



PATIENT

Hank Redick

SPECIES

Canine

BREED

Boxer X

SEX

MN

AGE

11 years

WEIGHT

60.8 lbs

INTERPRETED BY

Tam Mengine, DVM,
DABVP (canine/feline
practice)

**IMAGING
PERFORMED BY**

Sara Hansen

HOSPITAL NAME

Edgewood AC

REFERRING VET

Dr. Leduc

INVOICE

10995

DATE

12/19/2025

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Dental wear Nuclear sclerosis OA hips Diminished to absent appetite
ABNORMAL Labwork Values Phosphorus 6.4 ALT 371 AST 84 ALP 545 GGT 52 Creatine kinase 964
T4 0.4 UA USG 1.024 urine culture pending Fecal no parasites detected Current Medications SQ fluids
LRS, 1.5 ml B12, Maropitant injection 12/16 Radiographic Findings none.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine, and luminal sediment is not present. The bladder wall is diffusely thickened and there are irregularities to the mucosal surface. The ureteral papillae, trigone and pelvic urethra are of normal appearance, and the ureters are not visible (normal). No masses or calculi are noted. Urethra visualized to 4.0 cm

The prostate is of appropriate size for patient age and neutering status, with a homogenous parenchyma and smooth capsule. The prostatic urethra is non-dilated with normal margins.

The kidneys are of normal size and shape and exhibit appropriate corticomedullary differentiation with a normal 1:3 cortex to medulla ratio. There is no evidence of nephrolithiasis, mineralization, pyelectasia, cystic change or hydronephrosis. The proximal ureter is not visible (normal). Left kidney measures 6.9 cm, and the right kidney measures 7.2 cm.

Adrenal Glands

Both adrenal glands are diffusely enlarged and hypoechoic. They have normal phrenic vasculature and are found in the normal location. The left adrenal gland height is 1.3 cm at the cranial pole and 1.3 mm at the caudal pole. The right adrenal gland height is 1.6 mm at the cranial pole and 1.5 mm at the caudal pole

Spleen

The spleen is of appropriate size and has a normal, homogenous parenchyma with a smooth, continuous capsular surface. The splenic vasculature is normal with no evidence of congestion or thrombosis, and blood flow through the splenic hilus appears normal.

Liver

The liver is diffusely hyperechoic and subjectively enlarged, with sharp borders. There are hypoechoic nodules present throughout the parenchyma. The portal and hepatic vasculature are of normal size and appearance with no evidence of congestion or thrombosis.

The gallbladder is moderately distended with anechoic contents and a moderate amount of freely-moveable echogenic sludge. The wall was thin and continuous with no focal lesions. The cystic and common bile ducts are normal / not visible.

Gastrointestinal

The stomach is mildly distended with fluid. The gastric wall is 4.8 mm with normal deviations due to rugal folds, and exhibits appropriate wall layering. The pylorus is of normal appearance.



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The visualized portions of the duodenum, jejunum, and ileum are of normal thickness with intact wall layering that exhibits the appropriate 1:3 muscularis to mucosa ratio. Intestinal motility appears normal.

The visible portions of the colon are of normal thickness, 1.7 mm, with intact wall layering. The ileocecal junction is not visualized.

Pancreas

The areas of the limbs and body of the pancreas are isoechoic to the surrounding mesenteric fat, with normal capsular appearance. There is no evidence of peripancreatic inflammation. The pancreatic duct appears normal.

Free Abdomen

There is no evidence of free fluid within the peritoneal cavity. The omentum and intra-abdominal fat are of appropriate echogenicity. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

PRIMARY FINDINGS

- Diffusely, mildly thickened bladder wall, which may indicate cystitis.
- Mildly bilaterally enlarged adrenal glands.
- Diffusely hyperechoic liver, consistent with non-specific hepatopathy.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The thickened bladder wall may be incidental, but may also indicate bacterial cystitis. The pending urine culture should clarify whether this change is of concern. The appearance of the adrenal glands is most typical of benign hyperplasia. Pituitary dependent hyperadrenocorticism would be another possible explanation, but would not typically be expected in a patient that is inappetent.

The changes in the liver are non-specific and could be attributed to endocrine disease, other vacuolar hepatopathies, reactive hepatopathy, storage hepatopathy, chronic infectious or inflammatory disease (including leptospirosis), hepatic lipidosis, or less likely neoplasia. Additional recommendations include:

- Screening for hyperlipidemia with a fasted triglyceride level is recommended, if not already performed
- Testing for Cushing's disease is recommended only if clinical signs support the diagnosis
- Bile acid testing is recommended to further assess severity of hepatic disease - if elevated then liver biopsies are strongly recommended
- If bile acids are normal, then initiation of liver support therapies such as SAMe, Vitamin E and ursodiol, along with serial monitoring of liver enzyme levels every 2-3 months, could be initiated



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- Ultrasound-guided or laparoscopic biopsies would be needed for definitive diagnosis. Fine needle aspirate for cytology could also be performed but is less likely to yield a definitive diagnosis.

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If not already performed, additional diagnostics to investigate the patient's inappetence might include:

- Three view-chest radiographs.

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- A thorough oral cavity exam to rule out dental pain.

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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.

Tam Mengine, DVM, DABVP (canine/feline practice)

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