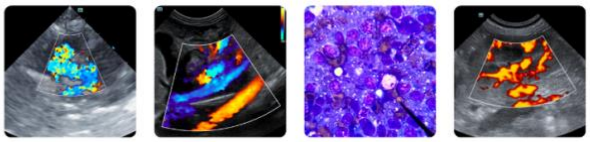

PATIENT

Warren Thomas

SPECIES

Canine

BREED

Pomeranian

SEX

Neutered Male

AGE

10 years 5 mos

WEIGHT

13.4 lbs

INTERPRETED BY

Andrea Nicastro, DVM, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Kaitlyn Rudie, DVM

HOSPITAL NAME

Sherwood Family PC

REFERRING VET

Delany Kriz, DVM

INVOICE

22525

DATE

2-6-26

PRESENTING CLINICAL SIGNS

History: Warren was seen on 1/26 for a recheck following bloody diarrhea managed at a different clinic. At the clinic, he had a negative cPL and fecal. He had improved at that time but still had a small amount of blood in his stool. Ultrasound to investigate continued weight loss and bloodwork changes. He defecated loose stool with no blood present during ultrasound.

Abnormal PE/Chem/CBC/UA Results: Albumin 2.5. Globulin 2.4 ALP 271. Hypoproteinemia, ALP, low thyroid, eosinophilia, low USG with 1+ protein. 4DX negative (See attached bloodwork)
Weight loss: was 19.28 lbs 3/21/25, 14.2 on 1/26/26 and now 13.4 (2/6/26) V/VI murmur on exam, no arrhythmias. Abdomen soft and comfortable.

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 visible portion of the proximal urethra are normal.

The prostate is normal in size (0.80 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 (3.80 cm in length) with a normal shape, smooth peripheral margins, and normal internal architecture. There is moderate loss of corticomedullary distinction. Pinpoint hyperechoic foci are observed within the cortex. Several hyperechoic shadowing diverticular foci are observed. Trace pyelectasia is present (0.15 cm in the longitudinal plane). There is no evidence of infarcts or hydronephrosis. Renal vasculature is normal.

The right kidney is normal in size (3.71 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. Trace pyelectasia is present (0.14 cm in the transverse plane). There is no evidence of infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.58 cm at cranial pole) (0.55 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 mildly enlarged (0.73 cm at cranial pole) (0.59 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 (10.2 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.

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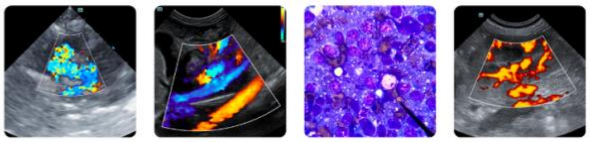

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath.com info@sonopath.com 1.800.838.4268

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Liver
The liver is subjectively normal-in-size, with normal 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 gallbladder lumen is moderately distended. The wall is thin and smooth. Luminal contents are mostly anechoic. 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 to mildly-thickened (up to 0.34 cm). There is disruption in the normal 1:3 muscularis: mucosal ratio in several segments. Discreet masses are not identified. The wall of the descending colon is normal- to mildly-thickened (up to 0.40 cm) with retention of the normal layering pattern. The lumen of the distal descending colon contains some granular-appearing fecal material. There is no obvious evidence of an obstructive pattern.

Pancreas
The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional inflammation or effusion.

Lymph Nodes
One-to-two prominent medial iliac lymph nodes are visualized (one measuring 1.26 x 0.45 cm). One-to-two prominent mesenteric lymph nodes are also seen (one measuring 1.27 x 0.62 cm).

Free Abdomen
There is no obvious evidence of free fluid.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The small intestinal wall changes could be consistent with inflammatory bowel disease or may be a normal variant for this patient.
- The colonic wall changes are suggestive of colitis.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- Bilateral nonspecific age-related renal changes with dystrophic mineralization and trace pyelectasia

Secondary Findings

- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory disease, infiltrative neoplasia and other hepatopathies are considered less likely.
- Mild bilateral adrenomegaly

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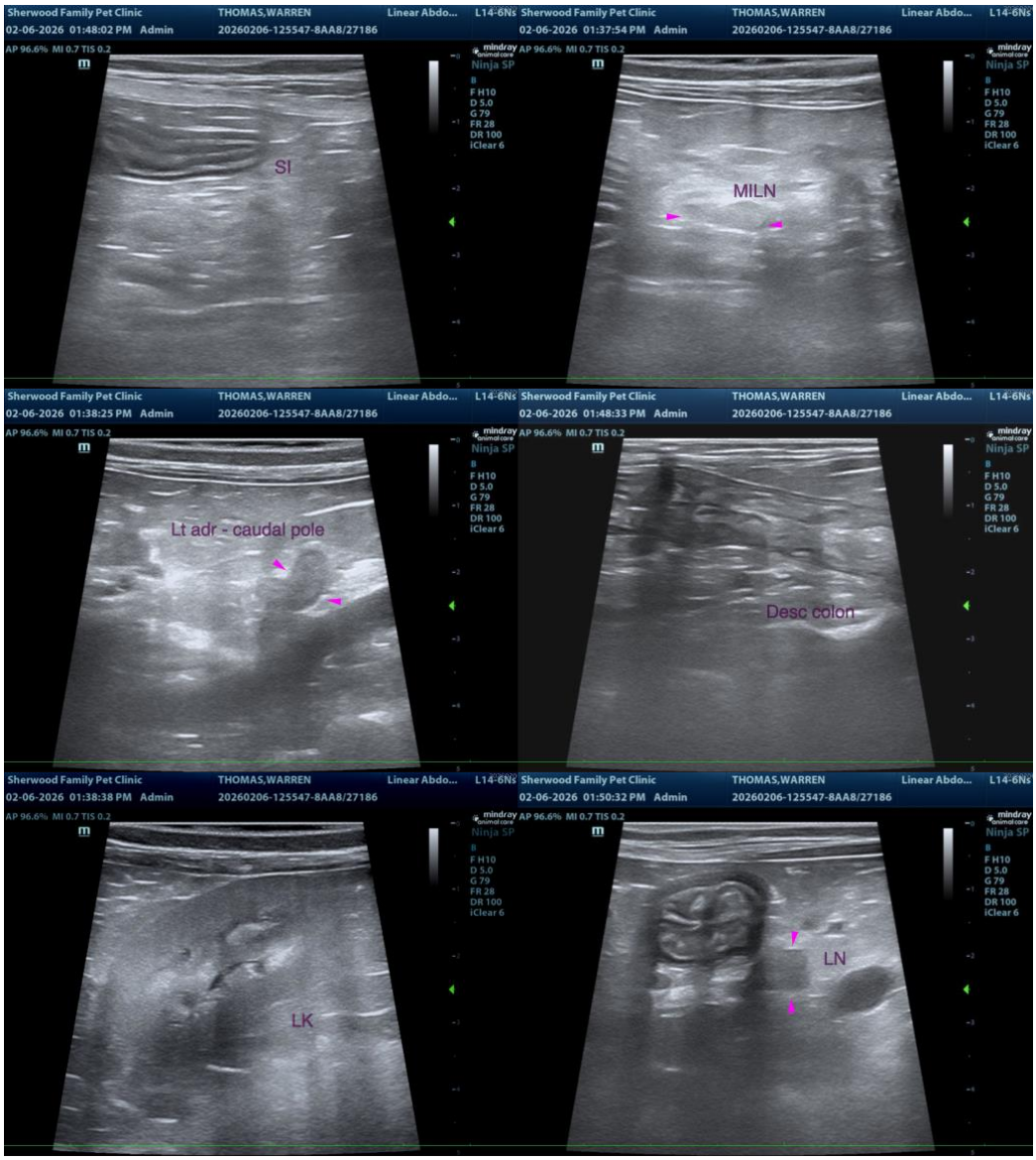
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the patient's clinical history of hypoalbuminemia, consider the following:

1. Fecal evaluation for ova and Giardia
2. GI panel including serum cobalamin and folate, TLI, PLI and resting cortisol level
3. Pre- and postprandial serum bile acids to assess for hepatic dysfunction
4. UPC if proteinuria is present in the absence of infection
5. +/- endoscopic or surgical GI biopsies. Three-view thoracic radiographs are recommended prior to any anesthetic event.
6. In the meantime, supportive care is recommended, including a probiotic, fiber supplement, and a low-fat, limited antigen diet



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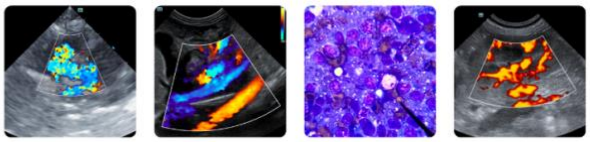

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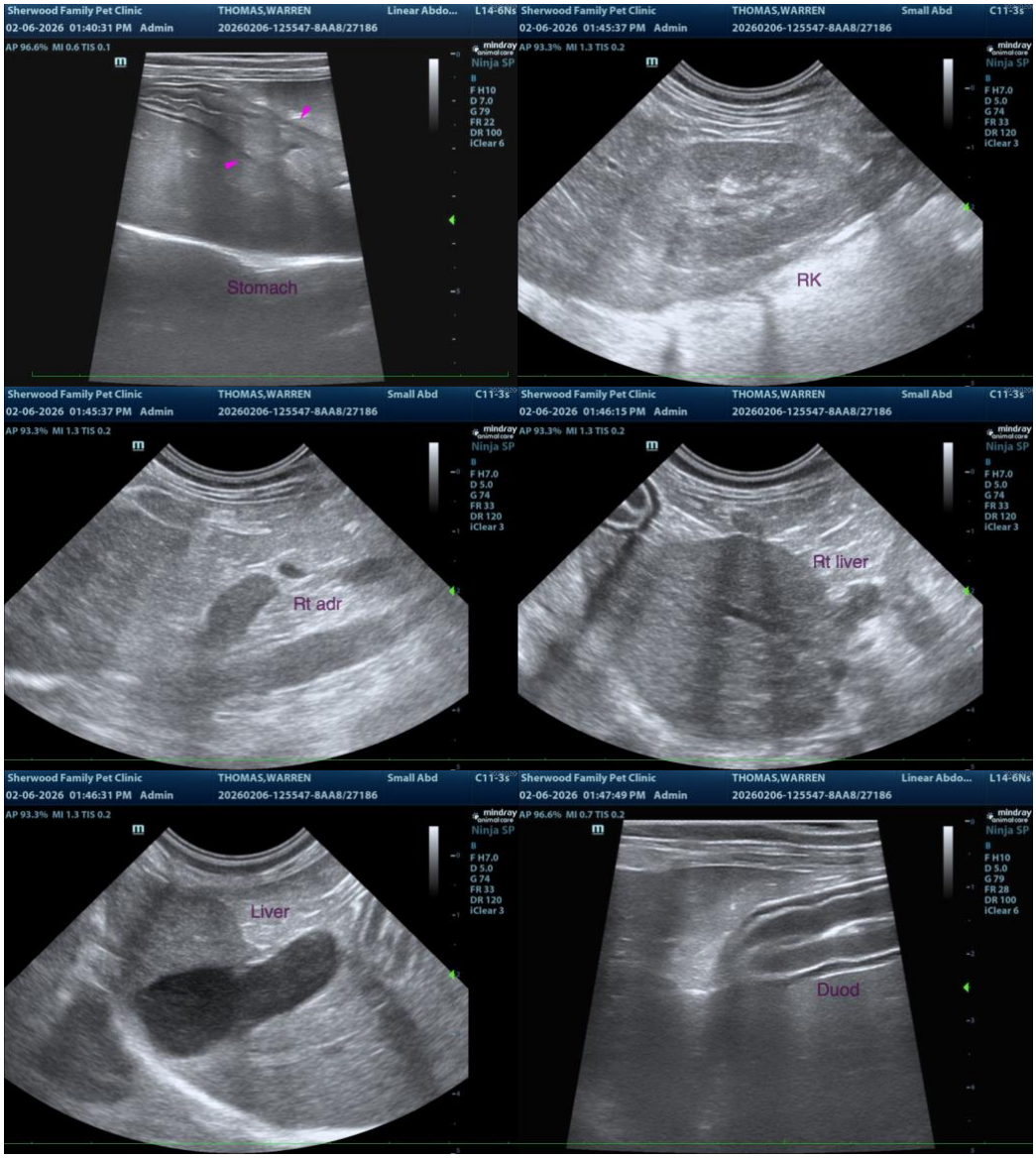

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com