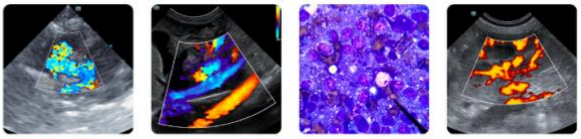


PATIENT

Tobih Fine

SPECIES

Canine

BREED

Cairn Terrier

SEX

Neutered Male

AGE

14 Years 6 Months

WEIGHT

6.4 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Sookhoo

HOSPITAL NAME

Calusa Veterinary Center

REFERRING VET

Dr. Krane

INVOICE

14899

DATE

04/07/26

PRESENTING CLINICAL SIGNS

Tobih presented yesterday for anorexia. Declining over past couple weeks. Disorientation: standing in middle of room appearing confused. Vomiting: yellow bile yesterday, water today after drinking. Last ate yesterday. Polydipsia. No coughing. Stool normal this morning. Respiratory rate at home under 30. Chronic liver disease (historical). Stable heart disease (historical). Cycling through different foods over time - would eat well initially then refuse. Medications: Pimobendan. Soloxine (thyroid medication) Ursodiol, Apoquel. Preventative medications/ supplements: Denamarin (recently discontinued due to difficulty administering). Previous ultrasound done - August 11 2025 - cystoliths, CKD bilaterally with L pyelectasia, plump left adrenal gland, Hyperechoic rounded liver, gall bladder sludge small to moderate amount 50% congealed, hypoechoic normal right limb pancreas, mild thickened SI and LI.

Abnormal PE/Chem/CBC/UA Results: CPL suspect 287 ng/mL, ALT 303 U/L , ALKP 1940 U/L , GGT 14 U/L

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. Echogenic to particulate nondependent mild to moderate sediment was present. Minor indistinctly visualized dependent lumen mineral was also present. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were noted.

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

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 with areas of medullary mineral and hyperechoic foci which may indicate pinpoint to focal areas of cortical microinfarction, fibrosis or concurrent mineralization. Mild left kidney pyelectasia was visualized. The left kidney measured 4.7 cm in length. The right kidney measured 5.1 cm in length.

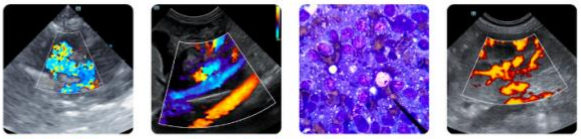
Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.47 cm width at the caudal pole.

The right adrenal gland was indistinctly visualized yet overtly normal in size, position and shape. The right adrenal gland subjectively measured 0.53 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. Small nondisruptive perihilar 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



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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 revealed generalized hepatomegaly. The parenchyma of the liver was subjectively increased in echogenicity compared to the spleen and renal cortices. 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 with nonorganized mild to moderate primarily peripheral lumen debris. 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 was empty with mild lumen gas and no signs of ileus, obstruction or foreign material.

The small intestine presented overtly intact mildly thickened wall given the patient's body weight with propensity for mildly thickened intestinal mucosa layer. The duodenum wall measured 0.50 cm wall width. The jejunum wall measured 0.38 cm wall width. Discrete hyperechoic duodenojejunal mucosal speckling.

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

Pancreas

The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia. A solitary cystic appearing pancreatic nodule was present in the area of the pancreas base caudal to the pylorus measuring 1.9 cm in diameter.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Empty stomach with suspect nonspecific chronic enteropathy.
- Chronic pancreatitis with remodeling and cystic nodule.
- Urine sediment with discrete dependent lumen mineral.
- Chronic renal changes exhibiting medullary mineral, hyperechoic cortical foci and mild left kidney pyelectasia.
- Enlarged hyperechoic liver- chronic, vacuolar, inflammatory or cholestatic hepatopathy, lipidosis, occult neoplasia thought less likely.
- Nonorganized gallbladder debris (non-mucocele).

Secondary Findings

- Small hyperechoic splenic nodules- most consistent with benign criteria i.e. myelolipomas.

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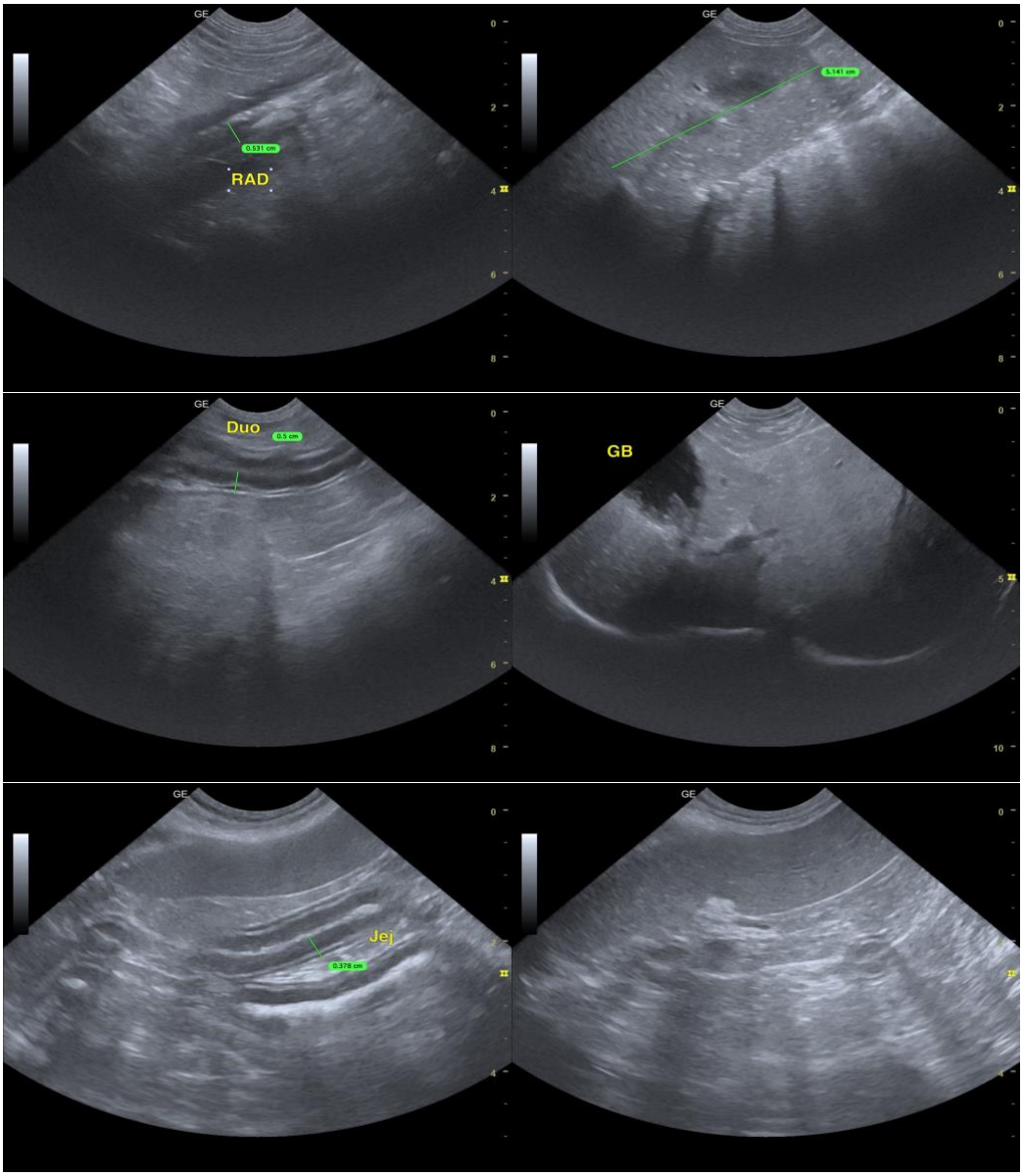
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of mechanical gastrointestinal obstruction. GI panel to include PLI, TLI, cobalamin and folate to correlate with pancreas and small intestine may be considered.

Recheck three view chest radiographs and correlation with a neurological exam is suggested if not done. Assuming normal clotting status and using a 25-guage needle, hepatic FNA cytology could be considered for further clarification. Recheck urinalysis with suggested screening culture/sensitivity or UPC level for renal staging is recommended. Hepatogastrointestinal support with clinical and as needed sonographic monitoring, if continued or progressive hepatopathy or gastrointestinal signs, is recommended.



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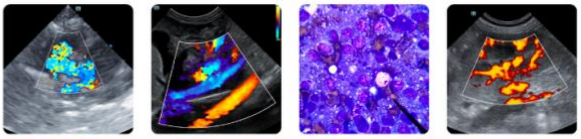

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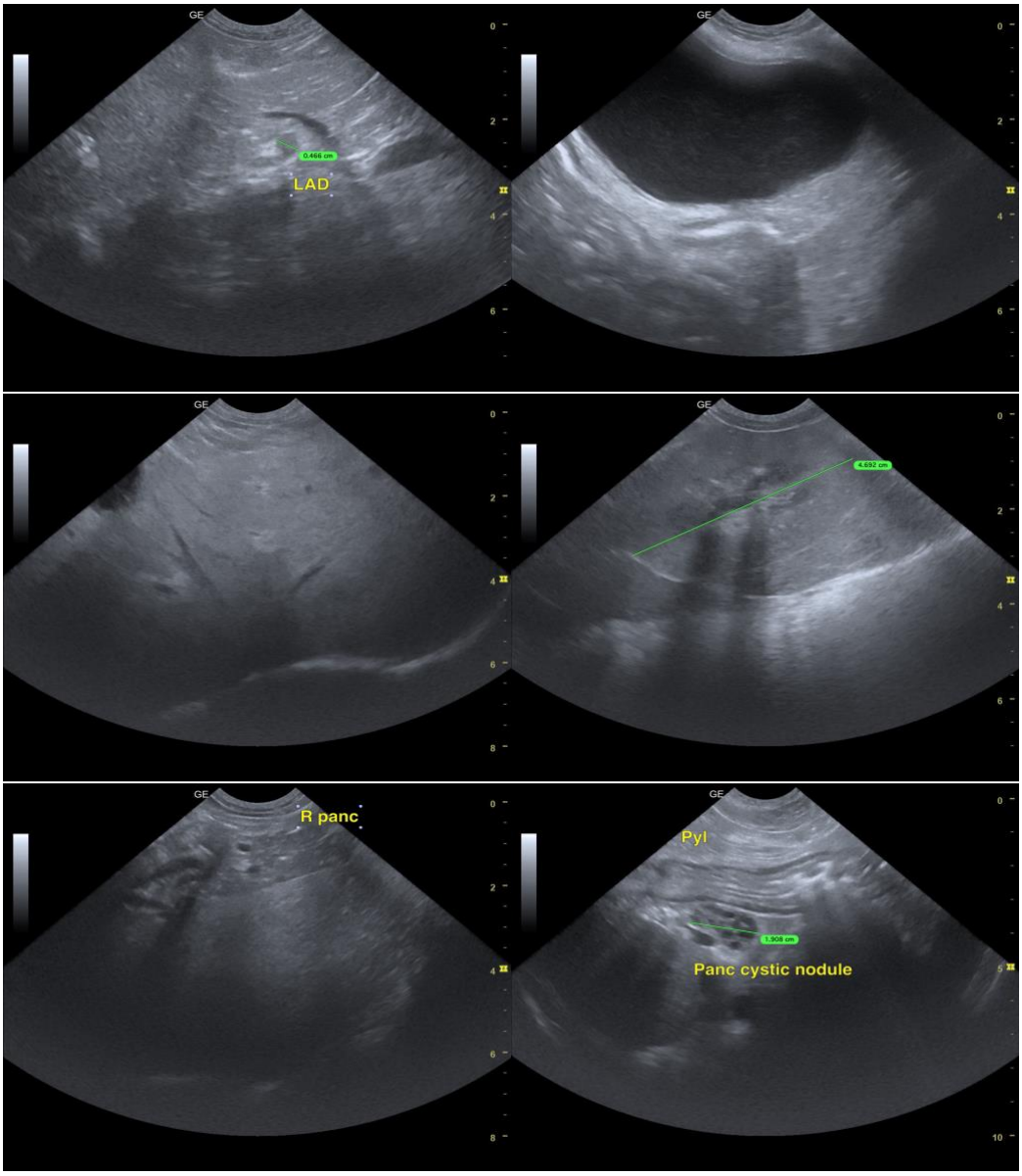

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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