



PATIENT

Dekker Lawrence

SPECIES

Canine

BREED

Australian Shepard

SEX

Male Neutered

AGE

11y

WEIGHT

53.2 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Amy Murphy, CVT

HOSPITAL NAME

Wauwatosa VC

REFERRING VET

Dr. Ericka Haynes

INVOICE

13438

DATE

4/23/26

PRESENTING CLINICAL SIGNS

History: Dekker has a several month histories of intermittent loose stool, elevated Lipase and Spec cPL. Loose stool improved with low fat diet and Tylosin 25 mg/kg/day. 6+ months history of mild azotemia. BUN, not creatine, markedly increased when checked 2 weeks ago. Marked proteinuria (UPC >12) present 2 weeks ago, along with weight loss. Blood pressure normal. Pet began on Benazepril 0.25 mg/kg/day, and Hill's K/D. Pet's appetite markedly decreased for past 5-6 days: no improvement with Entyce and subcutaneous fluid therapy. Pet has hypothyroidism; managed with Thyroxin. Screening for renal neoplasia, chronic kidney disease, GI tract disease, other cause of recent weight loss, decreased appetite, elevated BUN.

Abnormal PE/Chem/CBC/UA Results: IDEXX Cystatin B (Urine) 1,420 (0-99 ng/ mL) Urine Protein: Creatinine Ratio 12.2 Specific Gravity: 1.012 Creatinine: 2.4 (0.5-1.8 mg/ dL) BUN: 129 (7-27 mg/ dL) Phosphorus: 10.9 (2.5-6.8 mg/dL) Lipase: 2,595 (200-1,800 U/L) Cortisol: 4.8 (2.0-6.0 mcg/dL) Value in November; repeat cortisol performed on 4/22, results pending.

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. Primarily anechoic urine was present in the lumen. Mild, echogenic to particulate non-dependent sediment was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were noted.

No obvious pathology in the area of the residual prostate.

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. Mild, indistinct loss of corticomedullary distinction was also present. Mild pyelectasia was present. The left kidney measured 7.7 cm in length. The right kidney measured 8.1 cm in length.

Adrenal Glands

The bilateral adrenal glands were borderline to mildly enlarged in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 1.1 cm width in the caudal pole. The right adrenal gland measured 0.9 cm width in the caudal pole.

Spleen

The spleen exhibited primarily finely textured parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Mild generalized parenchyma heterogeneity was present without evidence of nodular changes. 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. The parenchymal heterogeneity is likely consistent with benign changes such as extramedullary hematopoiesis or age-related remodeling with minor potential for inflammatory or neoplastic disease.



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Liver

The liver exhibited generalized hepatomegaly with asymmetrical to rounded capsule contour and homogeneous parenchyma. Mild coarse echotexture present. Solitary, non-homogeneous, hypoechoic macronodule with a small mass present deep mid liver measuring 3.3 cm in diameter. The gallbladder was non distended in size with moderate, non-organized, echogenic, nonmineralized biliary sludge. The cystic duct and common bile ducts were normal without evidence of dilation.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild gas and non-shadowing ingesta.

The small intestine presented intact wall layering with overall wall layer ratio and non-thickened wall. Segmental, hyperechoic jejunum mucosal speckling present. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material. Duodenum wall measured 0.46 cm.

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

Pancreas

The right pancreas was prominent in size with capsule asymmetry and non-homogeneous, hypoechoic parenchyma exhibiting adjacent mildly hypoechoic peripancreatic omentum. Mild asymmetrical capsule margination was present with mild variable parenchymal swelling and mild peripancreatic reactivity / inflammation.

Free Abdomen

No obvious visualized significant omental lymphadenopathy and Mild perihepatic to peri intestinal hyperechoic omentum present.

ULTRASONOGRAPHIC FINDINGS

- Urinary bladder sediment
- Bilateral chronic nephropathy
- Nonspecific borderline/mild adrenomegaly
- Asymmetrical hepatomegaly with intraparenchymal macronodule/small mass
- Non-organized gallbladder debris (non-mucocele)
- Chronic active pancreatitis
- Nonspecific enteritis patten with mild, non-shadowing gastric ingesta and soft fecal matter in colon

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Urine C/S recommended if inflammatory sediment on urinalysis with monitoring of UPC and continued PLN therapy given severe elevated UPC. Assuming normal clotting status, hepatic FNA cytology warranted to assess for occult disease as a contributing factor to the weight loss. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Correlation with pending screening cortisol level is recommended, although borderline to mild adrenomegaly is not overtly consistent with adrenal hypofunction. Full adrenal workup could be considered if clinical signs consistent with Cushing's Syndrome arise. No overtly visualized gastrointestinal masses as an obvious contributing factor to the elevated BUN. Continued renal and gastrointestinal support with empirical therapy for chronic active



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pancreatitis is recommended.

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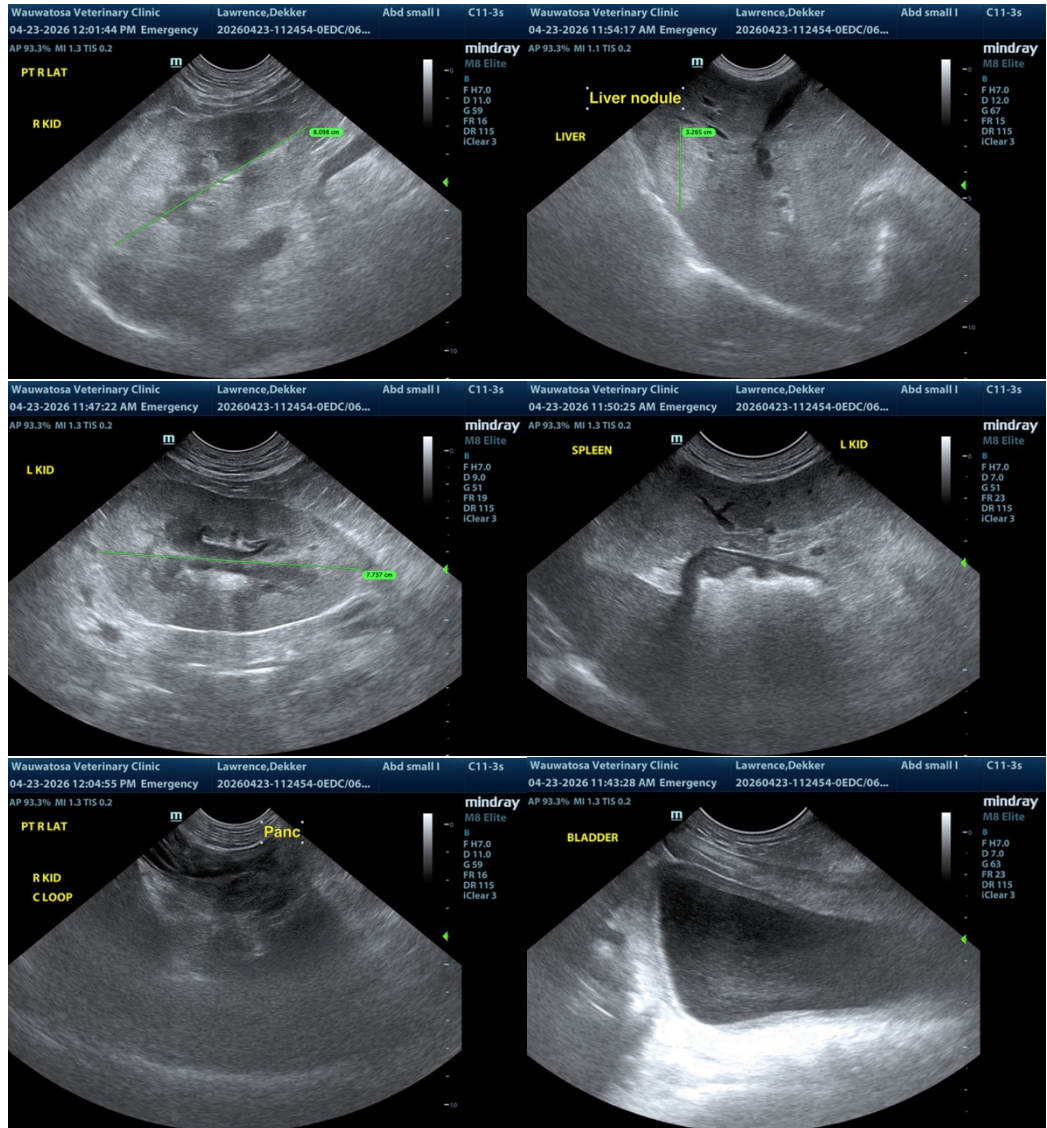
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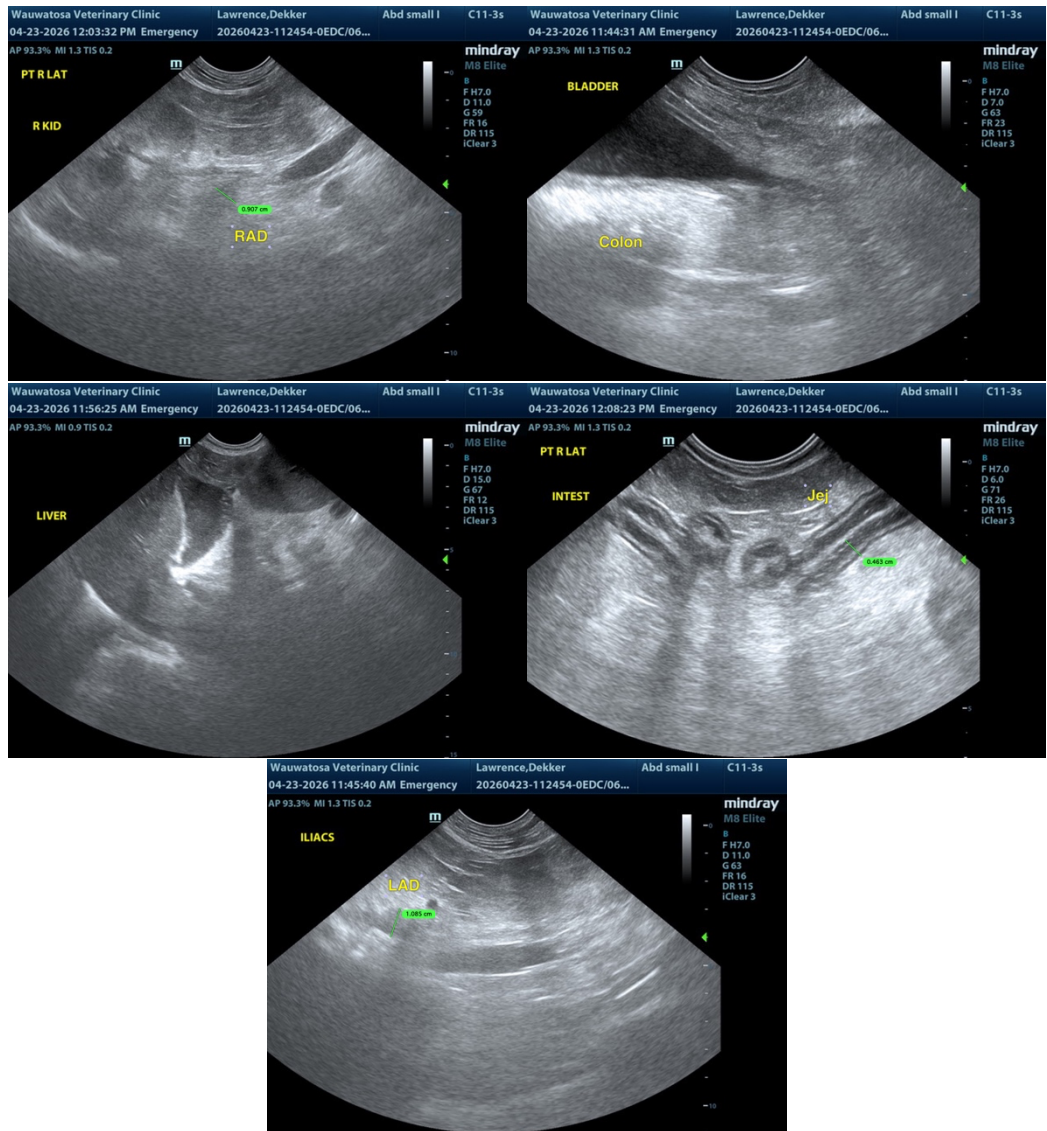
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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