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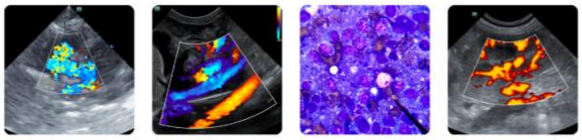

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PATIENT

Ziggy Elliott

SPECIES

Canine

BREED

Dachshund

SEX

Neutered Male

AGE

10

WEIGHT

13.4 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques LVT

HOSPITAL NAME

Incline VH

REFERRING VET

Dr Sovyk

INVOICE

22540

DATE

2-9-26

PRESENTING CLINICAL SIGNS

History of chronic GI upset, now experiencing episodes of vomiting and diarrhea approximately once a month since October. Episodes typically last about 24 hours. Manifests as vomiting in the middle of the night, followed by diarrhea the next morning. Client administers a half dose of DiaGel for diarrhea, which resolves the signs. Appetite returns by the evening of the episode.

Three episodes have occurred:
- First episode: unknown cause.
- Second episode: suspected dietary indiscretion, ate another dog's vomit.
- Third episode: occurred after a rapid diet change attempt to a small dog version of his current food.
- A recent episode occurred the week of 1/20/26. A week before the appointment.

Doctor Sovik recommended a routine abdominal ultrasound to evaluate for gastrointestinal ulceration or other sources of chronic blood loss.
Working diagnosis: Chronic intermittent gastroenteritis, IBD – well-managed on a diet
Diagel and Cerenia 24mg

Abnormal PE/Chem/CBC/UA Results: Mild nonregenerative anemia. Chemistry panel unremarkable. RBC 5.09 5.65 - 8.87 M/µL LOW HCT 34.2 37.3 - 61.7 % LOW HGB 12.4 13.1 - 20.5 g/dL LOW MPV 15.7 8.7 - 13.2 fL HIGH CHOL 93 110 - 320 mg/dL LOW (SENDING TODAY'S LAB TO YOUR EMAIL DIRECTLY)

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 3 cm, are normal.

The prostate is normal in size (0.76 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 (4.05 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (3.84 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal-in-size (0.54 cm at cranial pole) (0.50 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 (0.55 cm at cranial pole) (0.41 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.

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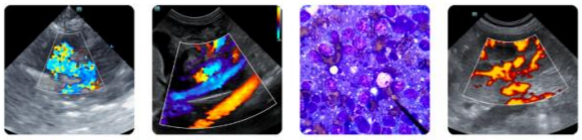

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Spleen

The spleen is prominent-in-size (1.75 cm in width at the level of the hilus) with smooth peripheral contours. Using a high-frequency probe, the parenchyma appears subtly mottled. 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. A 1.35 x 0.65 cm ill-defined, hypoechoic nodule is observed left- to mid-liver. The remaining parenchyma is homogenous. 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 moderate amount of aggregated, hyperechoic, partially dependent sludge/sand is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is minimally fluid-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 base and limbs are visible/prominent, with minimal deviation from the normal peripheral contours. The parenchyma is hyperechoic relative to surrounding omental fat, and slightly heterogenous in appearance. The pancreatic duct is not overtly dilated.

Lymph Nodes

At least one cystic periportal lymph node is visualized (one measuring 0.89 x 0.60 cm).

Free Abdomen

There is no obvious evidence of free fluid.

Other

A brief echocardiogram reveals no evidence of pericardial effusion or obvious right atrial/auricular mass.

ULTRASONOGRAPHIC FINDINGS

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Excessive gall bladder sludge. Considerations include cholestasis, fasting, or an emerging mucocele.
- The hypoechoic hepatic nodule could be consistent with a benign process (i.e., regenerative nodule, inflammatory focus). Alternatively, an emerging tumor cannot be completely excluded, although it is considered less likely.
- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or antigenic stimulation with a lower possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).

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- The prominent periportal lymph nodes are likely reactive, with a lower possibility of more insidious pathology.

*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, other.

**An obvious cause for the patient's nonregenerative anemia is also not identified in this study. Considerations include anemia of chronic disease, other.

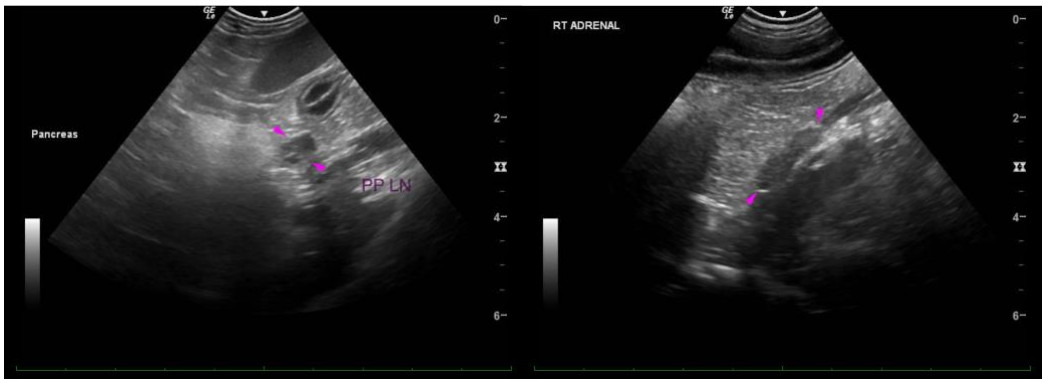
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- The following diagnostics/treatment recommendations can be considered:

1. Texas GI panel including serum cobalamin, folate, PLI, TLI and resting cortisol level
2. A fecal evaluation for ova/Giardia
3. Prophylactic deworming with Fenbendazole.
4. A 3-4-week hypoallergenic or hydrolyzed protein diet trial
5. Also consider initiating a probiotic with a high colony count +/- fiber supplement (i.e., psyllium).
6. Depending on the results of the above diagnostics/therapeutics, endoscopic or surgical gastrointestinal biopsies may be warranted.
7. Three-view thoracic radiographs should be performed prior to any anesthetic event.

- Regarding the nonregenerative anemia, consider a repeat CBC with a reticulocyte count and clinical pathology review. A T4 +/- free T4 by equilibrium dialysis is also recommended, as hypothyroidism can be associated with anemia.

- Given the gall bladder changes, Ursodeoxycholic acid (Ursodiol) is recommended. Serial sonographic monitoring (e.g., every 4-6 weeks) of the gall bladder is recommended to assess for progression to a fully formed mucocele. If progression occurs, a cholecystectomy may be warranted.



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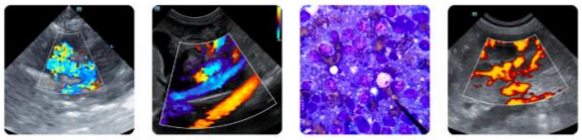

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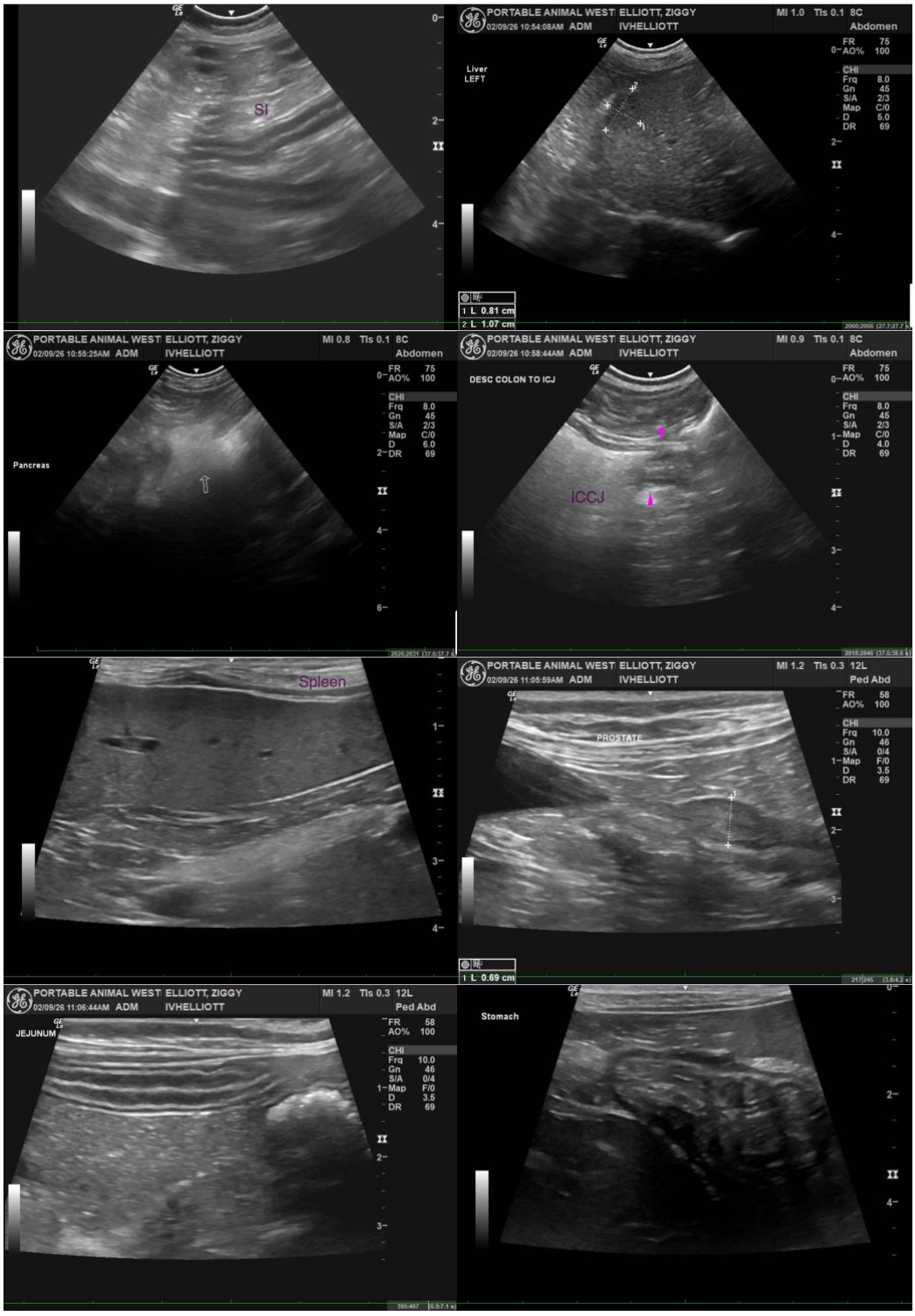

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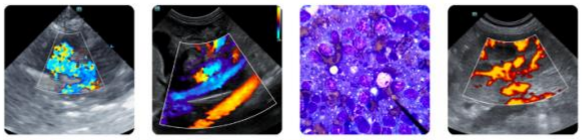

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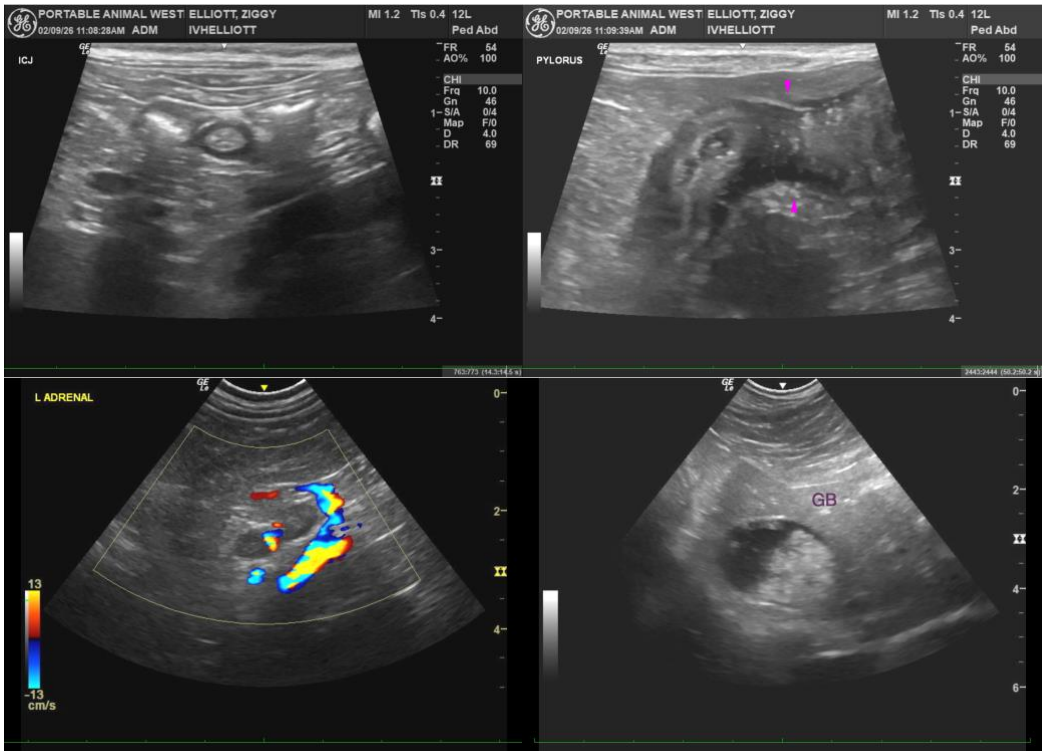

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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