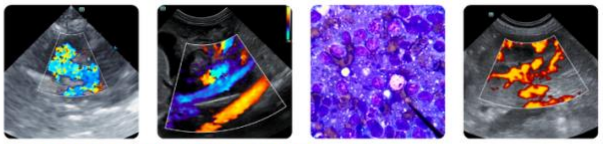

PATIENT

Diesel Andersen

SPECIES

Canine

BREED

Dogue De Bordeaux

SEX

Neutered Male

AGE

2 Years

WEIGHT

150 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Chrissy Krell DVM

HOSPITAL NAME

Prairie Sounds Mobile Vet

REFERRING VET

Skylar Brenden DVM

INVOICE

16146

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05/12/26

PRESENTING CLINICAL SIGNS

Diesel is a 2Y 8MO MN Dogue De Bordeaux. Diesel was initially seen on 5/6/26 for anorexia and alopecia. No oral medications, O applied PetArmor FT topical ~2W prior. PE showed T 103.5 and moth-eaten alopecia on bilateral flanks. O only consented to T4 as he was concerned about hypothyroidism- T4 0.9 (L). Started levothyroxine 0.8mg PO BID, carprofen 150mg PO BID x 3d. O was instructed to return for 4DX if no improvement. Diesel returned on 5/8/26 for anorexia, no V/D/C/S, O unable to medicate easily so unsure if and how much carprofen had been given. CBC- Marked thrombocytopenia. Chem- Moderate mixed hepatopathy (ALP>ALT) with Marked hyperbilirubinemia, Marked total hypercalcemia, Mild azotemia with Mild hyperphosphatemia. Tick disease and lepto screening negative. Blasto test pending. Started prednisone 40mg PO BID with recheck planned in 5-7d. Diesel returned on 5/9/26 for vomiting, O had only given one dose of prednisone (24hr prior) but withheld after due to vomiting. PE showed T 101.6, 9lb weight loss, icteric MM and sclera. Performed lateral AXR unremarkable. Admin LRS 1500mL SQ and Cerenia 1mg/kg SQ. O advised to continue prednisone. 5/10/26 started amoxicillin 14mg/kg PO BID.

Abnormal PE/Chem/CBC/UA Results: 5/6/26 PE: T 103.5 and moth-eaten alopecia on bilateral flanks. *T4 0.9 5/8/26 PE showed T 103.5. *4DX neg; *CBC LYM 0.54 (L), HGB 18.5 (H), PLT 21K (L, manual est 18-23.5K); *Chem ALT 615 (H), ALP 1290 (H), TBILI 6.6 (H), CA 14.5 (H), CRE 1.7 (H), BUN 27 (H), PHOS 8.7 (H); *Lepto neg; *Blasto pending. 5/9/26 PE showed T 101.6, 9lb weight loss, icteric MM and sclera. Performed AXR R Lat to assess for gallstones- NSF. DDX: Marked thrombocytopenia (IMTP) Marked total hypercalcemia Moderate mixed hepatopathy with hyperbilirubinemia Mild azotemia with hyperphosphatemia

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 4.0 cm 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 change were noted.

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

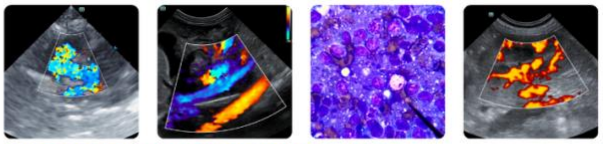
Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 7.8 cm in length. The right kidney measured 8.2 cm in length.

Adrenal Glands

The adrenal glands were indistinctly visualized owing to adrenal depth and patient size with no obvious pathology. The left adrenal gland subjectively measured 0.64 cm width at the caudal pole. The right adrenal gland subjectively measured 0.49 cm width at the caudal pole.

Spleen

The spleen presented subjectively mildly enlarged with mildly rounded medial capsule contour and focal area of medial parenchyma expansion and mildly associated capsular distortion. Mild generalized heterogeneous splenic parenchyma. No definitive mass or nodules were evident.



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Liver & Gallbladder

The liver revealed hepatomegaly with rounded capsule contour exhibiting nonhomogenous mildly increased hepatic parenchyma with variable coarse echotexture and indistinct portal vascular borders. Subjective normal hepatic vascular volume without overt congestion.

The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The common bile duct was not visualized.

Gastrointestinal

The stomach presented overtly normal intact visible wall. The stomach contained a mild amount of retained fluid without obstruction to pyloric outflow.

The intestinal walls demonstrated intact wall layering and maintained 1:3 muscularis / mucosa ratio. Segmental jejunal decreased mural echogenicity and non-obstructive jejunal ileus. The jejunum wall measured 0.46 cm wall width.

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

Pancreas

The area of the pancreas was sonographically normal.

Free Abdomen

Mild perihepatic/perisplenic effusion was present with intermittent primarily mild to asymmetrically enlarged isoechoic to nonhomogenous mesenteric and medial iliac lymph nodes with an example of mesenteric lymph node measuring 3.7 cm x 2.3 cm and medial iliac lymph node measured 4.5 cm x 1.5 cm. Mid abdomen peri-intestinal mild hyperechoic omentum.

ULTRASONOGRAPHIC FINDINGS

- Enlarged nonhomogenous liver.
- Sonographically normal gallbladder.
- Nonenlarged nonhomogenous spleen with mild medial parenchymal expansion.
- Nonspecific gastroenteropathy exhibiting mild nonobstructive gastric and segmental jejunal ileus.
- Variably enlarged nonhomogenous mesenteric/medial iliac lymph nodes.
- Perisplenic/perihepatic mild effusion and mid abdomen mild hyperechoic omentum.
- Sonographically unremarkable bilateral kidneys and subjective adrenal glands.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of post-hepatic or mechanical gastrointestinal obstruction. Although sampling is required for further clarification, primary concern for multicentric hepatosplenic, lymphatic and potential segmental gastrointestinal neoplastic criteria is warranted versus multicentric inflammatory versus infectious disease.

If adequate platelet count and assuming normal clotting status, screening hepatosplenic cytology, +/- accessible lymph node cytology and correlation with effusion analysis, if possible, is recommended for further assessment. Pending additional diagnostics, hepatogastrointestinal support and empirical therapy for possible infectious or inflammatory hepatopathy would be reasonable.

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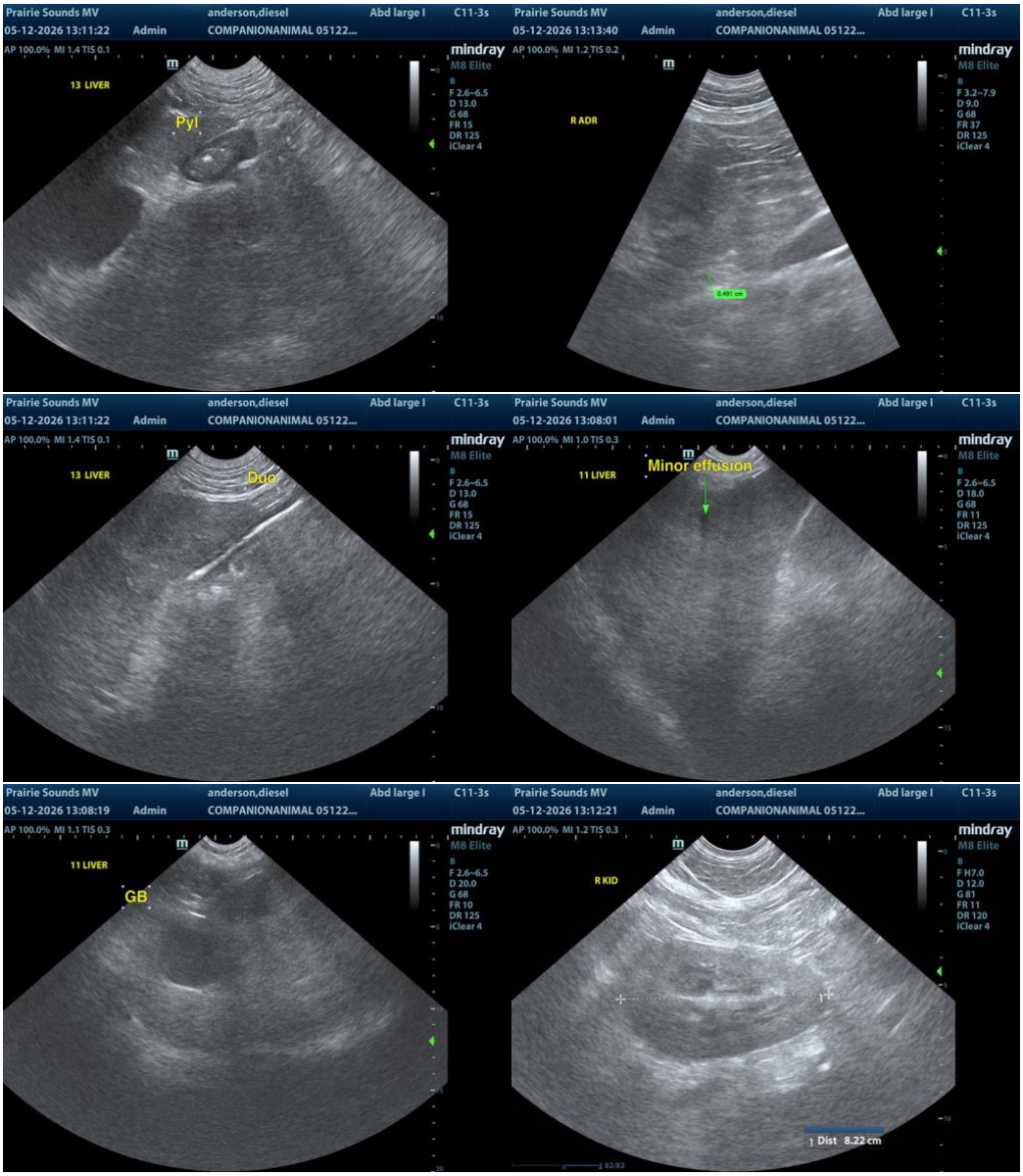
Three view chest radiographs and a GI panel to include PLI, TLI, cobalamin and folate may be considered. Suspect extremely guarded prognosis, pending additional diagnostics and monitoring.



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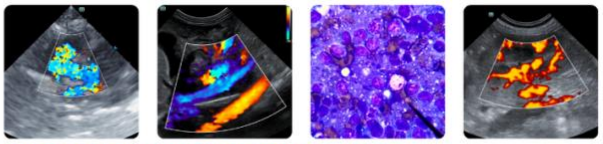

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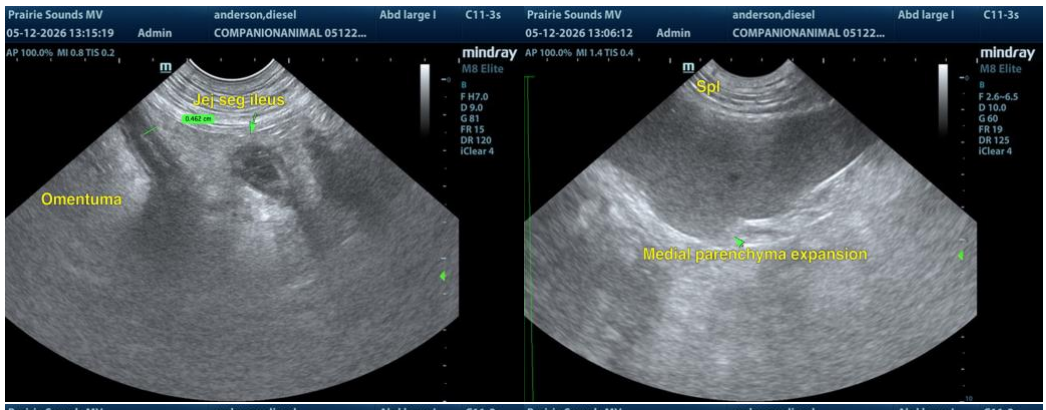

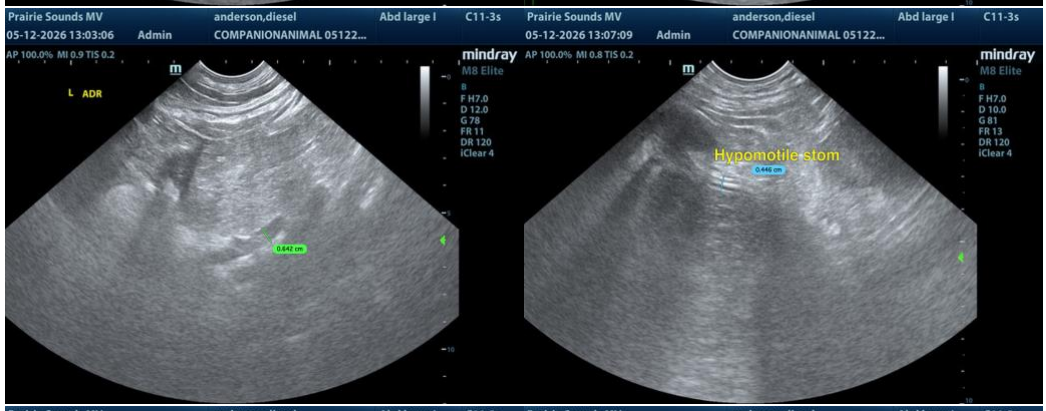

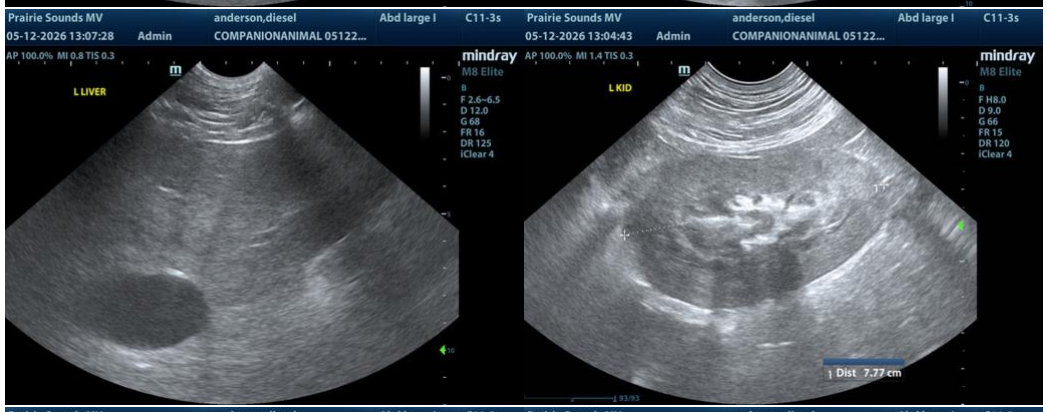

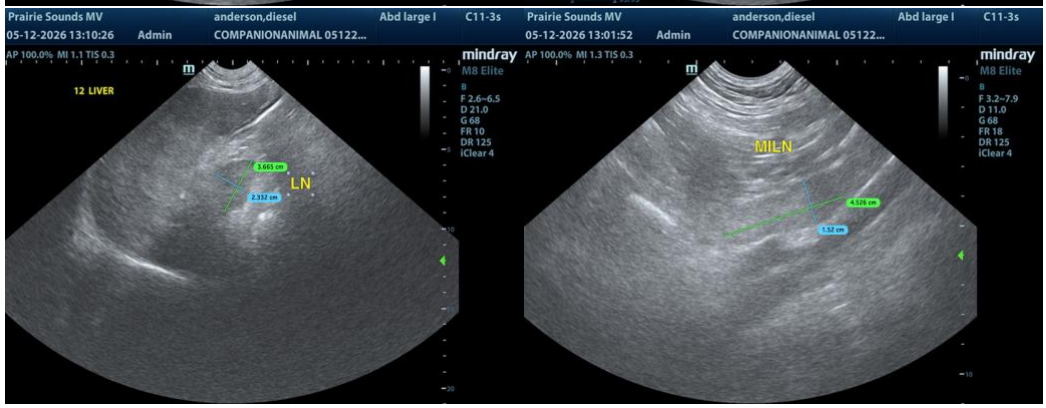

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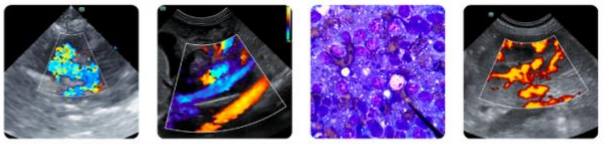

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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