



PATIENT

Brownie Burdick

SPECIES

Canine

BREED

Labrador Mix

SEX

Neutered Male

AGE

10 Years

WEIGHT

39.8 kg

INTERPRETED BY

R. McKenzie Daniel,
DVM, DABVP (Canine
/ Feline Practice)

IMAGING PERFORMED BY

Ryan Bergner LVT

HOSPITAL NAME

Waterville Veterinary
Clinic

REFERRING VET

Dr. James Gilchrist
DVM

INVOICE

14908

DATE

04/06/26

PRESENTING CLINICAL SIGNS

P was attacked by another dog 2 days ago and presented to ER clinic yesterday with a bite wound over the L shoulder, then discharged same day with Clavamox, gabapentin and codeine. ER clinic found elevated renal values on BW. P admitted to our hospital today for lethargy and hyperemia. P now has a mild soft swelling over the R shoulder.

Abnormal PE/Chem/CBC/UA Results: Lethargy Hyporexia Mild swelling over R shoulder Elevated Hct, Mild leukocytosis, Mild neutrophilic, Mod monocytosis Mild-mod elevations of BUN, Crea, SDMA and Phosphorus Mild ALT and ALP elevations

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was nondistended to subnormal in size, prohibiting full evaluation of the urinary bladder wall. Diffusely thickened urinary bladder wall exhibiting mild asymmetrical luminal surface contour and potential for indistinct luminal surface polypoid component. Mild nonhomogenous nonmineralized urinary bladder wall echogenicity with urinary bladder wall measuring 1.1 cm wall width. The trigone, cystourethral junction, and visible pelvic urethra to a depth of 5.0 cm exhibited normal thickness and tone. Minimal 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 change were noted.

The area of the aortic trifurcation was free of pathology.

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. Indistinct corticomedullary border demarcation was also present. Indistinct cortical infarcts and mild pyelectasia was present bilaterally. The left kidney measured 8.2 cm in length. The right kidney measured 8.5 cm in length.

Adrenal Glands

The adrenal glands were subjectively enlarged in size exhibiting intact mild asymmetrical contour and mild nonhomogenous nonmineralized parenchyma. The left adrenal gland measured 1.42 cm width at the caudal pole. The right adrenal gland measured 1.45 cm width at the caudal pole.

Spleen

The spleen exhibited primarily finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Intermittent subtle hyperechoic nodules were present. 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 or neoplastic changes were not noted. The echogenic nodules tend to trend benign and are most consistent with benign hyperplasia or myelolipomas.

Liver & Gallbladder

The liver presented mildly enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in



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margination. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was non-distended in size with mildly thickened hyperechoic wall. Mild nonorganized dependent to nondependent hyperechoic nonmineralized bile sediment was present. The common bile duct was normal without evidence of posthepatic obstruction.

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 ileus, obstruction or foreign material.

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

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 was evident.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

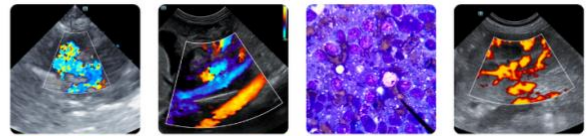
- Nonspecific chronic renal changes exhibiting cortical infarcts and mild pyelectasia.
- Nondistended yet subjective generalized thickened urinary bladder with mild polypoid component.
- Hepatopathy- subjective benign.
- Possible mild chronic cholecystitis with nonorganized bile debris (non-mucocele).
- Sonographically normal gastrointestinal tract.
- Bilateral adrenomegaly.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The kidneys are most consistent with chronic renal disease or nephropathy, although acute on chronic renal insult are not definitively excluded. Diffuse cystitis is favored with minor potential for diffuse urinary bladder neoplastic criteria. Correlation with urinalysis, culture/sensitivity on sterile urine sample, UPC level if non-inflammatory proteinuria and BRAF assay is recommended.

Leptospirosis titers/PCR may be considered if clinically applicable and in conjunction with azotemia and hepatopathy. Assuming normal clotting status, hepatic FNA cytology is warranted for further clarification, although no overt suspicion of hepatic neoplastic criteria. Although current clinical presentation is not overtly suggestive of primary adrenal disease, adrenal screening or workup is warranted if clinical signs consistent with Cushing's syndrome are non-reported or arise.

Supportive care for nonspecific nephropathy with concurrent hepatogastrointestinal support, clinical monitoring and sonographic reassessment of progressive azotemia, hepatopathy or gastrointestinal signs is recommended.



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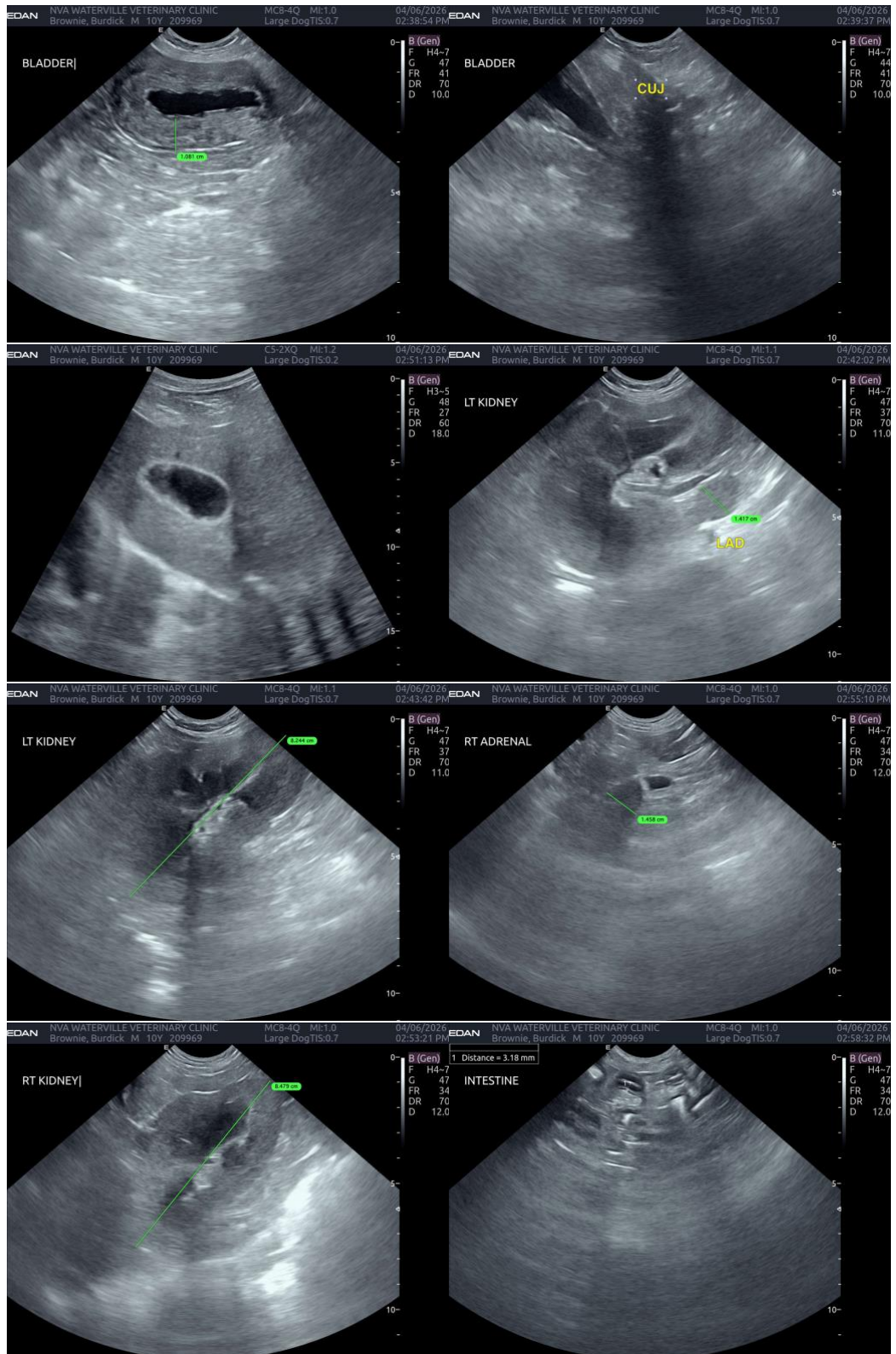
Dr. James Gilchrist
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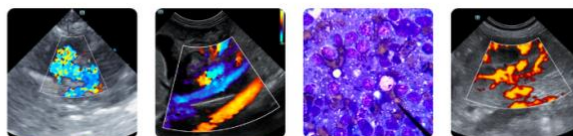
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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