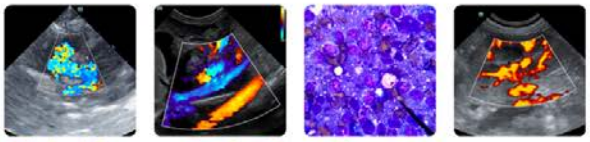


PATIENT

Darwin Cox

SPECIES

Canine

BREED

Rhodesian Ridgeback

SEX

Neutered Male

AGE

9 Years 11 Months

WEIGHT

62.8 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Michael Wasserman

HOSPITAL NAME

Highlands Animal Hospital

REFERRING VET

Dr. Daniel Jutras

INVOICE

74609

DATE

4/19/26

PRESENTING CLINICAL SIGNS

2 day history inappetence. Vomited undigested food at 10:00PM last night and a large amount of bile once in-hospital at 10:25AM this morning. Grade 2/6 murmur.

Current meds: Gabapentin 300mg TID / Tramadol 50mg TID / Methocarbamol 500mg BID / Prednisone 15mg BID / Trazodone 150mg BID PRN. Sedated with butorphanol 10mg/ml: 0.6ml IV for 90% of the ultrasound. Additional Right adrenal attempts made with dexdomitor given at that time (end of sonogram) 0.5mg/ml, 0.2ml IV.

Abnormal PE/Chem/CBC/UA Results: Historically elevated ALKP (>2000 today) and new elevated ALT (300). Hx of IVDD-suspected episode(s). CBC within normal limits

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine, and a small amount of luminal sediment is present. The bladder wall is focally thickened and there is a 2.0 cm long, wide base mass arising from the right apical region. There is also tissue echogenicity noted within the trigone region. The ureteral papillae and pelvic urethra are of normal appearance, and the ureters are not visible (normal). No calculi are noted. The urethral is seen to 3.0 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 7.6 cm. Right kidney measures 7.2 cm.

Adrenal Glands

The adrenal glands are diffusely enlarged and normal in echogenicity. They have normal phrenic vasculature and are found in the normal location. Left measures 1.4 cm at the cranial pole and 1.1 cm at the caudal pole. Right measures 9.6 mm at the caudal pole.

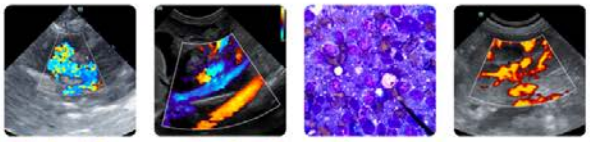
Spleen

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 and a homogenous echotexture. 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 small 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. d



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Gastrointestinal

The stomach is moderately distended with fluid and gas. The gastric wall is 5.3 mm with normal deviations due to rugal folds, and exhibits appropriate wall layering. The pylorus is of normal appearance.

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 (1.9 mm) with intact wall layering. The ileocecal junction is normal.

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 free fluid noted within the abdomen. There is hyperechoic, inflamed omental fat noted in the region of the stomach. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

PRIMARY FINDINGS

- Steatitis in the region of the gastric fundus, consistent with gastritis.
- Bilateral adrenomegaly.
- Mass effect within the bladder, which appears more typical of a blood clot, but the possibility of a true neoplastic lesion cannot be excluded.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The inflammation associated with the stomach is non-specific and likely associated with the current vomiting. This may be a self-limiting gastritis. However, if vomiting persists, then endoscopy or surgical exploratory would be recommended for biopsies.

Interpretation of the elevated ALP and ALT is challenging in the presence of chronic corticosteroid use. The changes to the liver parenchyma are typical for a dog on long-term steroids and might also be seen with vacuolar hepatopathy or reactive hepatopathy.

The enlarged adrenal glands are unexpected in a dog on long-term steroids and may represent benign physiologic hyperplasia, or possibly hyperadrenocorticism. Testing for hyperadrenocorticism would not be rewarding unless the patient is taken off corticosteroid treatment for several weeks. If the patient does not have clinical signs to support of a diagnosis of hyperadrenocorticism, then this investigation would not be recommended.

The changes in the bladder wall and trigone may represent a blood clot or other sediment, or less likely a neoplastic lesion. Interrogation of these areas with color or power doppler will be helpful in determining their significance. If there is vasculature demonstrated with doppler interrogation, then a urine BRAF test would be recommended to further investigate. Either way, urinalysis would be recommended to investigate whether there is clinically significant hematuria present.

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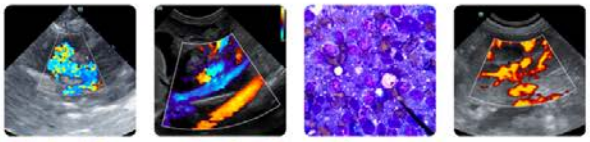

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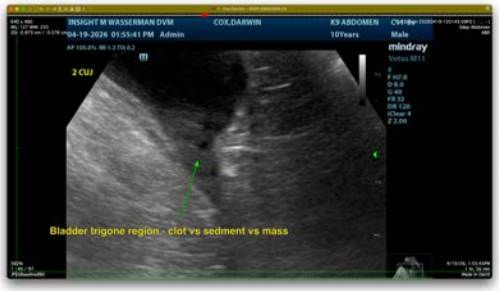

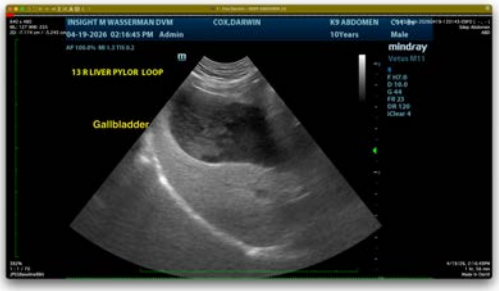

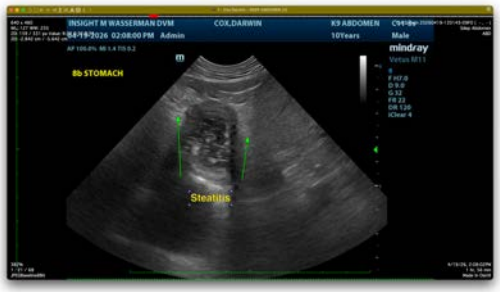

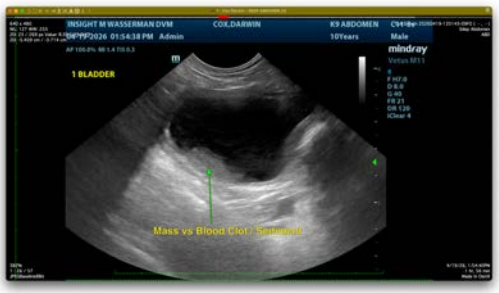

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

info@SonoPath.com