Charleston Mobile Veterinary Services
IN PARTNERSHIP WITH SONOPATH VETERINARY ULTRASOUND

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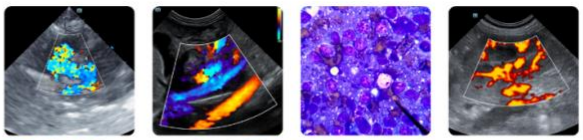

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Ruby Rios

SPECIES

Canine

BREED

Cavachon

SEX

Female Spayed

AGE

Aug 08, 2015

WEIGHT

11.9

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

Saddleback Mobile Vet

REFERRING VET

Dr Kelli Klein

INVOICE

23184

DATE

6-18-26

PRESENTING CLINICAL SIGNS

Bloodwork from a month ago revealed an ALP of 325. BUN 67. Fecal negative.

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 the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal in size (4.23 cm in length) with an irregular shape. The cortex is hyperechoic relative to the spleen and variably thickened, with moderate- to severe loss of corticomedullary distinction. A few, small, cortical cysts are seen. Hyperechoic shadowing diverticular foci are visualized. Trace pyelectasia is present. There is no evidence of hydroureter. Renal vasculature is normal.

The right kidney is normal in size (4.37 cm in length) with a normal shape and architecture. The cortex is hyperechoic relative to the spleen. There is moderate loss of corticomedullary distinction. Hyperechoic shadowing diverticular foci 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 (0.50 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 mildly enlarged (0.67 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.

Spleen

The spleen is normal in size (0.95 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 enlarged, with swollen peripheral contours. The parenchyma is isoechoic relative to the spleen and subtly heterogenous in appearance. A 0.57 cm cyst is observed approximately mid-liver. Hepatic vasculature and intrahepatic 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 of normal contours and contains some dependent echogenic debris. The wall is normal in thickness. No choleliths are observed. The cystic and common bile ducts are normal/not seen. The duodenal papilla is normal-in-size (0.46 cm in width).

Gastrointestinal

The stomach and intestine are free of stasis and exhibit normal peristaltic activity. 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 0.40 cm). There is slight disruption in the normal 1:3 muscularis: mucosal ratio in

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most segments. 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 normal-in-size with normal curvilinear peripheral contours. The parenchyma is largely isoechoic relative to surrounding omental fat and slightly heterogenous 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 evidence of pericardial effusion or obvious right atrial/auricular mass.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The small intestinal wall changes could be consistent with inflammatory bowel disease, normal variation, or emerging lymphoma (less likely).
- 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. Small parenchymal cyst.
- Bilateral nonspecific age-related renal changes with subtle dystrophic mineralization, left cortical cyst, and trace left pyelectasia

Secondary Findings

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Gallbladder debris, non-mucocele
- Mild right adrenomegaly

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Given the bowel changes and the patient's clinical history, consider the following:

  1. GI panel including serum cobalamin and folate, TLI, PLI and resting cortisol level
  2. Limited antigen or hydrolyzed protein diet (once the patient's appetite has normalized)
  3. +/- endoscopic or surgical GI biopsies
  4. While awaiting test results, symptomatic care (i.e., appetite stimulants) are recommended.

- Serial monitoring (i.e., every 3-4 months) of the patient's liver values is recommended. If liver values continue to increase, a repeat abdominal ultrasound +/- hepatic tissue sampling may be warranted.

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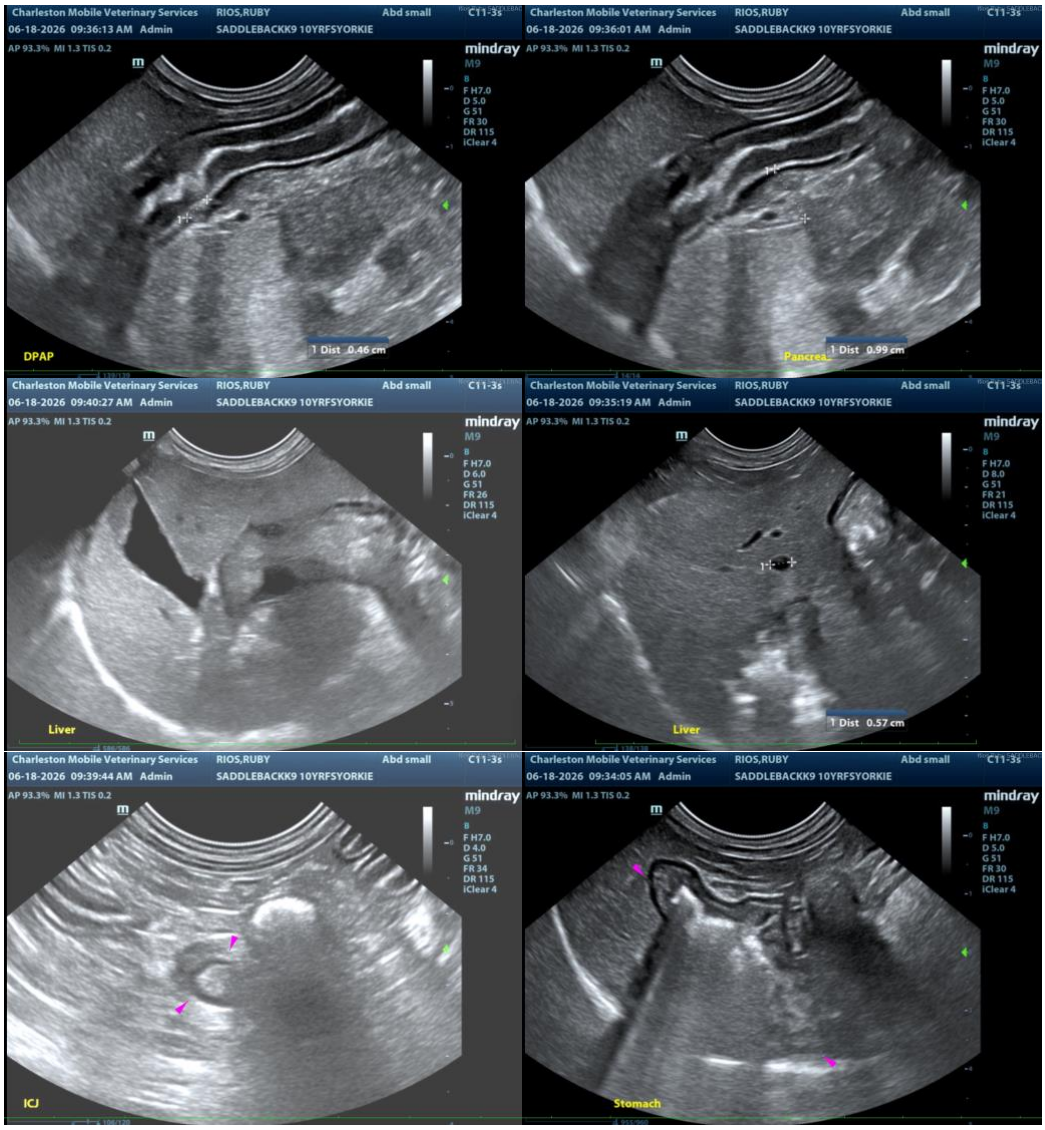
- Consider testing for hyperadrenocorticism with a low-dose dexamethasone suppression test or ACTH stimulation test if clinical signs (i.e., PU/PD) develop in the future.



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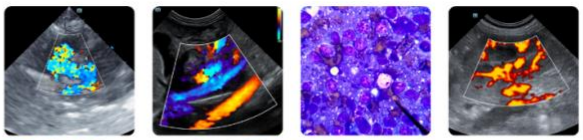

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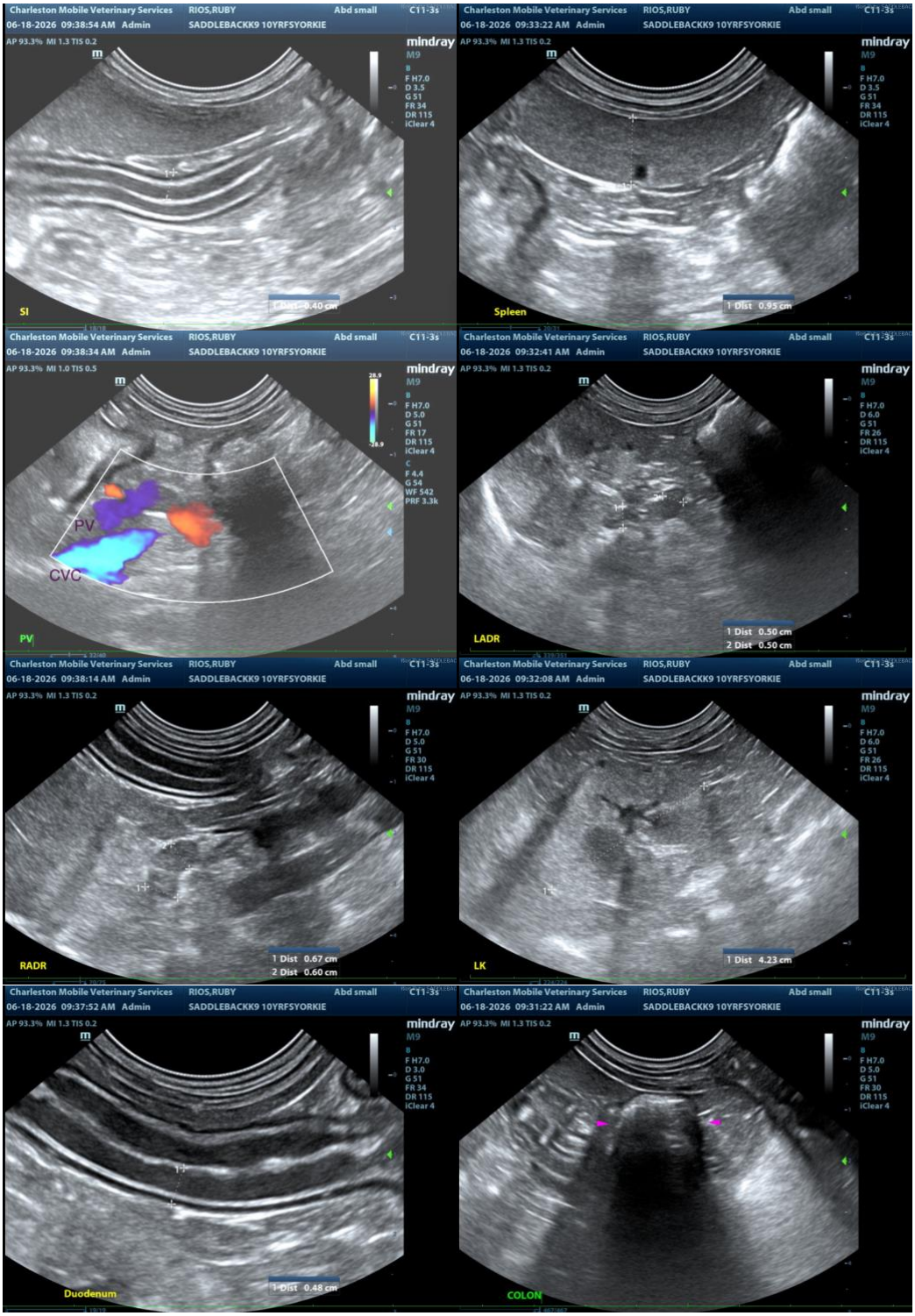

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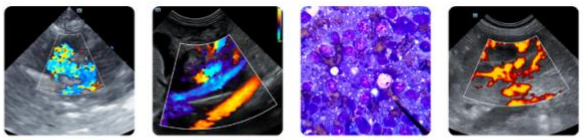

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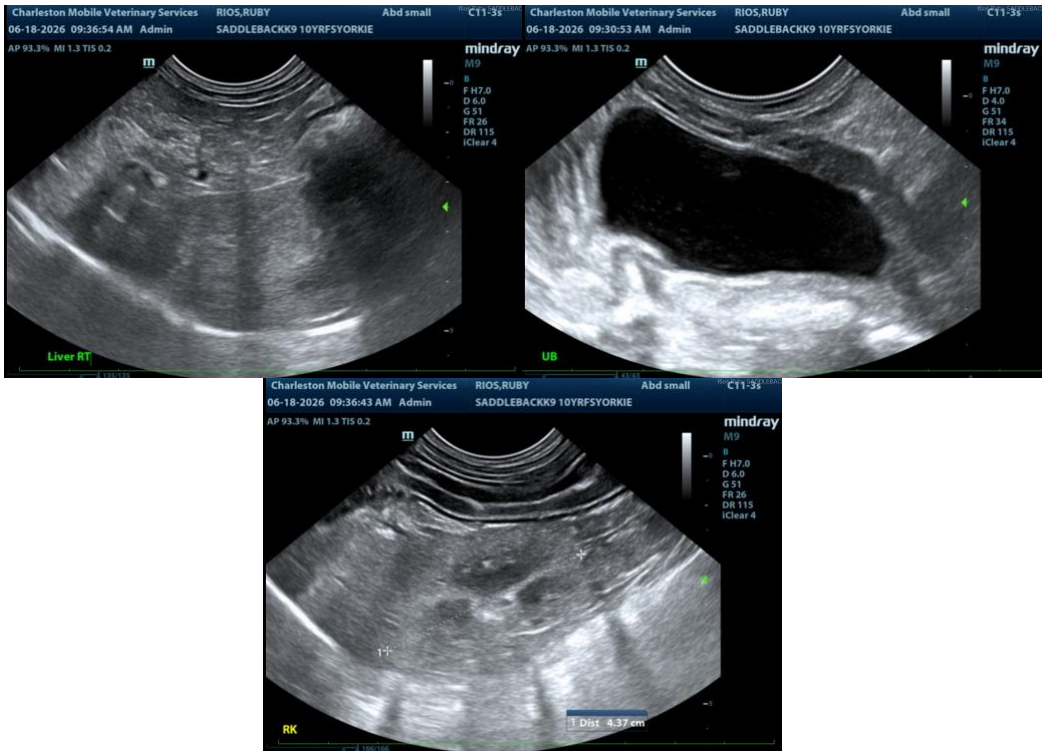

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@SonoPath.com