

PATIENT

Ruby Whitcomb

SPECIES

Canine

BREED

Labrador Retriever Mix

SEX

Spayed Female

AGE

9 Years

WEIGHT

32.1 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Kari Wilson, DVM

HOSPITAL NAME

AEH Deland

REFERRING VET

Kari Wilson, DVM

INVOICE

35579

DATE

11/23/25

PRESENTING CLINICAL SIGNS

History: Ruby is a 9 YO FS Lab mix who was presented for vomiting. P has been vomiting on and off for the last 2 weeks. Her appetite has decreased to nothing for the last 3 days. No diarrhea.

Abnormal PE/Chem/CBC/UA Results: CPL: Normal HWT: Negative Lepto Snap: Negative Icteric TCHO 575 mg/dl (120-310) 10x Dilution ALT 2353 U/l (0-120) 10x Dilution ALP 5337 U/l (0-140)10x Dilution.

PRESENTING CLINICAL SIGNS

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine, and no luminal sediment is present. The ureteral papillae, trigone and pelvic urethra are of normal appearance, and the ureters are not visible (normal). No masses, calculi or mucosal irregularities are noted. Urethra visualized to 2.0 cm.

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). The left kidney is 7.1 cm in length. The right kidney is 7.77 cm in length.

Adrenal Glands

The adrenal glands are not distinctly visualized, but the regions appear unremarkable.

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

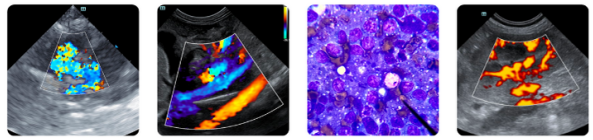
The liver is of appropriate size and shape, with sharp borders and a mildly coarse parenchymal echotexture that is hypoechoic to the spleen. The portal and hepatic vasculature are of normal size and appearance with no evidence of congestion or thrombosis.

The gallbladder is moderately distended with anechoic contents. There is a small nonobstructive cholelith present within the gallbladder, along with a small amount of intraluminal 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 moderately distended with gas and fluid. The gastric wall is 4.9 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.



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The visible portions of the colon are of normal thickness, up to 1.6 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 free fluid noted within the abdomen. There is hyperechoic, inflamed omental fat noted in the region of the liver and gallbladder. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Steatitis in the region of the liver and gallbladder, consistent with non-specific hepatopathy

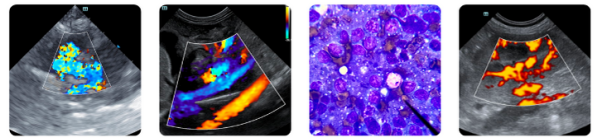
Secondary Findings

- Small, non-obstructive gallbladder cholelith, likely an incidental finding (but may be the mineralized foci noted on radiographs)

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Liver sampling would be needed to determine the cause of the hepatopathy, provided coagulation parameters are normal. Possible causes include inflammatory (bacterial or lymphoplasmacytic cholangiohepatitis), leptospirosis, acute toxic insult, storage hepatopathy, or infiltrative neoplasia. Recommendations include

- Fine needle aspirate, core biopsy or laparoscopic biopsy, if coagulation parameters are normal. Fine needle aspirate has a low risk of complications but is less likely to be diagnostic than a biopsy sample. However, it is useful for ruling in or out infiltrative neoplasia such as lymphoma. Samples should be obtained for both biopsy and culture.
- Testing for leptospirosis
- Initiation of liver support therapies such as SAMe, Milk Thistle, Vitamin E and ursodiol
- Symptomatic management, as needed, for inappetence, nausea or diarrhea
- If biopsy is not an option to guide treatment, then broad spectrum antibiotic therapy, such as a combination of amoxicillin or amoxi-clav, in combination with a fluoroquinolone, is recommended. If recheck lab values in 1 week show significant improvement, then a 4–6-week total course of antibiotics is recommended. If there is no response to empiric antibiotic therapy, then treatment with corticosteroids (such as prednisone at 2mg/kg/day) could be attempted.



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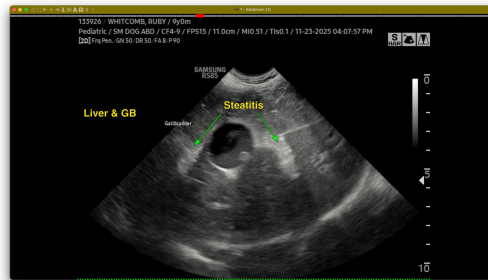
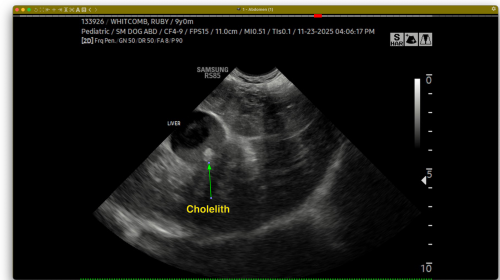
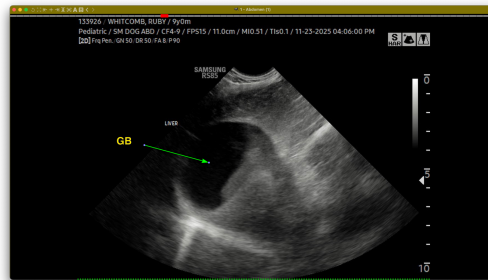
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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