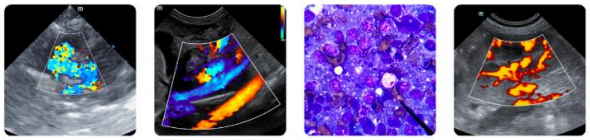

PATIENT

Percy Arnold

SPECIES

Canine

BREED

Shih Tzu

SEX

MN

AGE

8 years

WEIGHT

8.8 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Erica Harmon

HOSPITAL NAME

Wilvet South

REFERRING VET

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DATE

5/27/26

PRESENTING CLINICAL SIGNS

This is a chronological summary of Percy's recent veterinary visits, presenting concerns, and diagnostic results.

Visit on 05/22/2026 - Presenting Concern: Percy was suspected of becoming clinically diabetic. The owner was instructed to perform a blood glucose curve at home using an AlphaTrak 3 monitor to determine if insulin therapy or a referral to an internal medicine specialist was necessary.

Urinalysis Results: Collection: Cystocentesis, Color/Clarity: Dark Yellow, Slightly Cloudy
SG: >1.050, pH: 5.0, PRO: 30 mg/dL, GLU: 1000 mg/dL, KET: 150 mg/dL, BLD: 50 Ery/µL
Sediment: <1 WBC/HPF, 2 RBC/HPF, Suspect presence of cocci bacteria.

Visit on 05/27/2026 - Presenting Concern: Percy was brought in for a recheck due to acute vomiting, inappetence, and general lethargy. The owner reported he had lost more weight, was not eating, and was only drinking water. Polyuria, polydipsia, and dribbling urine were ongoing.
Physical Exam Findings: Percy was noted to be more dull than on previous exams.
A minor skin turgor was present, suggesting mild dehydration. No abnormalities were found on heart and lung auscultation, and no pain was noted on abdominal palpation.

Abnormal PE/Chem/CBC/UA Results: Bloodwork Results: 5/27 CBC: A mild stress response was noted. NEU: 13.56 K/uL MONO: 1.23 K/uL EOS: 0.02 K/uL Chem: GLU: 344 mg/dL FRU: 359 µmol/L ALB: 4.4 g/dL AST: 70 U/L ALKP: 949 U/L AMYL: 409 U/L K: 3.4 mmol/L Cl: 102 mmol/L cPL (Pancreatic Lipase): 395 U/L TT4: < 0.5 µg/dL Urinalysis: SG: 1.043 pH: 5.0 PRO: 30 mg/dL GLU: 1000 mg/dL KET: 150 mg/dL Sediment: No obvious bacteria were seen on sediment confirmation.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and cystourethral junction exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Mild to moderate, nondependent, particulate sediment was present with focal dependent lumen mineral. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were noted.

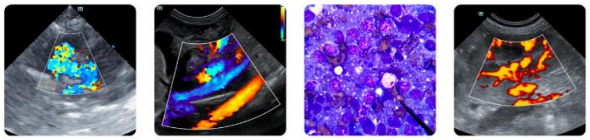
The area of the residual prostate appeared free of overt pathology

No evidence of pathology in the area of the aortic trifurcation.

Normal size and margination were 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 4.7 cm in length. The right kidney measured 5.4 cm in length.

Adrenal Glands

Both adrenal glands were overtly normal in size, position and shape with isoechoic parenchyma compared to adjacent omentum, resulting in indistinct right adrenal visualization. No obvious pathology was noted. The left adrenal gland measured 0.53 cm caudal pole width. The right adrenal gland subjectively measured 0.60 cm caudal pole width.



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Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. 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, neoplastic, or benign parenchyma changes were not noted.

Liver/ Gallbladder

The liver presented moderate 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 containing primarily anechoic content with mild, nonorganized gallbladder debris. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented an intact mildly prominent stomach wall. Intact wall layering was maintained and distinct. The stomach contained a mild to moderate amount of anechoic fluid and mild nonshadowing chyme. There was no obvious obstruction to pyloric outflow.

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 formed feces in lumen.

Pancreas

The pancreas was subjectively mildly prominent in size with indistinct pancreatic capsule compared to adjacent nonreactive or inflamed omentum. Isoechoic mildly heterogeneous pancreatic parenchyma was noted.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Enlarged hyperechoic liver – sonographically suggestive of metabolic diabetic hepatopathy with probable vacuolar changes, cholestasis, or lipidosis
- Mild gallbladder debris (non mucocele)
- Mildly prominent heterogeneous pancreas
- Hypomotile gastritis pattern, sonographically unremarkable empty small intestine
- Urinary bladder sediment with focal lumen mineral
- Overtly normal adrenal glands

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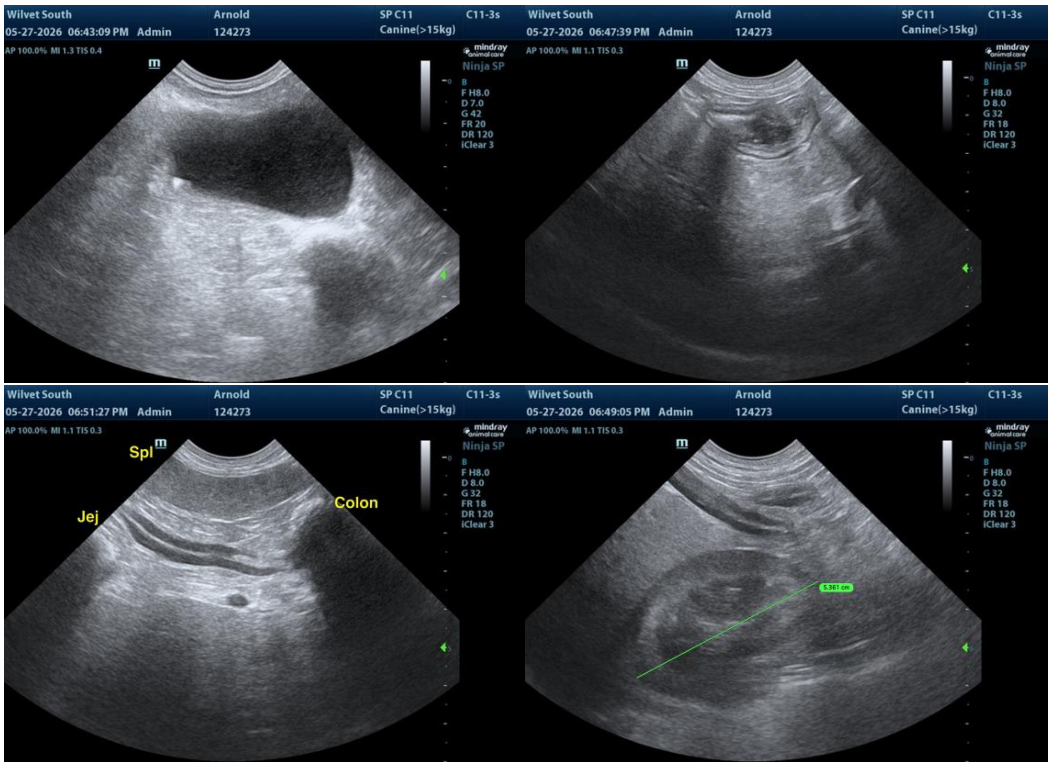
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is no sonographic evidence of significant / active pancreatitis. Mild to chronic pancreatitis may present with mild parenchymal changes. Empirical therapy for suspect diabetic ketoacidosis with gastrointestinal support and clinical monitoring is recommended. Urine C/S on a sterile urine sample is suggested, given glucose urea and if not done.

This is a suggestive checkoff list when faced with an unregulated diabetic patient:

UTI
Dietary indiscretion/intolerance
Pancreatitis
Hyperthyroidism/hypothyroidism
Exogenous steroids (including topical eye meds)
Cushing's
Acromegaly
Owner compliance
Insulin quality issues
Antibodies to insulin
Underlying Neoplasia
Diffuse liver disease



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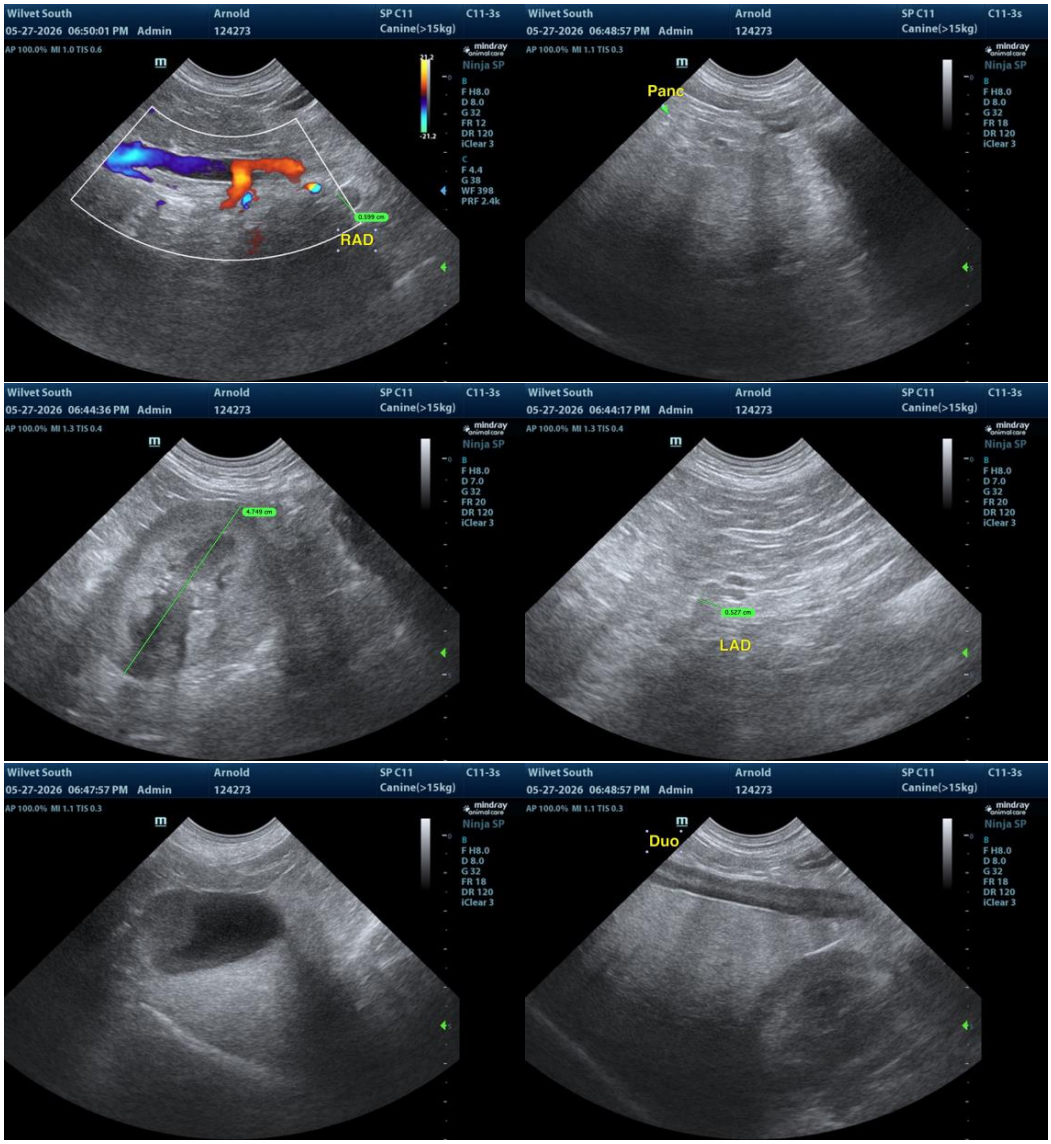

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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