



PATIENT

Dan Saad

SPECIES

Canine

BREED

Maltese

SEX

NM

AGE

10 years

WEIGHT

10.29 lbs.

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Sookhoo

HOSPITAL NAME

Calusa VC

REFERRING VET

Dr. Rodriguez

INVOICE

10825

DATE

4/22/26

PRESENTING CLINICAL SIGNS

Dan presents for evaluation and initial management of newly diagnosed diabetes mellitus. He has had a two-week history of polydipsia and recent bloodwork showed marked hyperglycemia (glucose 590 mg/dL) with electrolyte abnormalities. His first insulin dose (1 unit) was administered today. He is otherwise clinically stable, with a normal appetite and no vomiting, diarrhea, or respiratory signs. There is no history of seizures, and prior antibiotics dispensed for dental disease were not used.

1. Diabetic ketosis - r/o poorly controlled diabetes mellitus vs concurrent infection (UTI) vs other
2. Urinary tract infection - r/o bacterial cystitis vs secondary to diabetes mellitus vs other
3. Hyperglycemia - r/o inadequate insulin therapy vs stress response vs DKA vs other
4. Elevated ALKP, GGT, ALT
5. Hyperkalemia
6. Hypertriglyceridemia
7. Thrombocytosis
8. Proteinuria, ketonuria, glucosuria

Abnormal PE/Chem/CBC/UA Results: I-stat: GLU 535 H, CREA 0.4 L, BUN 17, Na 138, K 5.1 H, Cl 102 L, iCa 1.1 L PCV/TP: 54%/too lipemic Blood glucose: 654 Lactate: 1.6 Blood Ketones: 1.3

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was mildly distended in size. The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm exhibited normal tone. Anechoic urine was present in the lumen with no uroliths or sediment. 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 size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 4.7 cm in length. The right kidney measured 4.6 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.51 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 0.48 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



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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 generalized hepatomegaly with homogeneous, hypoechoic parenchyma. 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. The gallbladder was non-distended in size containing primarily anechoic content with mild to moderate, congealed, nonorganized gallbladder debris. The common bile duct was not definitively visualized.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild, variably echogenic, nonshadowing ingesta without signs of obstruction or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. Segmental, mild, nonshadowing intestinal ingesta was present without an obstructive pattern to the level of the colon.

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

Pancreas

The pancreas was mildly prominent in size with mild nonhomogeneous to subtle hypoechoic parenchyma compared to adjacent non-reactive or inflamed omentum.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Enlarged hyperechoic liver – consistent with diabetic hepatopathy, potential for cholestasis, lipidosi, inflammation, less likely occult neoplasia
- Nonorganized gallbladder debris (non mucocele)
- Mildly prominent nonhomogeneous to subtle hypoechoic pancreas – suspect mild chronic / chronic active inflammation
- Normal gastrointestinal tract with nonshadowing gastrointestinal ingesta – consistent with food echogenicity
- Normal bilateral kidneys / adrenal glands

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Urine C/S on a sterile urine sample, assuming glucose urea, is recommended. Spec cPL or a GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Hospitalization with empirical therapy for diabetic ketoacidosis with concurrent hepato-gastrointestinal support and empirical therapy for mild pancreatitis would be reasonable. There is no overt evidence of adrenal pathology as a contributing factor.



PATIENT

This is a suggestive checkoff list when faced with an unregulated diabetic patient:

Dan Saad

UTI

SPECIES

Dietary indiscretion/intolerance

Pancreatitis

Canine

Hyperthyroidism/hypothyroidism

Exogenous steroids (including topical eye meds)

BREED

Cushing's

Acromegaly

Maltese

Owner compliance

Insulin quality issues

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Antibodies to insulin

Underlying Neoplasia

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Diffuse liver disease

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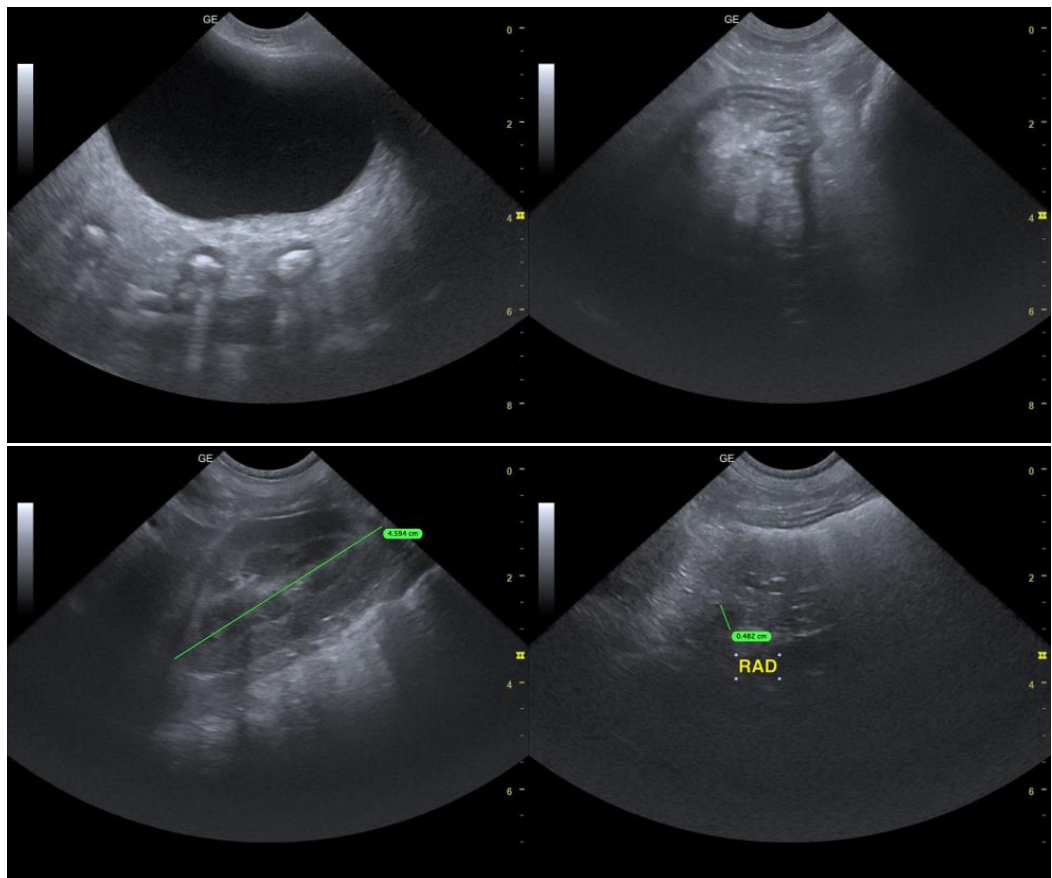
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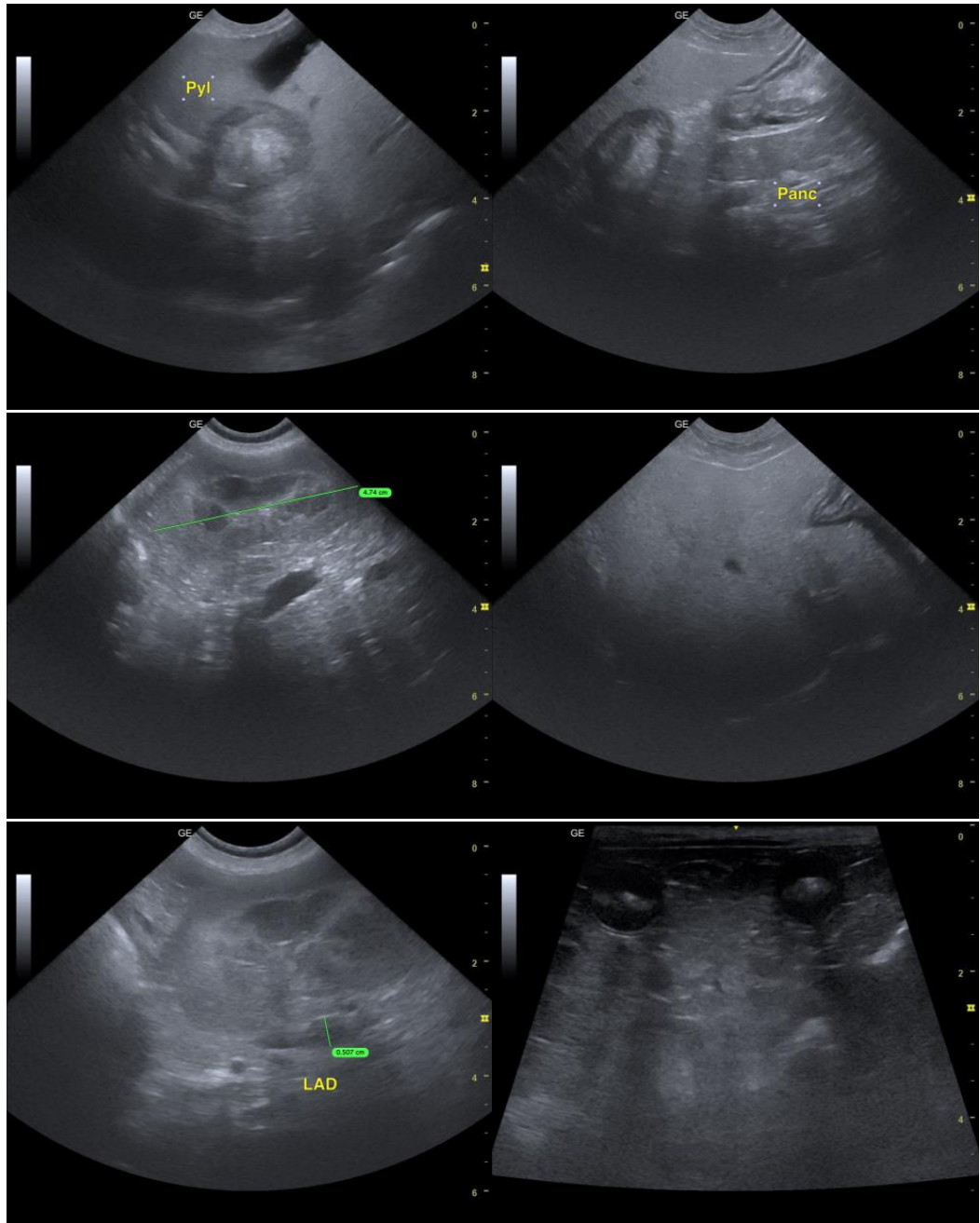
Dr. Rodriguez

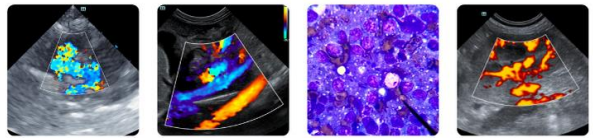
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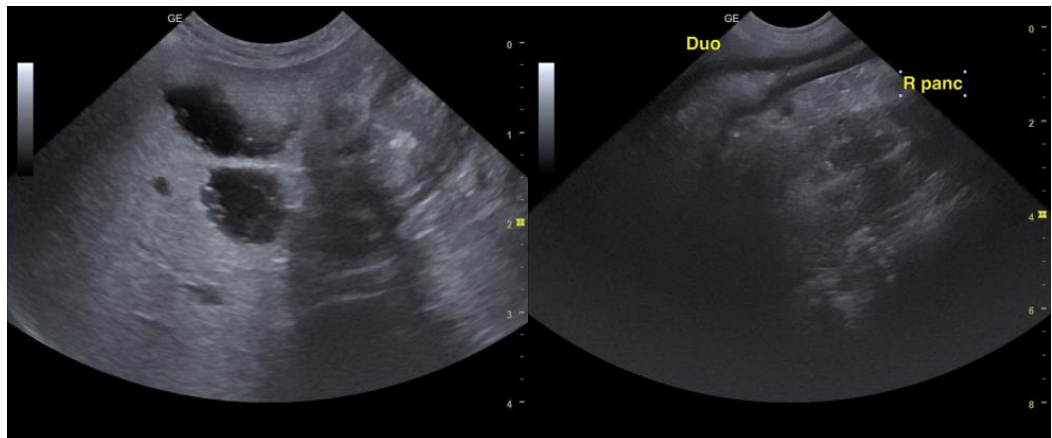
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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