows mild elevations to BUN, TP , ALB, K, and ALP . - His remaining liver and kidney values are WNL.

PE findings: Moderate to severe dental disease. Grade IV heart murmur- static/chronic. Mildly overweight - CBC: HCT 39.4 (39.8), HGB 12.3 (13.4), MCH 20.9 (20.7), MCHC 31.2, RET-HGB 21.8, PLT 868,000 remainder (RBC 5.88, RETIC 88, WBC 10.5, NEU 7.78) - Chem: BUN 44, K 5.9, Na:K 25, Cl 105, TP 7.9, ALB 4.1, ALP 430, CK 213 remainder WNL (GLU 81, SDMA 11, CRE 0.9, Phos 4.4, Ca 11.8, Na 147, TCO2 24, Anion gap 24, Glob 3.8, ALT 104, AST 34, GGT 4, TBIL 0.1) - UA: USG 1.023, pH 5.0, 2+ protein, UPC 0.6Recheck UPC (3 samples): 0.4 - T4: 1.4 - Fecal: Giardia cysts present, remainder WNL

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 uroliths or sediment. No urine, mineral or calculi. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

The area of the residual prostate appeared normal and free of pathology.

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

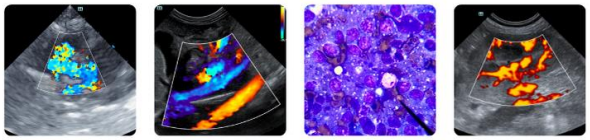
Normal renal size with asymmetrical margination was present in both kidneys. The renal cortex presented uniformly increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Loss of corticomedullary border demarcation was also present with intermittent small cortical cysts. The left kidney measured 5.4 cm in length. The right kidney measured 5.2 cm in length.

Adrenal Glands

The bilateral adrenal glands were mildly enlarged in size. Mild parenchyma heterogeneity and mild capsule asymmetry were present without suspicion for overt neoplasia. The left adrenal gland measured 0.81 cm width in the caudal pole. The right adrenal gland measured 0.67 cm width in the caudal pole.

Spleen

The spleen exhibited overall normal size and primarily homogeneous parenchyma with symmetrical contour. A solitary, mixed echogenic, mildly expansive, small, mid-splenic mass was present, measuring ~2.5 cm in diameter. Mild associated, primarily symmetrical medial capsule distortion was noted.



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Liver/ Gallbladder

The liver presented generalized hepatomegaly. Diffuse, variable, nonhomogeneous, remodeled parenchyma was noted, exhibiting variable coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size containing primarily anechoic content with mild to moderate, nonorganized, primarily peripheral lumen gallbladder debris. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach revealed in the caudal gastric body, an asymmetrical nonhomogeneous hypoechoic mural lesion with possible cystic component and loss of associated gastric wall layer detail, measuring ~4.4 cm x 1.9 cm. The remainder of the stomach wall was non-thickened, exhibiting intact wall layering. The stomach lumen was empty with mild lumen gas.

The small intestine presented intact prominent wall secondary to subjective prominent intestinal mucosa. The small intestinal lumen was empty. There is no evidence of mechanical / metabolic ileus to the level of the colon. The duodenum wall measured 0.54 cm width. The jejunum wall measured 0.48 cm width.

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

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease were evident.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Enlarged, nonhomogeneous liver
- Nonorganized gallbladder debris (non-mucocele)
- Small, mildly expansive, mixed echogenic splenic mass
- Caudal gastric mural mass with possible cystic component
- Intact mildly thickened small intestine wall
- Chronic renal changes exhibiting small cortical cysts
- Bilateral mild adrenomegaly

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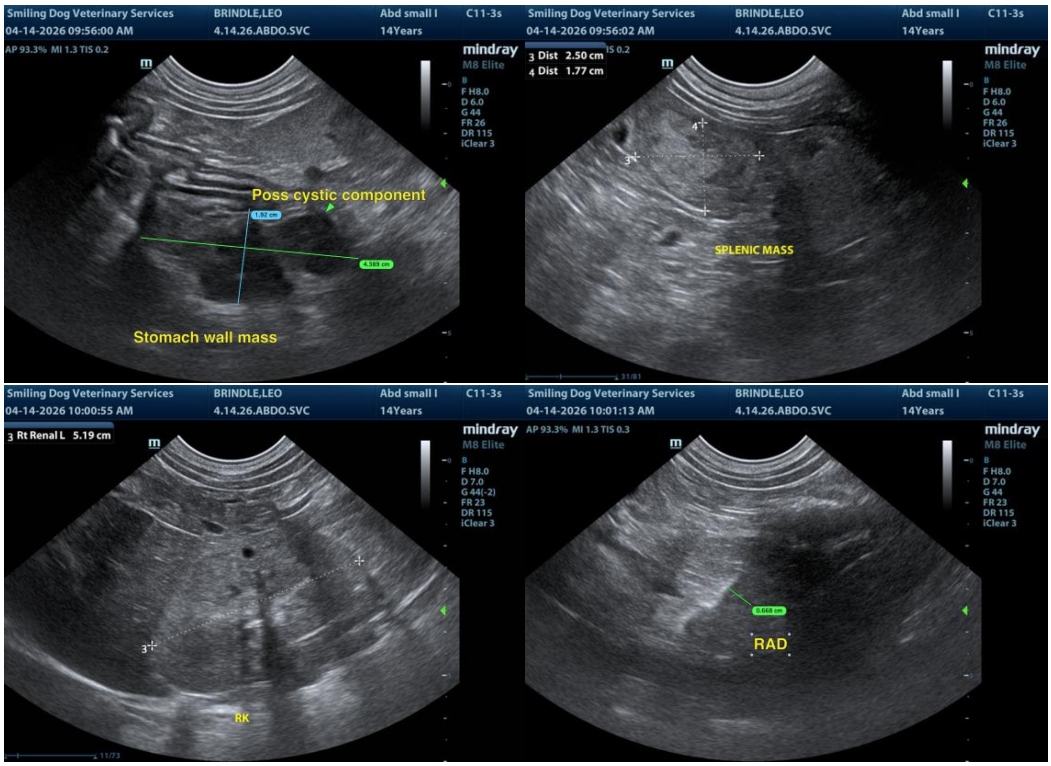
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The hepatopathy and small splenic mass are nonspecific, with both benign vs. neoplastic etiologies possible. However, a primary concern for a neoplastic gastric mural mass with potential for cystic component, given the loss of associated gastric wall layer detail, is warranted. Further assessment may include, assuming normal clotting status and using a 25-gauge needle, hepatic parenchyma and small splenic mass FNA cytology, while gastric mass biopsies are required for a definitive diagnosis.

Hepato-gastrointestinal support with serial monitoring of the liver, spleen, and stomach mass for evidence of progression would be a more conservative approach.

The bilateral adrenomegaly and intact mildly thickened small intestinal wall are of unclear clinical significance, given the current clinical signs and without additional gastrointestinal signs. Adrenal screening could be considered if clinical signs which suggest adrenal disease arise, as well as screening a GI panel to include PLI/TLI/Cobalamin/Folate.



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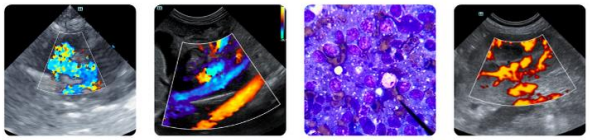

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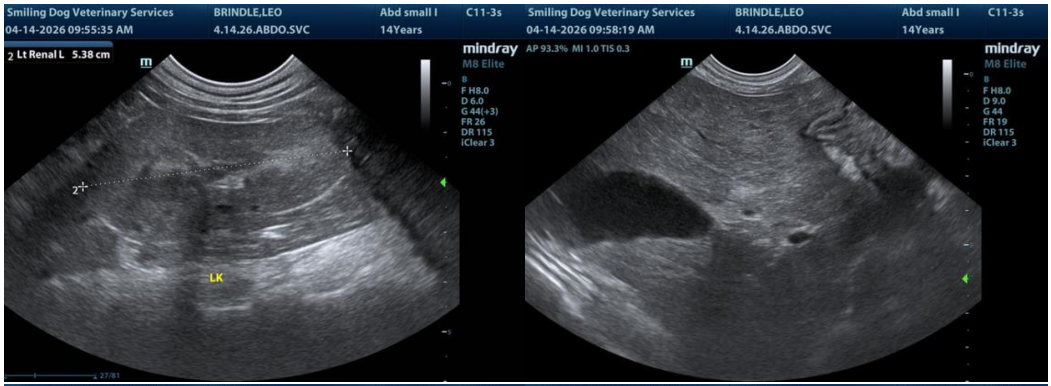

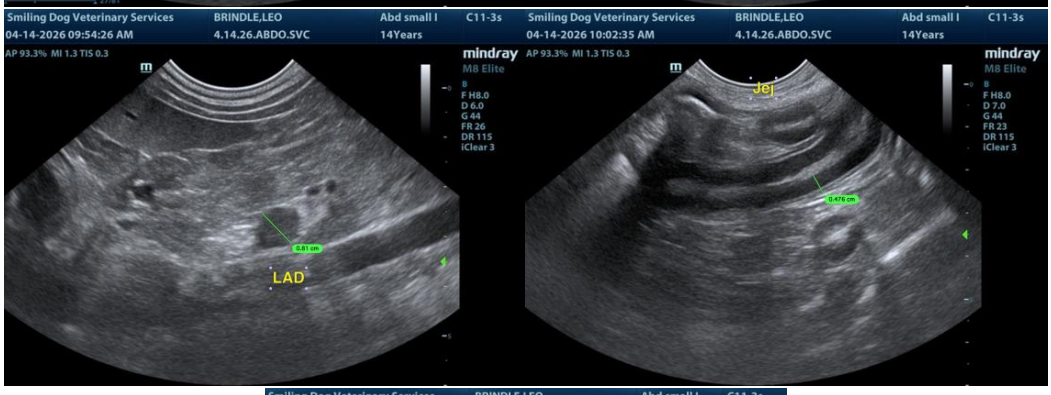

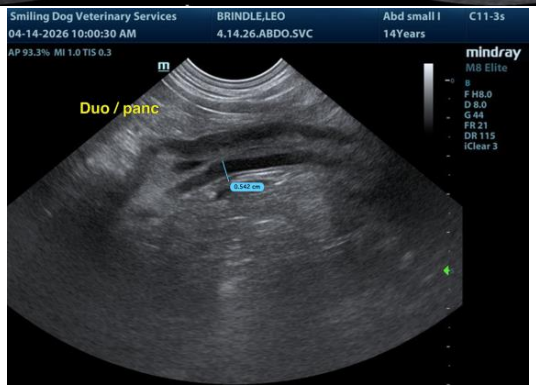

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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