



PATIENT

Drake Holz

SPECIES

Canine

BREED

Labrador

SEX

Neutered male

AGE

9 years

WEIGHT

68 lbs

INTERPRETED BY

Remo Lobetti, BVSc,
MMedVet (Med),
PhD, Dipl. ECVIM

IMAGING PERFORMED BY

Brian Klug.

HOSPITAL NAME

Sondel Family VC

REFERRING VET

Dr. Sondel

INVOICE

69457

DATE

12/9/25

PRESENTING CLINICAL SIGNS

History: 12 lb wt loss chronic diarrhea here for second opinion Did not get records from primary vet, Hx of "all normal cbc and chem" per Owner.

Abnormal PE/Chem/CBC/UA Results: alk phos= 943, 4/17/25

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is small with a normal thickness and smooth appearance of the wall. Normal anechoic urine with no sediment or uroliths evident.

Normal appearance of the trigone area, proximal urethra, and iliac blood vessels.

Normal appearance and size of the iliac lymph nodes. Ureters not visualized, which can be considered a normal finding.

Normal renal size (left measured 7.7 cm, right measured 7.6 cm), architecture, echogenic appearance, cortico-medullary differentiation, which maintains a 1:3 cortex to medulla ratio, pelvis, and capsule. No infarcts, mineralization or renoliths evident.

The prostate is small and hypoechogenic measuring 1.0 x 1.1 cm in size.

Adrenal Glands

The left adrenal gland is normal in shape, echogenic appearance, size, position, and appearance of the visible peri-adrenal vasculature. Left adrenal gland measured 0.86 cm and 0.73 cm in width. The right adrenal gland was enlarged with a rounded shape and hyperechogenic appearance, but maintained normal position and appearance of the visible periadrenal vasculature. The right adrenal gland measures 1.49 cm and 1.23 cm in width.

Spleen

Normal size and echogenic appearance. Smooth homogenous parenchyma and regular curvilinear capsule. Incidental myelolipoma is present. Normal volume of the splenic vasculature without any overt congestion or thrombosis evident. No inflammatory, neoplastic, infarction, or infiltrative changes evident. The spleen measured 1.5 cm in width.

Liver

Normal size, echogenic appearance, portal markings, and regular curvilinear capsule. Focal, hyperechogenic, parenchymal nodule in the right lobe measuring 0.9 x 1.0 cm in size. No additional nodules or masses are evident. Normal appearance of the hepatic and portal vasculature.



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Gallbladder

The gallbladder is full containing normal anechoic bile. Normal thickness and echogenic appearance of the wall. Normal size and appearance of the cystic and common bile duct.

Gastrointestinal

Normal appearance of the stomach, duodenum, ileo-cecal junction, and colon with no loss of layering, 1:3 muscularis to mucosa ratio, normal wall thickness and peristaltic activity, and no distension of the lumen. Segmental thickening of the small intestine (up to 0.78 cm) with no loss of layering and maintaining a 1:3 muscularis to mucosa ratio, normal peristaltic activity and no distension of the lumen. Patchy, mucosal stippling was present. A moderate amount of ingesta is present in the stomach and chyme in the proximal small intestine both compatible with a recent meal.

Pancreas

The visible sections of the pancreas are of normal size and echogenic appearance with a regular capsule. Normal echogenic appearance of the mesentery and fat surrounding the pancreas.

Free Abdomen

Normal mesenteric lymph nodes.

No ascites evident.

ULTRASONOGRAPHIC FINDINGS

- Enteropathy.
- Right adrenomegaly.
- Hepatic nodule.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Etiologies for the enteropathy would be parasitic enteritis, dietary hypersensitivity and inflammatory bowel disease although mucosal stippling is often associated with primary lymphangectasia. With ingesta and chyme present in the GI tract the most likely etiology would be the recent meal.

Etiologies for the right adrenomegaly would be reactive hyperplasia, disease stress and possibly emerging neoplasia (non-functional carcinoma, pheochromocytoma).

The hepatic nodule can be considered an incidental nodular hyperplasia.

Further assessment would be fecal analysis, cobalamin and folate assay and endoscopy of the upper GI tract with biopsies.



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Monitoring of the right adrenal gland would be recommended and if there is any progressive enlargement then ruling out a pheochromocytoma would be indicated by means of serial blood pressure determination and a urine/plasma catecholamine assay.

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Specific therapy would be dependent on an etiological diagnosis.

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Symptomatic management of the enteropathy would be feeding a novel protein/hypoallergenic diet, course of Fenbendazole, cobalamin supplementation and if there is still not a satisfactory improvement then a course of Prednisolone would then be indicated.

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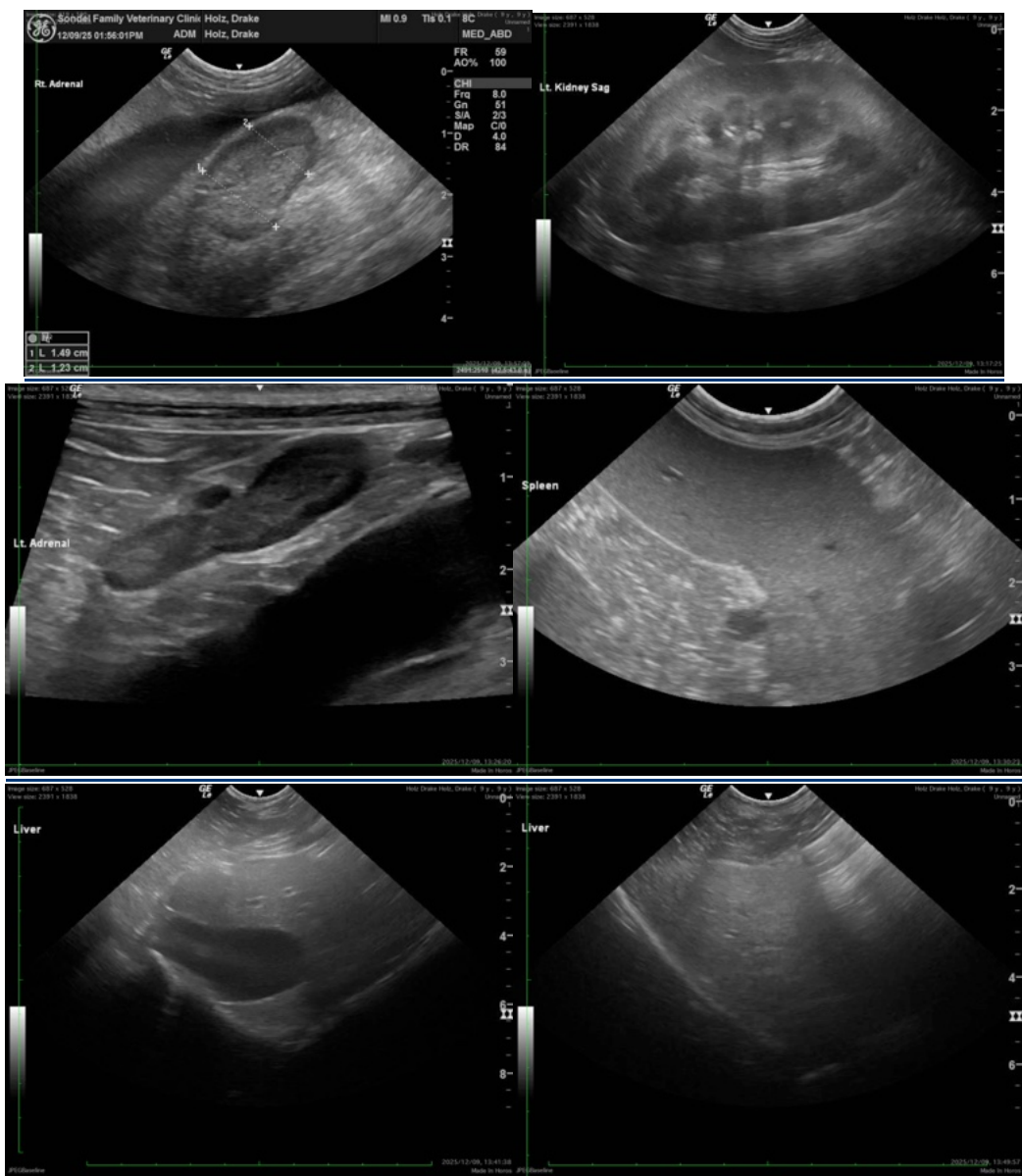
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Remo Lobetti, BVSc, MMedVet (Med), PhD, Dipl. ECVIM (Internal Medicine)

info@sonopath.com