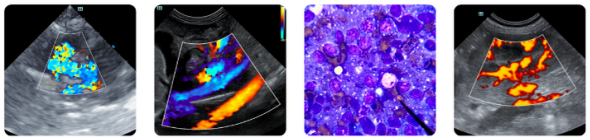


PATIENT

Buddy Maimone

SPECIES

Canine

BREED

Bichon

SEX

MN

AGE

12 years

WEIGHT

17 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Wasserman

HOSPITAL NAME

Village Pet Clinic

REFERRING VET

Dr. Defabio

INVOICE

11791

DATE

4/24/2026

PRESENTING CLINICAL SIGNS

Patient presented for vomiting. Bloodwork revealed increased ALT and amylase with elevated BUN. Abdominal ultrasound was performed under sedation with dexmedetomidine (0.07 mL of 0.5 mg/mL IV), which provided adequate sedation for imaging; however, the patient exhibited abdominal discomfort during the study. Following reversal, the patient was reassessed and demonstrated increased pain on palpation and with ultrasound probe pressure, most notably at SDEP position 8b. The patient is current on Heartgard and NexGard. Renal values were within normal limits in February of this year, and the last fecal exam (August 2025) was negative.

Abnormal PE/Chem/CBC/UA Results: 4/24/26 labs abnormals: CBC: HCT (Calculated): 25.1, HGB 7.6, BUN 74, Creat 1.8. Urine obtained by cystocentesis to be evaluated today.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The ureteral papillae, trigone and pelvic urethra are of normal appearance, and the ureters are not visible (normal). There are multiple shadowing uroliths present, measuring less than 5.0 mm. The bladder wall is normal. No masses 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.

Both kidneys exhibit adequate corticomedullary differentiation. There is a small, non-obstructed nephrolith present within the renal medulla of the left kidney. There is no evidence of pyelectasia or hydronephrosis. The proximal ureters are not visible (normal). The left kidney is 4.7 cm in length. The right kidney is 4.6 cm in length.

Adrenal Glands

The adrenal glands are both identified in their normal locations. They are normal in size and shape with appropriate parenchymal echogenicity and normal phrenic vasculature. Left adrenal measures 5.1 mm at the cranial pole and 5.6 mm at the caudal pole. Right adrenal measures 4.2 mm at the cranial pole and 7.1 mm at the caudal pole.

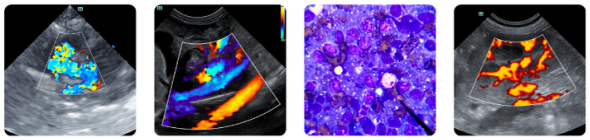
Spleen

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 parenchyma is diffusely heterogeneous and subjectively enlarged, with rounded margins. 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.



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Gastrointestinal

The stomach is mildly distended with gas. The gastric wall is 4.7 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, 1.7 mm, with intact wall layering. The ileocecal junction is not visualized.

Pancreas

The pancreas is not distinctly visualized, but there is hyperechoic omental fat observed in the region of the left limb of the pancreas.

Free Abdomen

There is an 8.4 mm cystic lesion seen within the region of the left pancreas, which is undifferentiated and not seen to arise from any organ. The surrounding omental fat is mildly hyperechoic. There is also hyperechoic omental fat in the region of the pancreas. There is no evidence of free fluid within the peritoneal cavity. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

PRIMARY FINDINGS

- Diffusely heterogenous liver consistent with non-specific hepatopathy.
- Steatitis in the region of the left pancreas, consistent with pancreatitis.

SECONDARY FINDINGS

- Small left kidney stone.
- Small bladder stones.
- Cystic structure in the region of the left pancreas, which may represent an incidental cystic lymph node or possibly a pancreatic pseudo cyst which would also be incidental.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The appearance of the pancreas is consistent with pancreatitis, and this is the most likely explanation for the patient's clinical signs. The patient's kidneys appear normal, with the exception of a small nephrolith, and given that the urine is concentrated, there may be a pre-renal component to the patient's azotemia. Reassessment of renal values once the patient is rehydrated is recommended. Empiric treatment for pancreatitis is recommended including antiemetics, analgesics, fluid therapy, and other supportive care as clinically warranted.

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 or less likely neoplasia. Additional recommendations include:

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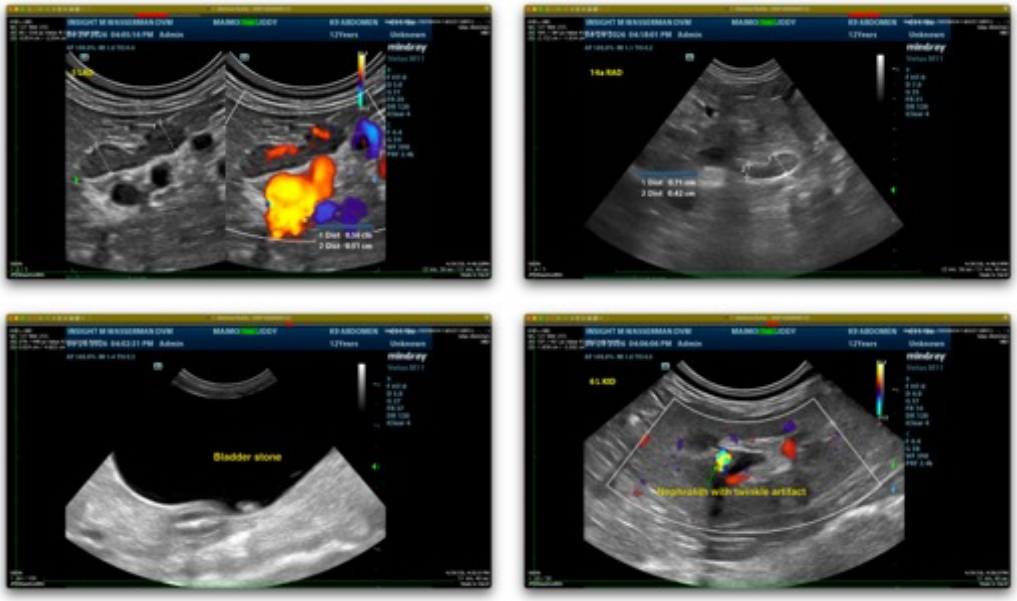
- Screening for hyperlipidemia with a fasted triglyceride level is recommended, if not already performed.
- Bile acid testing is recommended to further assess severity of hepatic disease - if elevated then liver biopsies are strongly recommended.
- If bile acids are normal, then initiation of liver support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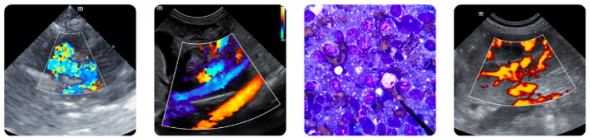

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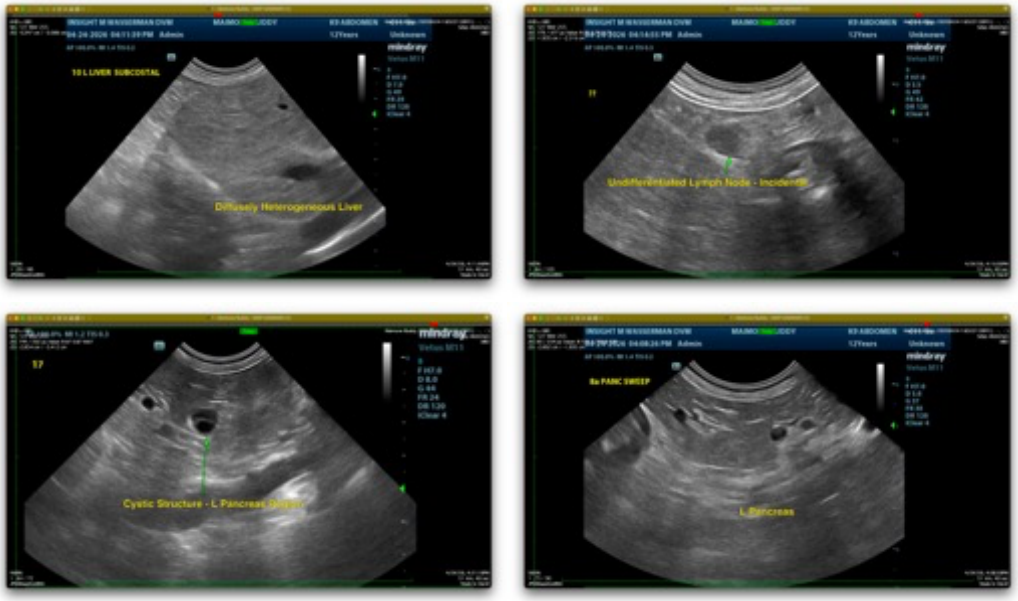

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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