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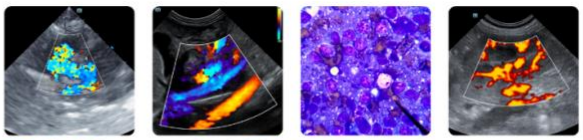


Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Bentlee Moquin

SPECIES

Canine

BREED

Chihuahua

SEX

Neutered Male

AGE

15

WEIGHT

Not Provided

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

Sun Dog Cat Moon

REFERRING VET

Dr Abby Clayton

INVOICE

22580

DATE

2-19-26

PRESENTING CLINICAL SIGNS

Has been having episodes of chronic intermittent vomiting that have been treated symptomatically. Also has a history of Stage B1 degenerative valve disease. BUN 33. Precision PSL 96. CBC unremarkable. USG 1.034. No proteinuria. Inactive sediment. 4dx negative. Fecal PCR negative. T4 0.5.

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 mostly anechoic. No cystic calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

The prostate is normal in size (0.68 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is overall enlarged (3.55 cm in length) with a slightly irregular shape. There is a normal 1:3 cortex to medulla ratio with mild-to-moderate loss of corticomedullary distinction. A 2.1 cm cortical cyst is observed at the lateral aspect. Several nonobstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (3.63 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild to moderate loss of corticomedullary distinction. A few nonobstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.42 cm at cranial pole) (0.48 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 (0.57 cm at cranial pole) (0.45 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 (0.62 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

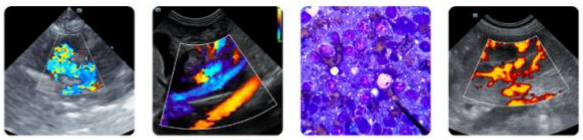
Liver

The liver is subjectively normal-in-size with normal peripheral contours. The parenchyma is isoechoic relative to the spleen and diffusely homogeneous in appearance. No distinct focal lesions are observed. Vascular 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 lumen is moderately distended. The wall is thin and smooth. A small amount of echogenic, gravity-dependent debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is mildly fluid-distended. The gastric wall and pylorus are normal in thickness with a



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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 obvious evidence of an obstructive pattern.

Pancreas
The base and limbs of the pancreas are visible with normal curvilinear peripheral contours. The parenchyma is slightly hyperechoic 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
The peritoneal cavity is normal. There is no evidence of inflammation or effusion.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis. Changes are similar to the previous sonogram.
- Mild retained gastric fluid. This may represent recent water ingestion or delayed gastric emptying. Correlation with the patient's clinical history is recommended.

Secondary Findings

- Bilateral nonspecific age-related renal changes with nonobstructive nephrocalcinosis and a left cortical cyst
- The diffuse hepatic changes are most consistent with vacuolar hepatopathy (i.e., endocrine, idiopathic) with a lower possibility of inflammatory disease, infiltrative neoplasia, or other hepatopathy.
- Gallbladder debris, non-mucocele

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

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- The following diagnostics/treatment recommendations can be considered:

1. Texas GI panel including serum cobalamin, folate, PLI, TLI and resting cortisol level
2. Despite the negative fecal evaluation, consider prophylactic deworming with Fenbendazole.
3. A 3-4-week hypoallergenic or hydrolyzed protein diet trial
4. Also consider initiating a probiotic with a high colony count +/- fiber supplement (i.e., psyllium).

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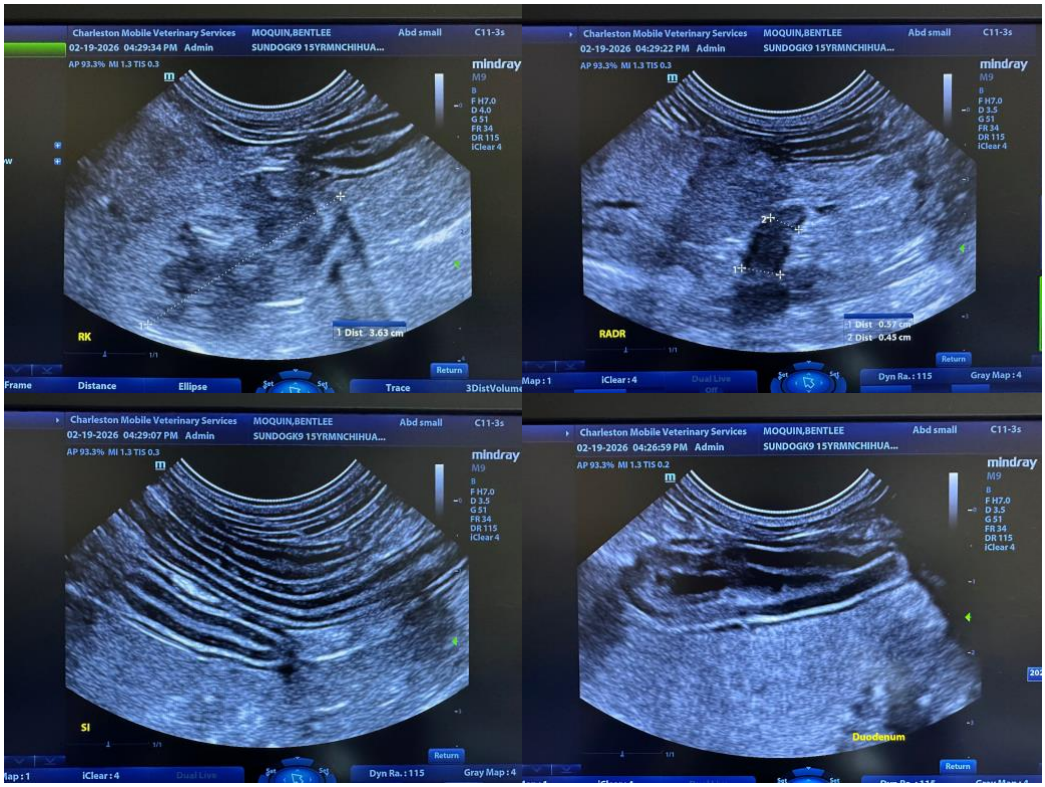
5. Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be warranted.
6. Three-view thoracic radiographs should be performed prior to any anesthetic event
7. If further testing is not pursued, symptomatic care is recommended.

- Further recommendations should be based on the echocardiogram report.



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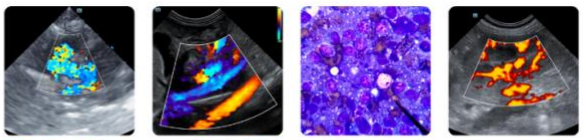

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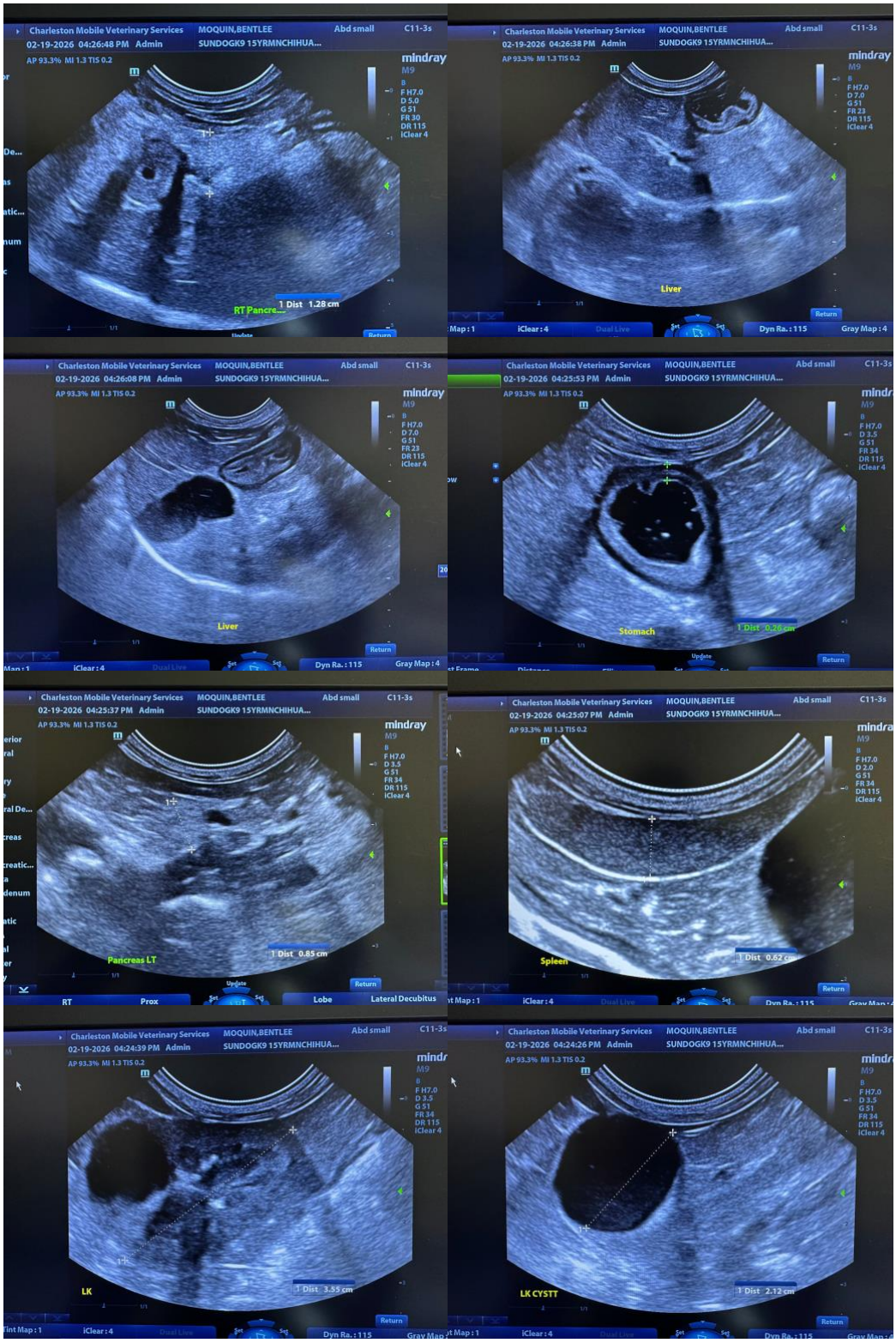

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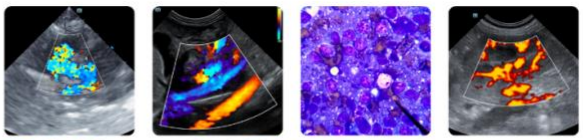

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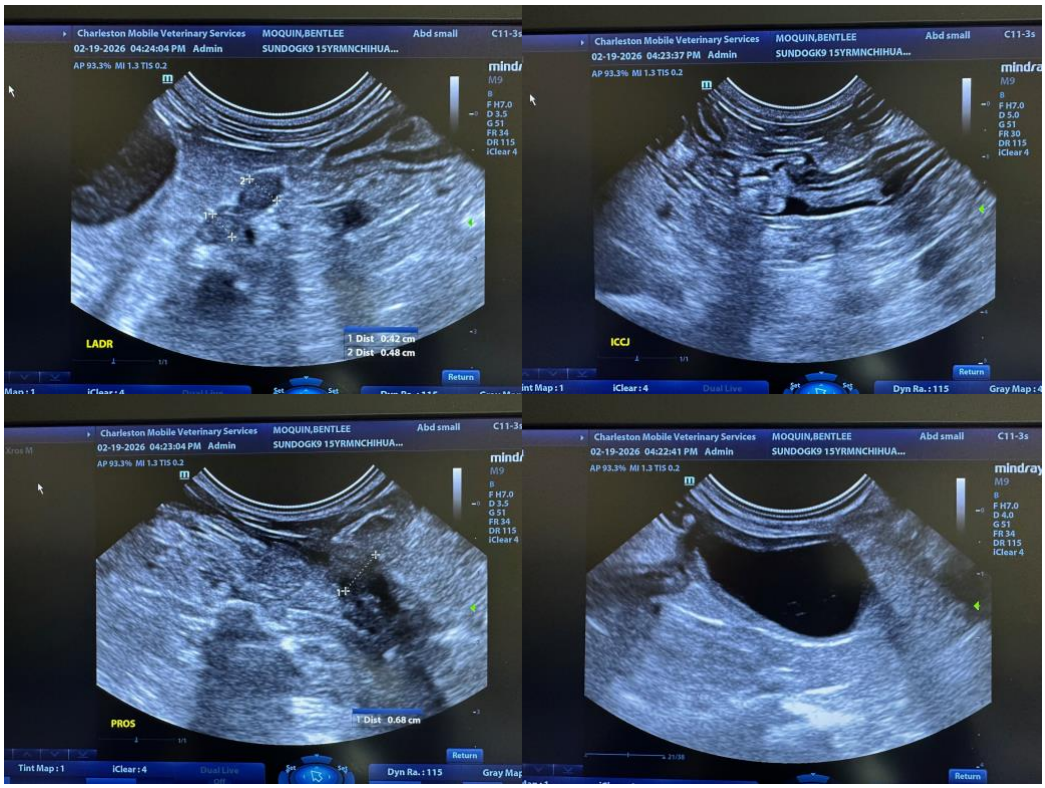

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
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