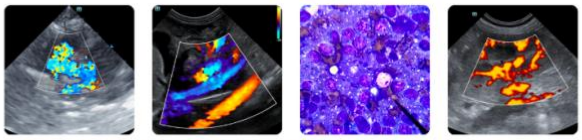


DATE

1-18-26

PATIENT

Molly Izzo

SPECIES

Canine

BREED

Mini Goldendoodle

SEX

Female Spayed

AGE

1-17-17

WEIGHT

28.1 lbs

INTERPRETED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Jones

INVOICE

22395

PRESENTING CLINICAL SIGNS

Patient History: Molly presents as referral from Bel air Hospital for elevated blood glucose with ketonuria and suspected diabetic ketoacidosis Patient History: - Referred from Bel air Hospital with blood work showing elevated blood glucose and urinalysis positive for ketones - Radiographs at referring hospital showed cardiac enlargement with possible pulmonary congestion - Diagnosed with cardiac disease at referring hospital - Started on Vetmedin (pimobendan) but unable to administer second dose due to vomiting - Vomited once last night - No diarrhea currently - Blood work from current visit shows pancreatitis.

Current Medications: Gabapentin, Ondansetron, Buprenorphine, Dextrose 50% solution, furosemide, Pantoprazole, Insulin, Trazadone, Maropitant Citrate.
Labwork Results: Labwork submitted & attached.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed by: Andi Parkinson, BS, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is moderately distended. A scant amount of suspended echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The left kidney is normal in size (5.29 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. A hyperechoic medullary band is observed at the corticomedullary junction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (5.45 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. A hyperechoic medullary band is observed at the corticomedullary junction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.58 cm at cranial pole) (0.62 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

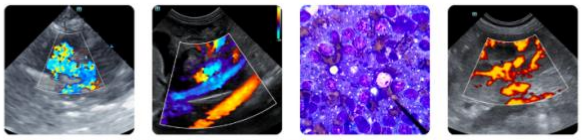
The right adrenal gland is upper limits of normal size (0.69 cm at cranial pole) (0.65 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (1.40 cm in width at the level of the hilus. A 0.50 x 0.41 cm hypoechoic nodule is observed at the mid-to-caudal aspect. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Liver

The liver is subjectively enlarged, with swollen peripheral contours. The parenchyma is hyperechoic relative



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to the spleen, attenuating, and subtly mottled in appearance. Hepatic vasculature and intrahepatic biliary tracts are of normal volume with no evidence of congestion.

The gallbladder lumen is moderately distended. The wall is thin and smooth. A small-to-moderate amount of aggregated, echogenic, partially dependent debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal
The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

Pancreas
The pancreas is subjectively prominent with slightly irregular curvilinear peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Lymph Nodes
The abdominal lymph nodes are normal/not visible.

Free Abdomen
There is no obvious evidence of free fluid.

Other
A brief echocardiogram reveals no obvious evidence of pericardial or pleural effusion in the visible window. There is no obvious evidence of cardiac masses in the available images.

ULTRASONOGRAPHIC FINDINGS

- The hepatic changes are most consistent with a diabetic hepatopathy. Other considerations include inflammatory disease (i.e., bacterial cholangiohepatitis, chronic hepatitis), hepatotoxicosis (i.e., copper), regenerative nodular hyperplasia, infiltrative neoplasia, and/or other hepatopathy.
- The gallbladder changes could be consistent with cholestasis, fasting, or less likely, an emerging mucocele.
- The pancreatic changes are suggestive of age-related parenchymal remodeling, without obvious evidence of active inflammation. However, low-grade chronic hepatitis cannot be excluded.
- The bilateral renal changes are most consistent with a diabetic nephropathy.
- The hypoechoic splenic nodule could be consistent with a benign focus (i.e., lymphoid hyperplasia or similar). Alternatively, an emerging tumor is possible.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A full minimum database (including a CBC, chemistry panel, urinalysis, and T4) is recommended if not already performed.

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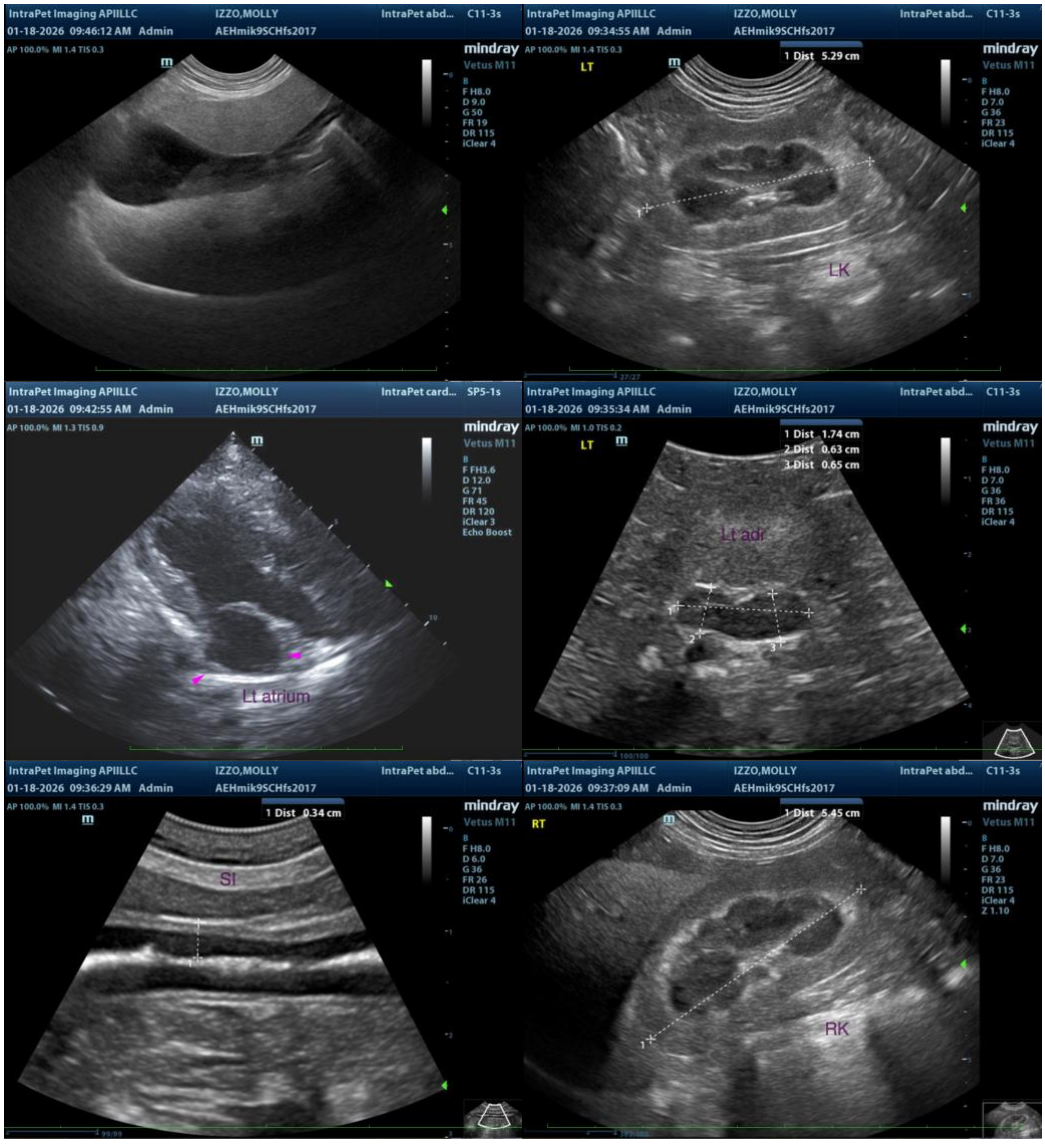
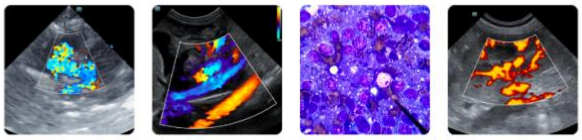
- Given the patient's diabetic status, consider a urine culture and sensitivity to assess for occult infection.
- Given the patient's age, three-view thoracic radiographs are recommended to assess cardiopulmonary status.
- Supportive care for diabetic ketoacidosis is recommended, with close monitoring of the patient's metabolic functions.



Imaging performed by IntraPet Imaging

IntraPet.com



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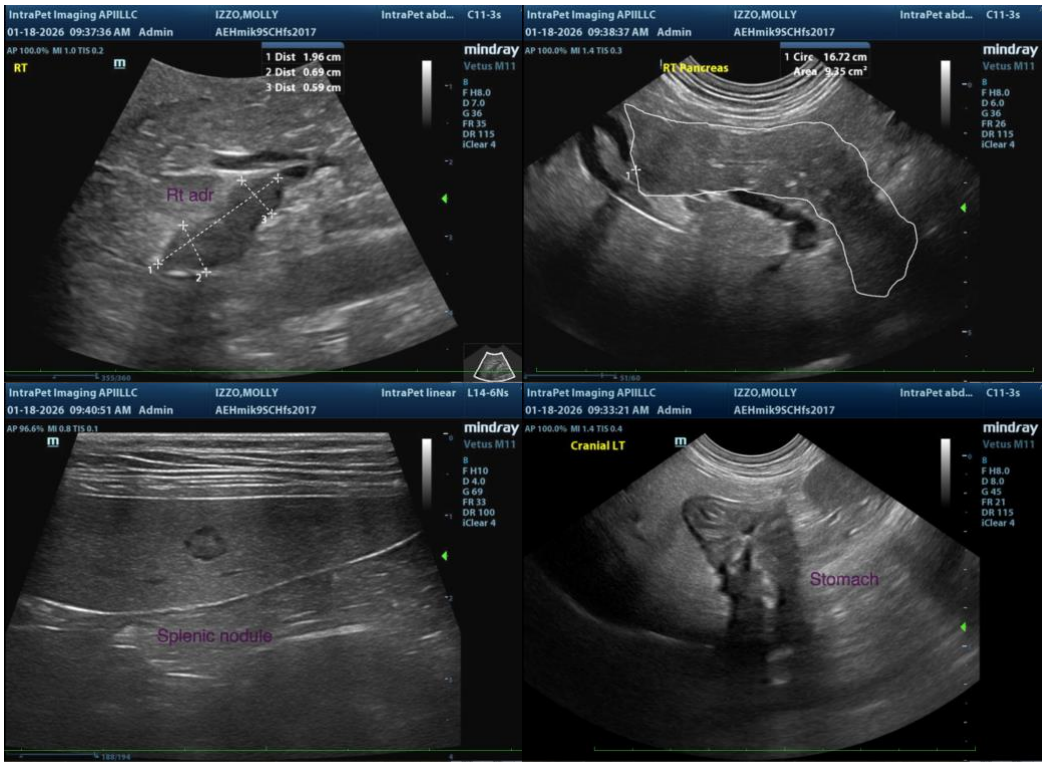

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com