Charleston Mobile Veterinary Services
IN PARTNERSHIP WITH SONOPATH VETERINARY ULTRASOUND

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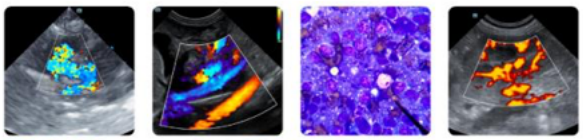

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Casey Erickson

SPECIES

Canine

BREED

Bichon Frise

SEX

Male Neutered

AGE

11Y

WEIGHT

11.1 kg

INTERPRETED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

IMAGING PERFORMED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME

BluePearl Summerville ER

REFERRING VET

Dr Ashley Adam

INVOICE

22303

DATE

11-24-25

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Casey 11y5m MN Bichon Frise is presenting for urinating/defecating in bed overnight, unable to walk, and vomiting.

O states around 6:20am this morning woke up to the smell of feces, woke up and realized Pt had urinated and defecated in the bed overnight, was excessively drooling and was unable to stand on his own. O picked Pt up and placed on the ground and Pt vomited up what O described to look like brown diarrhea, mucoid with foam. Pt fell to his side lateral and was trying to put his head up but couldn't. O did note a head tilt upwards to the right that did improve slightly over the time of getting ready to leave to head here. Drooling has improved as well. Pt is not known to get into things he shouldn't, was acting completely normal last night, e/d normal, no v/d leading up to this.

No current medications. Hx of growth removals and toe amputation due to cancer - O is not sure what kind.
MM/CRT: Pink, CRT <2sec
Hydration: Euhydrated
Attitude: BAR
Weight: 11.1kg
Pain score: 1/4
BCS: 8/9

Eyes: No ocular discharge, but tear staining OU
Ears: Mild yellow brown debris AU
Oral: Moderate dental tartar/gingivitis. No oral lesions noted
Integumentary: Clean haircoat.
Musculoskeletal: Ambulatory/weight bearing all limbs
Circulatory: Grade III/VI heart murmur, pulses strong/synchronous
Respiratory: Lungs clear bilaterally
Digestive: Abdomen soft, but painful, no palpable masses or abnormalities
Rectal Exam: Soft brown stool. No blood or mucous noted
Genitourinary: Normal externally
Neural System: Normal cursory neuro exam; no ataxia noted, cranial and spinal nerves intact, normal mentation
Lymph Nodes: Normal peripherally

Abnormal lab-work values: CBC: elevated WBC (17.24), elevated NEU (13.24)
CHEM17: elevated ALT (200), elevated CHOL (321), elevated AMYL (1666), elevated LIPA (4418)

Current Medications: Cerenia 11.1mg IV @ 12pm 11/23, Ondansetron 5.6mg SQ @ 12pm 11/23, 200 ml LRS SQ 12pm 11/23, sent home with Proviable

Radiographic Findings: Procedure: 6 orthogonal thoracic/abdominal radiographs from 11/23/25. No prior images available.
THORAX: The cardiac silhouette is slightly enlarged with a small bulge in the region of the left atrium. No additional intrathoracic abnormality is detected. The lungs are well expanded and aerated; a mass or nodule is not detected. The pulmonary blood vessels are normal in shape, size, and opacity. The thoracic lymph nodes (cranial-mediastinal, sternal, and tracheobronchial) are normal. No aggressive bone lesion is detected. The mediastinum, pleural cavities, and diaphragm are normal. Both shoulder joints have mild to moderate osteoarthrosis.
ABDOMEN The stomach is mildly distended with gas. The small and large intestine are slightly enlarged containing fluid opacity, gas, and slightly poorly formed feces in the colon. The liver is mildly to moderately enlarged with rounded caudal margins. Serosal detail is normal. The spleen, kidneys, and urinary bladder are

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normal in shape, size, and opacity. The hip joints bilaterally have at least mild osteoarthrosis and there is multifocal thoracolumbar spondylosis/disc degeneration.
Assessment: Mild, diffuse gastroenteropathy. Mild left sided cardiomegaly. Mild-to-moderate diffuse hepatomegaly. The patient's clinical signs are likely related to the described gastroenteropathy for which the differential diagnosis is broad (e.g. infection, immune mediated, less likely neoplasia or dietary indiscretion). Ultrasound could be considered. The results are negative for obstruction. Cardiomegaly might be secondary to sedation or physiologically normal variation, given the heart murmur valvular disease is possible and echocardiography is recommended.

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. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (0.82 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal in size (4.75 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is moderate loss of corticomedullary distinction. At least one, small, cortical cyst is seen. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal in size (5.15 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is moderate loss of corticomedullary distinction. Several hyperechoic shadowing diverticular foci are observed. There is no evidence of pyelectasia, infarcts or hydronephrosis. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.44 cm at cranial pole) (0.60 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 normal in size (0.47 cm at cranial pole) (0.56 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 (0.99 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. A 0.72 x 0.47 cm irregular, hypoechoic nodule is observed at the cranial-to mid-aspect. Splenic vasculature is normal.

Liver

The liver is subjectively prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits mild heterogeneity. No distinct focal lesions are observed. Hepatic vasculature and biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1: 1.

The gallbladder is mildly to moderately distended. The wall is normal in thickness. A few, polypoid-like lesions are arising from the mucosal surface. A small amount of aggregated, echogenic, partially dependent debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

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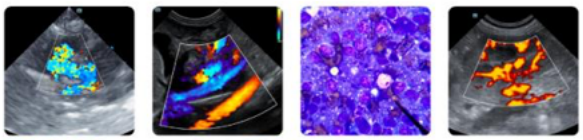

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Gastrointestinal
The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal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

Pancreas
The right limb of the pancreas is visible with normal 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
A 1.50 x 0.89 cm cystic lymph node is observed in the right cranial- to mid-abdomen.

Free Abdomen
There is no obvious evidence of free fluid.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The hepatic changes are nonspecific and could be secondary to inflammatory disease (i.e., cholangiohepatitis, chronic hepatitis), hepatotoxicosis, infiltrative neoplasia (i.e., lymphoma), vacuolar hepatopathy, regenerative nodular hyperplasia, reactive hepatopathy, other hepatopathy, or some combination thereof.
- The gallbladder changes could be consistent with cholestasis, fasting, or an emerging mucocele. Gallbladder polyps are also present. This is typically a benign incidental finding. However, they can occasionally be associated with cholecystitis.
- The splenic nodule could be consistent with a benign focus (i.e., lymphoid hyperplasia or similar). Alternatively, an emerging tumor is possible.

Secondary Findings

- Bilateral age-related renal changes with dystrophic mineralization
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Cystic lymph node in the right cranial- to mid-abdomen, the significance of which is unclear. It may represent benign incidental change, reactive node, or less likely, an emerging tumor.

*An obvious cause for the patient's vomiting is not definitively identified in this study. Broad considerations include a microscopic enteropathy (i.e., food allergy/intolerance, inflammatory bowel disease, infectious/parasitic disease), underlying metabolic issue, other.

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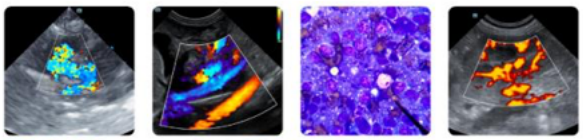

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

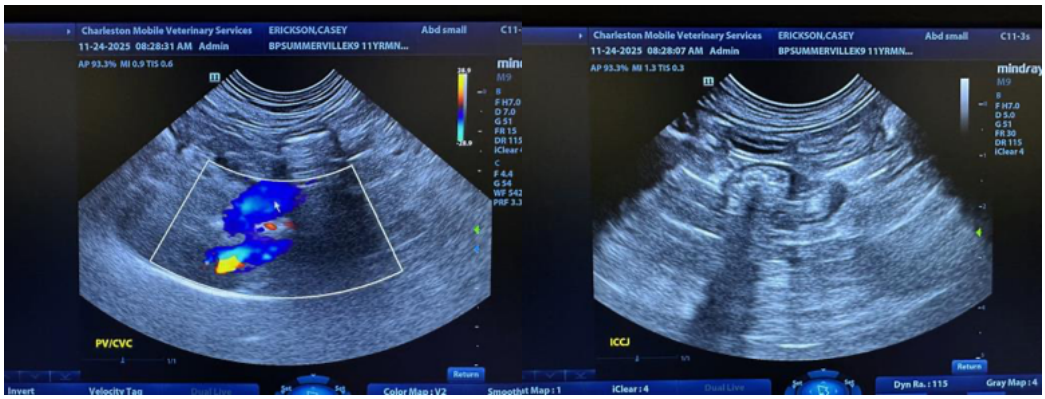
- To evaluate the elevated liver values, consider further work-up (i.e., pre- and postprandial serum bile acids, Leptospirosis testing (i.e., blood and urine PCR, serology), particularly if the clinical suspicion for disease is high, +/- hepatic tissue sampling (i.e., aspirates or biopsies). If biopsies are pursued, aerobic and anaerobic bile cultures and hepatic copper quantitation should also be performed.

- Given the gall bladder changes, Ursodeoxycholic acid (Ursodiol) is recommended. Serial sonographic monitoring (e.g., every 6-8 weeks) of the gall bladder is recommended to assess for progression to a fully formed mucocele. If progression occurs, a cholecystectomy may be warranted.

- Regarding the patient's vomiting, further work-up can be considered and could include the following:

  1. Fecal evaluation for ova and Giardia
  2. GI panel including serum cobalamin and folate, TLI, PLI and resting cortisol level, particularly if the vomiting is chronic in nature
  3. +/- endoscopic or surgical GI biopsies

- Regarding the splenic nodule, fine-needle aspiration can be considered (if clotting status is appropriate). A 25-gauge needle should be used. If tissue sampling is not pursued at this time, consider a recheck ultrasound in 1-2 months to assess for growth of the lesion.



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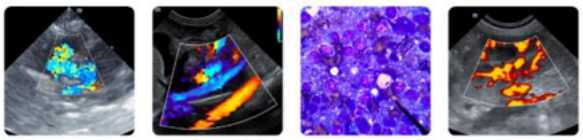

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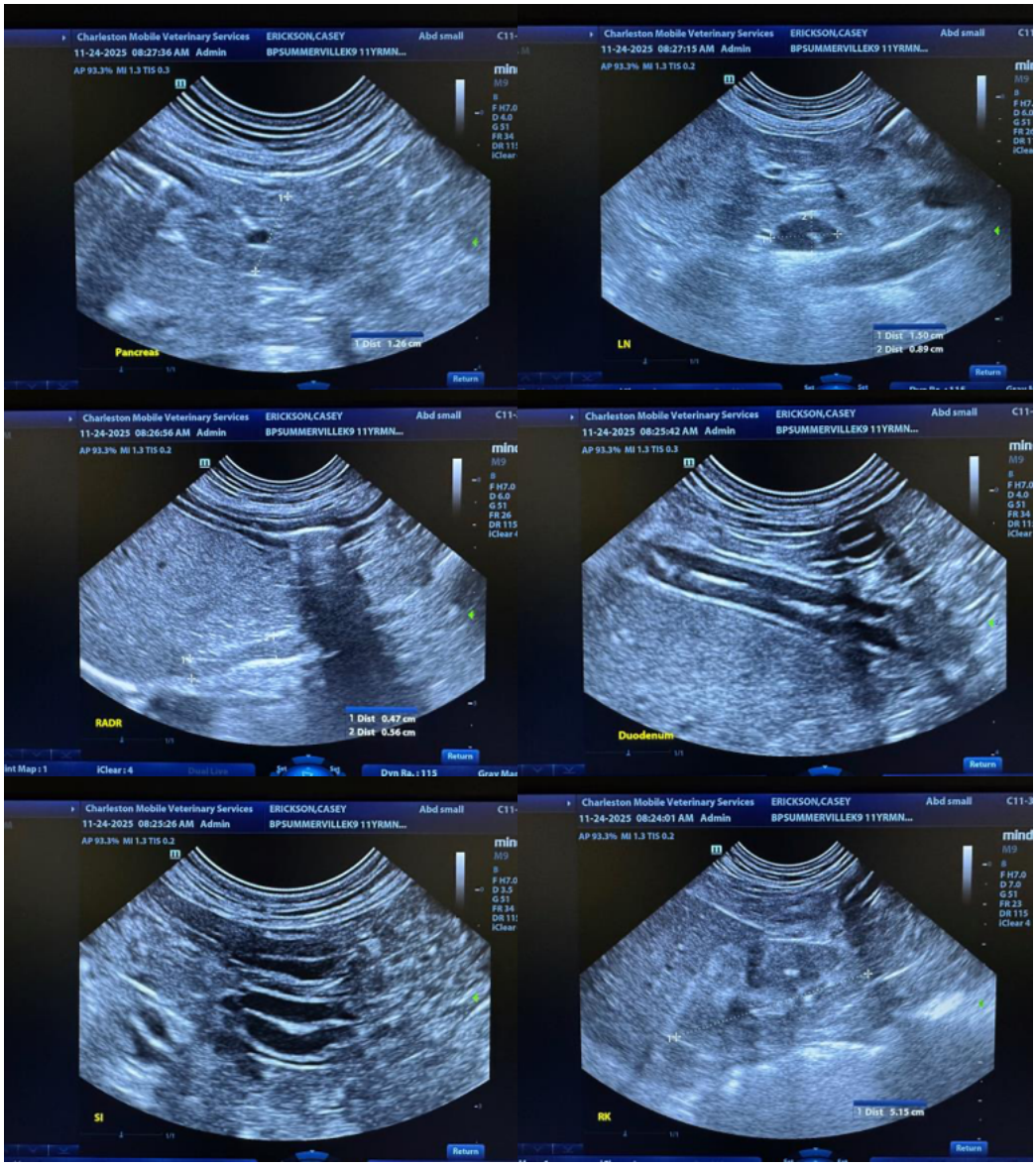

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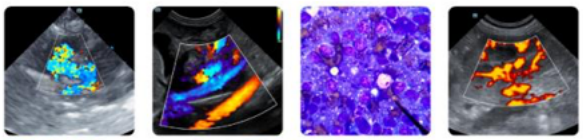

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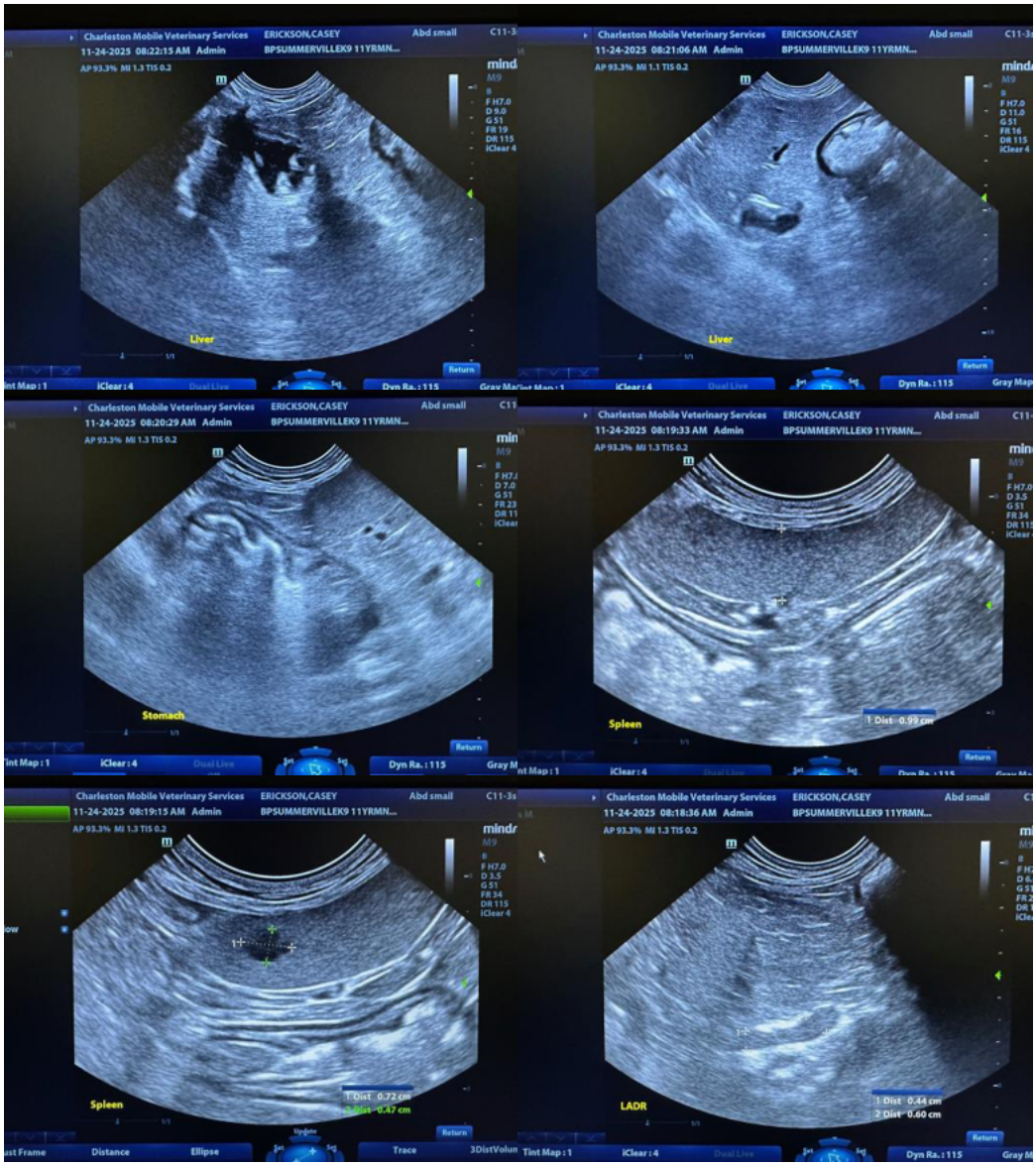

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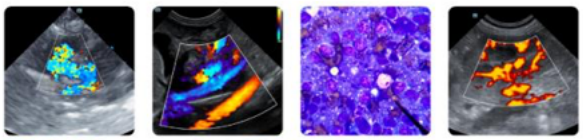

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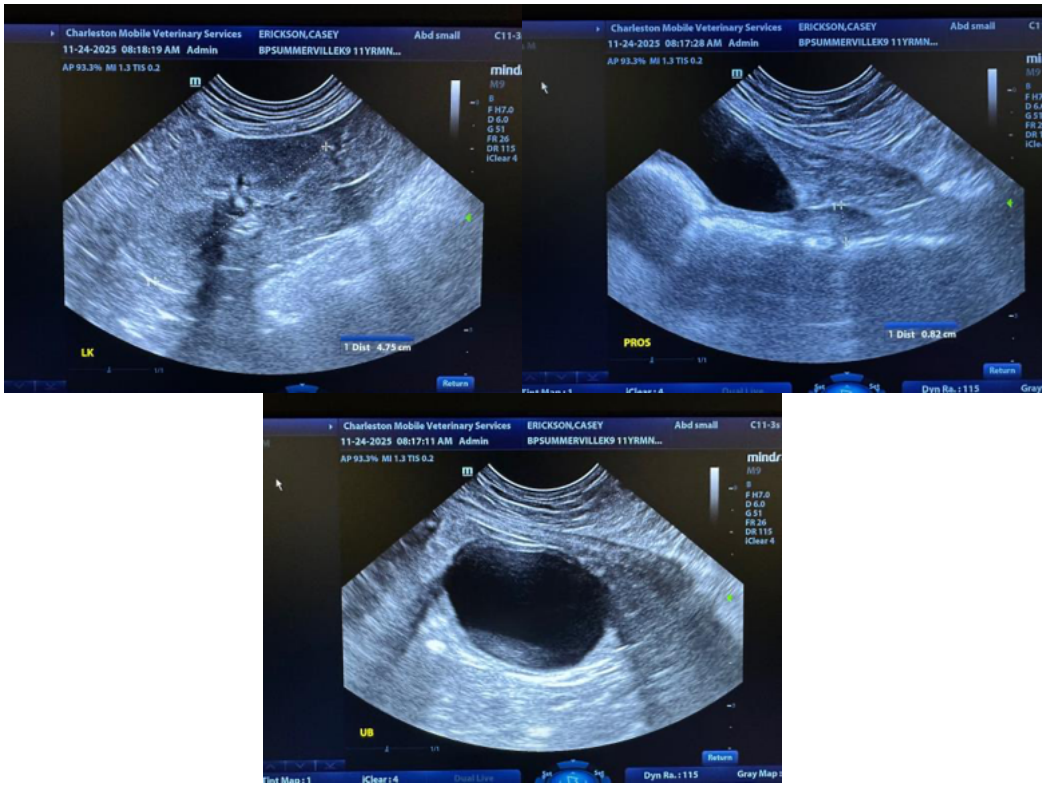

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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