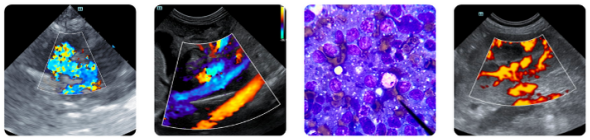


PATIENT

Riley Hardy

SPECIES

Canine

BREED

Golden Retriever

SEX

Male Intact

AGE

10y

WEIGHT

90.8 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Chrissy Krell, DVM

HOSPITAL NAME

Irom Range VC

REFERRING VET

Kaylea Peterson, DVM

INVOICE

13385

DATE

4/7/26

PRESENTING CLINICAL SIGNS

History: History: Left side under front arm pit fluid pocket, history of possible Cushing's (not tested). On Friday (4/3) he ate breakfast like normal, did start coughing and having a hard time walking around Friday afternoon. Client noted that Riley was suddenly hyper pigmented on left side, started out very small but overnight grew about 9 inches. Riley has had really bad gas lately. Not on any medications other than he has been given over the counter pain drops on food. He did not eat dinner last night or breakfast this morning. His RBC morphology appears to be starting to be regenerative, and there are no signs of agglutination for IMHA, and adequate PLTs is not typical of patients with ITP. DDX: immune mediated disease, infection, neoplasia, coagulopathy, endocrinopathy, tick disease, open. Edema change in location from left sided ventrum to caudal central ventrum. Bruising has spread past the ventral midline and is extending into the right ventral area. Area of bruising over the left forelimb from blood draw yesterday.

Current Medications: Due to BUN increase, Riley was started on a gastro protectant. In case of clotting disorder/hemangiosarcoma, starting Yunnan baiyao for supportive care.

Abnormal PE/Chem/CBC/UA Results: PE: Moderate pitting ventral edema limited to the left side of trunk extending from axillary to inguinal region, integument along entire area is bruised from red to black/blue in color. 4/6/26: CBC: emerging? leukocytosis WBC: 15k/uL, Lymph: 1.77 k/uL, Neu: 12 k/uL, Mono: 1.3 k/uL. Normocytic, normochromic anemia, no agglutination or rouleaux, occasional spherocytosis. RBC: 3.7 (L), HCT: 26% (L) 4/7/26: Recheck PCV: 24% (previously 26%) 4/6/26: Chemistry: BUN: 33 (H), ALP: 603 (H), K+: 5.0 Abdominal radiographs: round, soft tissue opaque potential mass effect in the mid-cranial abdomen (of left kidney vs mass splenic vs other). Prostatomegaly. Thoracic radiographs: very slight increase in soft tissue opacity of the cranial mediastinal area. Remainder WNL Pending Coag profile.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

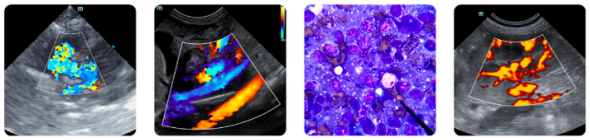
The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

The prostate was enlarged in size with intact, symmetrical capsule contour. The margins of the gland were intact and able to be differentiated from the surrounding tissue. The prostatic parenchyma was mildly echogenic to heteroechoic without parenchymal mineralization. The prostate measured 4.4 cm in diameter.

The left and right testicles were normal in size with subtle hypoechoic left testicle nodules measuring 0.54 cm in diameter.

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 mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 8.0 cm in length. The right kidney measured 8.2 cm in length.



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Adrenal Glands

The bilateral adrenal glands were borderline prominent in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured d 0.85 cm width in the caudal pole. The right adrenal gland measured 0.92 cm width in the caudal pole. No evidence of adrenal neoplastic criteria or tumors.

Spleen

The spleen exhibited primarily finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Multiple, well-defined, symmetrical, hyperechoic to multi shadowing nodules were present in the medial parenchyma with an example measuring 1.3 cm in diameter. 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 hyperechoic nodules tend to trend benign and are most consistent with benign hyperplasia or myelolipomas. No evidence of splenic mass present.

Liver

The liver exhibited subjective mild hepatomegaly with normal vascular volume. The liver parenchyma was mild nonuniform and hypoechoic to the spleen with a mild coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non distended in size with mild, non-organized, hyperechoic, 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, echogenic, non-shadowing ingesta without signs of 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 area of the pancreas presented sonographically normal.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

Heart

Rapid view of the heart revealed no evidence of pericardial masses or effusion in the visible window. Subjective normal left and right chamber dimensions and adequate LV systolic function. Brief examination of the left axilla revealed indistinctly marginated, primarily homogeneous to mildly hypoechoic subcutaneous mass vs lymphadenopathy measuring ~8.0 cm in diameter.

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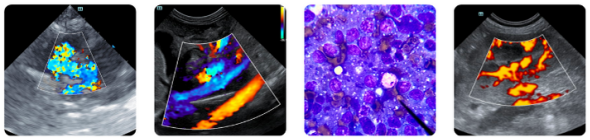

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PRIMARY FINDINGS

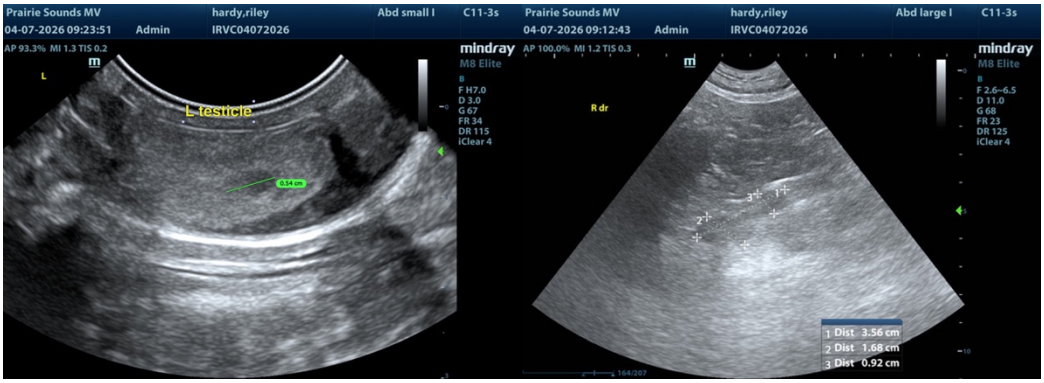
- Mildly enlarged non-homogeneous non-congested liver
- Mild gallbladder debris (non-mucocele)
- Well-demarcated, hyperechoic medial splenic nodules – most suggestive of benign criteria, i.e. myelolipomas, hyperplasia, emerging mineralization, potential for chronic infarcts, neoplasia thought less likely without evidence of splenic mass
- Mild chronic renal changes
- Borderline bilateral adrenomegaly
- Subjective normal cardiac structure/function
- Unspecified left axillary subcutaneous mass vs lymphadenopathy
- Sonographically unremarkable gastrointestinal tract and mild non-shadowing gastric ingesta – consistent with food echogenicity

SECONDARY FINDINGS

- Benign prostatic hyperplasia
- Non-enlarged testicles with subtle left testicular nodules

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of intraabdominal mass with benign hepatosplenic presentation suspected. If normal clotting status and static hematocrit, screening hepatosplenic and left axilla subcutaneous mass vs lymph node cytology warranted for further clarification/ CBC pathology review and +/- infections disease serology can be considered. Adrenal screening warranted if clinical signs consistent with Cushing's Syndrome, although no overt evidence of significant adrenal pathology. Empirical coverage for infectious anemia could be considered pending additional diagnostics.



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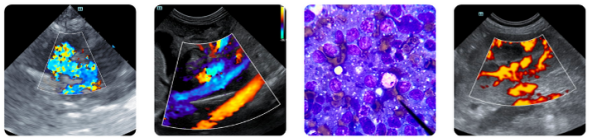

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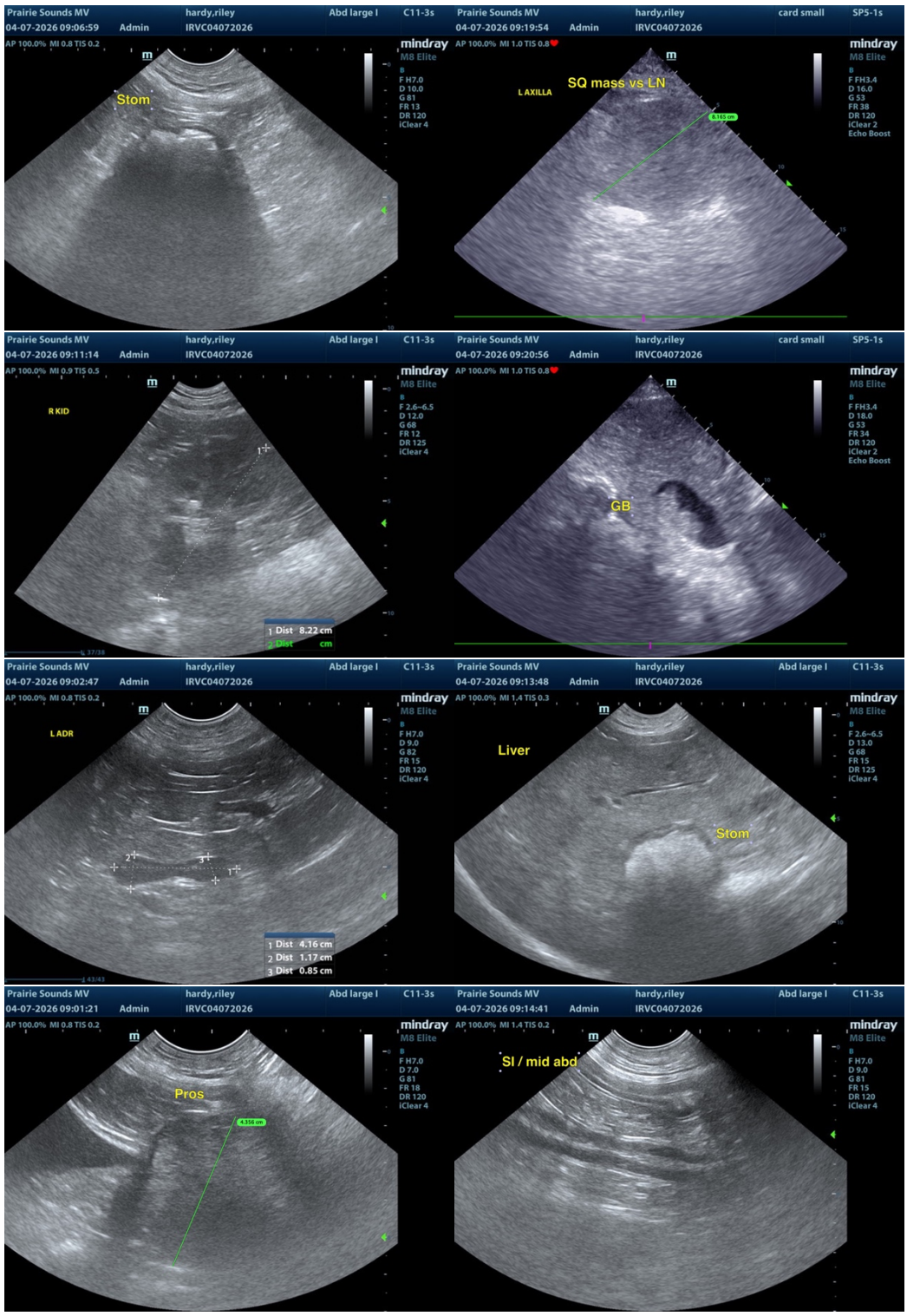

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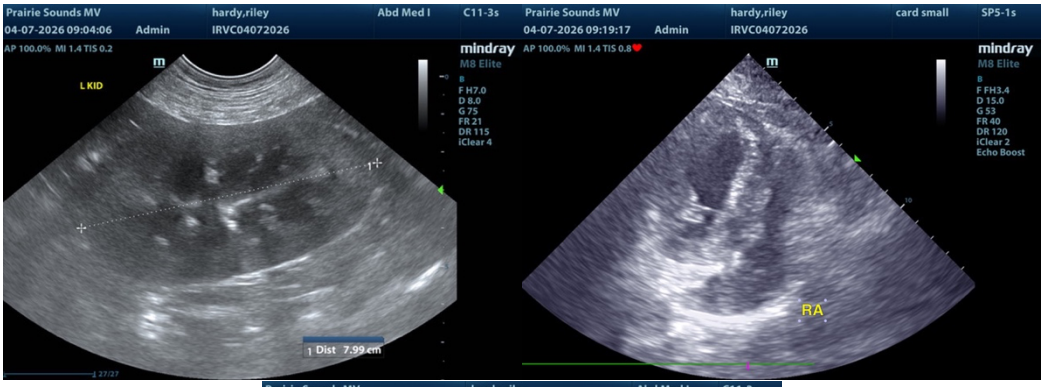

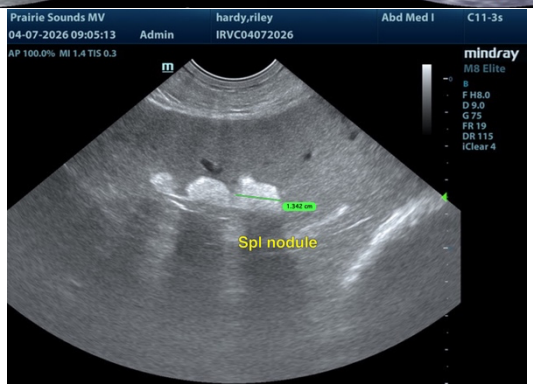

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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