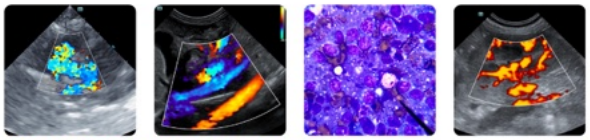


PATIENT

Azalea Ramm

SPECIES

Reptile

BREED

Bearded Dragon

SEX

Female

AGE

4 years

WEIGHT

0.462 kgs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Vincent Ravancho, CVT

HOSPITAL NAME

Paws, Wings, Scales AH

REFERRING VET

Dr. Stancel

INVOICE

77857

DATE

5/21/26

PRESENTING CLINICAL SIGNS

History: Abdominal Fluid, Blood in Stool and/Urates. Abdomen distended w/fluid, Wt. Loss. Current medications - Tazicef, Metacam
Abnormal PE/Chem/CBC/UA Results: TP low normal 3.0, HCT 22%

ULTRASONOGRAPHIC EXAMINATION OF THE CELOMIC CAVITY

Urinary System

The cloacal lumen is normally distended. The wall appears thin and smooth, and the luminal contents are predominantly anechoic with a small amount of suspended echogenic material.

The kidneys are intrapelvic in location and were not visualized on the current examination. In bearded dragons, renal evaluation is often limited during routine transcoelomic ultrasonography unless a dedicated pelvic acoustic approach is performed.

Reproductive System

The ovarian regions appear consistent with reproductive inactivity. No sonographic evidence of follicular stasis, retained eggs, oviductal distension, or active reproductive coelomic disease is identified on the current examination.

Spleen

The spleen measures 0.99x1.36 cm, appears rounded, homogeneous, and normoechoic.

Liver

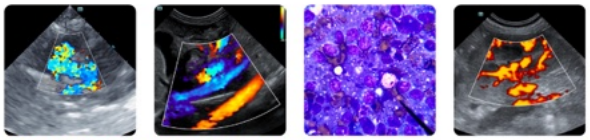
The liver is subjectively within normal size limits, with smooth margins and a regular contour. The hepatic parenchyma is homogeneous and isoechoic, with no focal hepatic mass lesion identified in the submitted views.

The gallbladder is normally distended. The wall is thin and smooth, and the luminal contents are predominantly anechoic.

Gastrointestinal

The stomach is moderately distended with ingesta. Gastric mural thickness measures approximately 0.91 mm and appears preserved.

The small intestine is fluid distended in some segments. Intestinal wall thickness measures approximately 2.58 mm. No focal obstructive lesion, obvious gastrointestinal mass, or overt foreign material is identified in the submitted examination.



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Fat bodies

The fat bodies are markedly reduced in size.

Celomic Cavity

A large volume of mildly complex coelomic effusion is present throughout the mesenteric recesses, gonadal recesses, and hepatopericardial recess, containing abundant suspended echogenic material/debris. Mild passive pulmonary atelectatic change/compression is present secondary to the marked coelomic effusion.

PRIMARY FINDINGS

- Marked complex coelomic effusion with suspended echogenic debris.
- Mild passive pulmonary compression/atelectatic change secondary to coelomic effusion.
- Small intestinal mural thickening with mild fluid distension.

SECONDARY FINDINGS

- Markedly reduced fat bodies.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Marked complex coelomic effusion is present throughout multiple coelomic recesses, containing abundant suspended echogenic material and associated with secondary passive pulmonary compression/atelectatic change. The ultrasonographic appearance is most supportive of a clinically significant inflammatory/exudative coelomic effusion (coelomitis). Septic and non-septic inflammatory etiologies are both considered realistic differential considerations at this stage.

Although the precise underlying cause cannot be definitively determined ultrasonographically, the current examination does not demonstrate convincing evidence of a primary reproductive etiology. No sonographic evidence of follicular stasis, retained eggs, marked oviductal distension, or reproductive coelomic mass effect is identified.

The small intestinal wall appears diffusely thickened relative to reported reference values for the species (most commonly reported physiologic range approximately 0.4–0.8 mm, with values >1.0 mm generally considered suspicious for distension, inflammatory, infiltrative, or content-related change), with associated mild fluid distension. In combination with the reported hematochezia/blood within the feces or urates, weight loss, anemia, and severe inflammatory coelomic effusion, clinically significant gastrointestinal inflammatory disease is considered increasingly likely. Differential considerations include severe enteritis, ulcerative gastrointestinal disease, bacterial translocation with secondary coelomitis, granulomatous/infectious enteropathy, or, less likely, diffuse infiltrative intestinal disease.

Mild splenic prominence/rounding may reflect reactive change in the context of the suspected systemic inflammatory process.

No convincing ultrasonographic evidence of severe primary hepatopathy or a dominant coelomic

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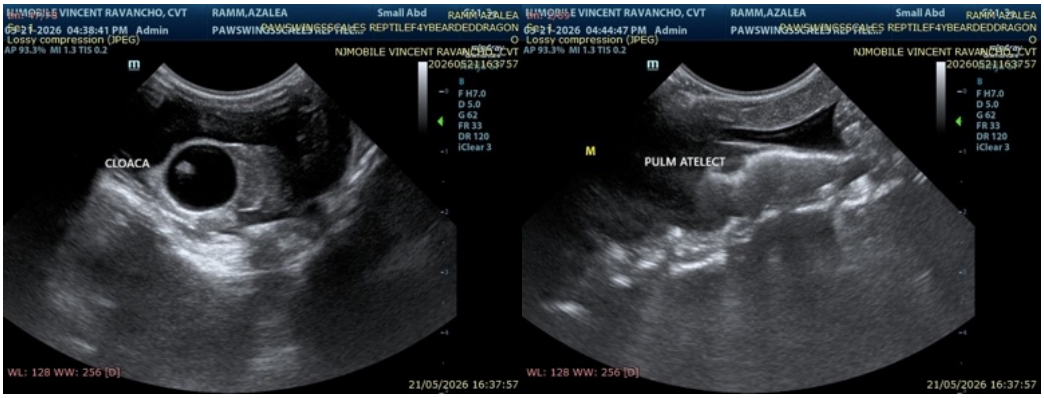
neoplastic mass is identified on the current examination. However, the kidneys could not be evaluated.

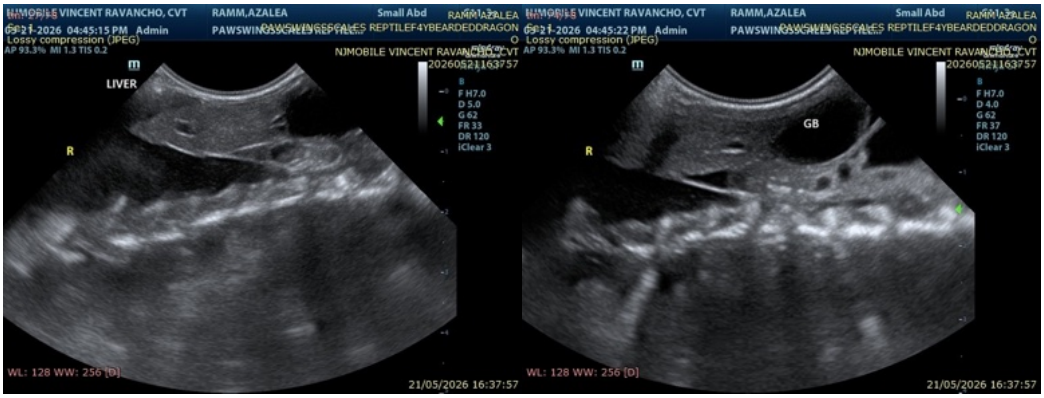
Overall, the current examination is most supportive of a severe diffuse inflammatory coelomic process of currently undetermined origin.

Recommendations

- Therapeutic and diagnostic coelomic fluid drainage is strongly recommended, both to improve respiratory mechanics and to obtain diagnostic samples.
- Cytology and fluid analysis are considered the highest-yield next diagnostic step in this case. Aerobic/anaerobic bacterial culture and sensitivity testing are also recommended if sample quality and volume permit.
- Complete plasma biochemistry is strongly recommended for assessment of hepatic, renal, inflammatory, electrolyte, and protein status, as the current ultrasonographic findings alone cannot determine the primary underlying etiology. Fecal evaluation (including parasitologic screening and bacterial assessment as clinically indicated) may be valuable given the reported blood within the feces/urates and suspected gastrointestinal involvement.
- Correlation with serial hematocrit/PCV, total solids, and leukogram findings is recommended to further assess inflammatory status, anemia progression, and possible protein loss.

Final diagnostic and therapeutic decisions should be made by the attending veterinarian, who can best integrate these findings with the patient's clinical status.





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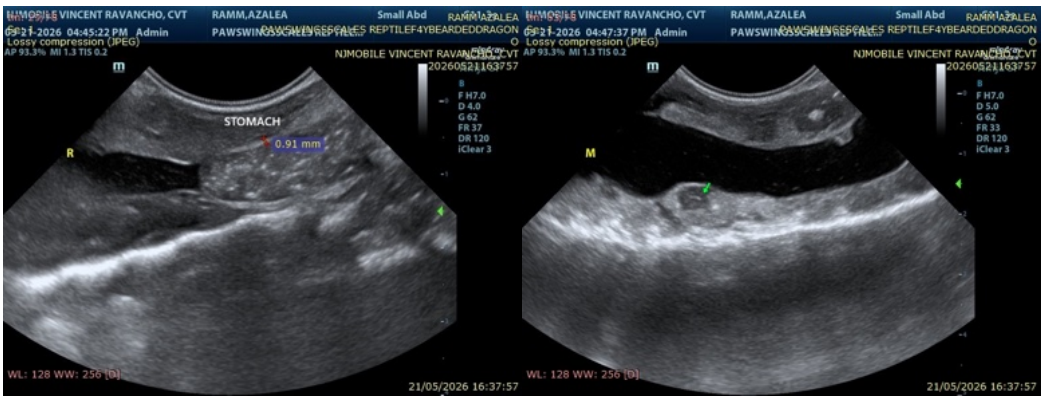

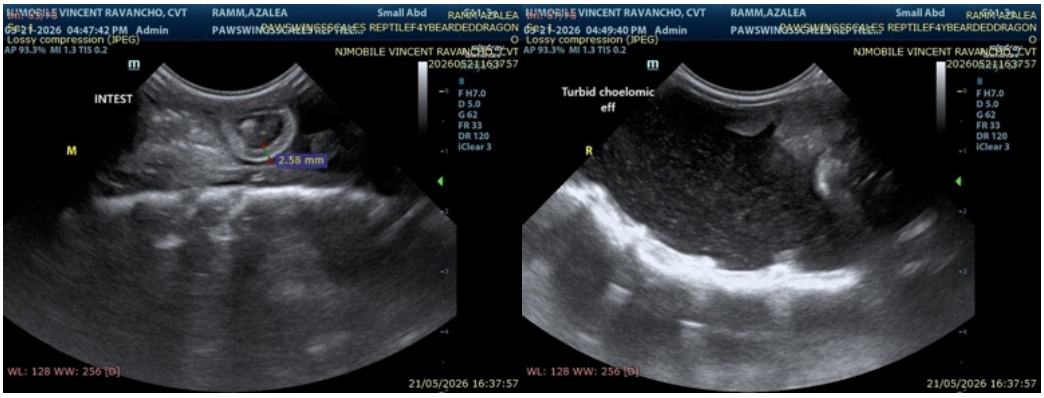

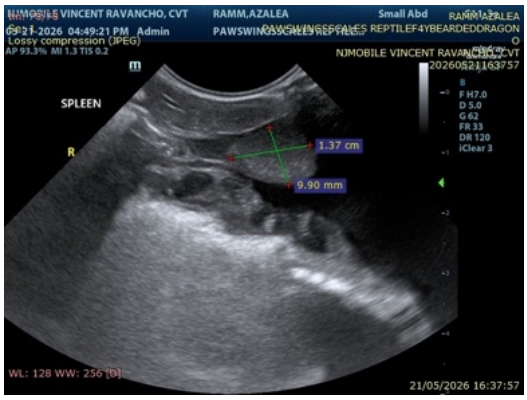

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

info@SonoPath.com