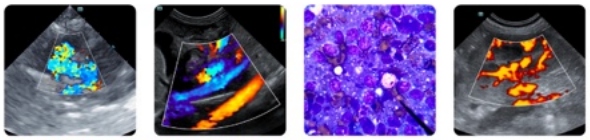




**PATIENT**

Ellie Kerbow

**SPECIES**

Canine

**BREED**

Corgi

**SEX**

Spayed Female

**AGE**

10 ½ years

**WEIGHT**

44 lbs

**INTERPRETED BY**

Bradley Harris, DVM, DACVECC, DACVIM (cardiology)

**IMAGING PERFORMED BY**

Jenny Russell

**HOSPITAL NAME**

Southwest Texas Veterinary Medical Center

**REFERRING VET**

Dr. Russell

**INVOICE**

78228

**DATE**

6/2/26

## PRESENTING CLINICAL SIGNS

History: Ellie was seen 5/11 for 3 day duration of diarrhea. Fecal/giardia were negative and pet was treated empirically for DI with probiotics and en diet. 5/15 Ellie's diarrhea had stopped and she was transitioned to OM diet. 5/26 Ellie was presented for acute moderate lameness on her right front foot. Pain was noted on palpation of the carpus and skin in the area appeared reddened. Ellie was started on cefpodoxime 100mgs and Rimadyl 75mgs sid. She represented on the 28th for worsening lameness/pain. Rads showed mild evidence of carpal djd. Miravista fungals sent off. Ellie presented again on the 29th for increasing pain and inappetence. Labwork on that day showed a mild neutrophillia and otherwise wnl. Pain medication was changed to Tylenol with codine and doxycycline was started as an antibiotic. On June 1 Ellie presented for boarding b/c her mother could not medicate her over the weekend. On June 2 Ellie vomited after medication administration. CBC at that time showed dramatic increase in neutrophillia. Chest and abdominal rads in house revealed nsaf. Mira vista fungals received back and negative for histo, cocci and aspirgillosis . 4dx negative today. Record review shows no evidence of pyrexia during the time
Abnormal PE/Chem/CBC/UA Results: Splenic aspirate in house today revealed markedly reactive spleen: neutrophills, monocytes, plasma cells, large and small lymphs

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder, trigone, and pelvic urethra are unremarkable with normal wall thicknesses and normal tone. The ureters were not visualized, which is a normal finding. A mild amount of suspended, echogenic debris is noted. The ureteral papillae appear normal. There is no evidence of inflammatory, infiltrative, or neoplastic disease.

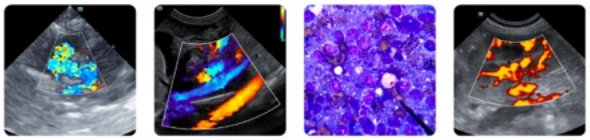
The kidneys are normal in size and structure. The cortices are hyperechoic with a loss of corticomedullary distinction. There are mild renal cortical cystic changes with normal cortex to medulla ratio. There is no significant pyelectasia. Mild, irregular, renal capsules are noted bilaterally. The left kidney measured 6.54 cm. The right kidney measured 6.43 cm.

### *Adrenal Glands*

Both adrenal glands are visualized and have normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. The caudal pole of the left adrenal gland was slightly swollen with a heterogenous parenchyma. No evidence of capsular expansion or vascular invasion. The phrenic vasculature is normal. The left adrenal gland measured 0.8 x 2.64 cm. The right adrenal gland measured 0.5 x 2.46 cm.

### *Spleen*

The spleen measured 2.0 cm at the hilus. It is subjectively enlarged with a diffusely, heterogenous or mottled reticular pattern and mixed hypoechoic and hyperechoic ill-defined, nodular regions throughout. The splenic capsule is smooth without significant irregularity. The vasculature is normal with no evidence of congestion, spontaneous echo contrast or thrombosis.





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### *Liver*

The liver is subjectively normal in size with a diffusely, mottled parenchyma. There are ill-defined, variably sized hyperechoic and hypoechoic nodular changes that do not deform the otherwise, smooth hepatic capsule. Vasculature is within normal limits with no evidence of congestion. The gallbladder contains a mild amount of suspended echogenic debris and dependent sediment. There is no evidence of intra- or extra-hepatic biliary dilation. The cystic and common bile ducts were normal. The gallbladder wall is appropriately thin.

### *Gastrointestinal*

The stomach and intestines are free of stasis and peristaltic activity, with no significant dilation noted. There is normal wall thickness and acceptable curvilinear mural detail. The pyloric-duodenal junction and ileocecocolic junction are patent, and the colon contains normal shadowing feces. There is no evidence of shadowing obstructive material or overt infiltrative disease noted. No associated abnormal lymphatic activity is documented.

### *Pancreas*

The base and limbs of the pancreas are isoechoic to surrounding omental fat. The pancreatic duct and capsular contour are normal. There is no overt evidence of active inflammatory or neoplastic disease.

### *Free Abdomen*

No lymphadenopathy and no free fluid was noted.

## ULTRASONOGRAPHIC FINDINGS

The urinary bladder contains echogenic, suspended debris contrasted with anechoic urine. This is often related to urinary tract infection but may represent exfoliated debris or sterile inflammation.

There is increased renal cortical echogenicity and thickening with a mildly irregular capsular contour. Multifocal cystic cortical changes are noted. This is secondary cystic formation consistent with chronic age related degeneration and remodeling. There is no evidence of abscessation or suspicion of neoplasia.

The caudal pole of the left adrenal gland was enlarged with a swollen capsule and mild heterogenous parenchymal changes. This is most consistent with hyperplasia or an adenoma. Capsular expansion was noted without capsular escape or vascular invasion.

The mildly enlarged spleen with a coarse/mottled reticular pattern is most consistent with a reactive spleen, or possible splenitis. Round cell neoplasia is considered less likely, but cannot be definitively excluded.

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The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory, immune-mediated, metabolic, or endocrine disease. Infiltrative neoplasia or acute hepatitis cannot be ruled out.

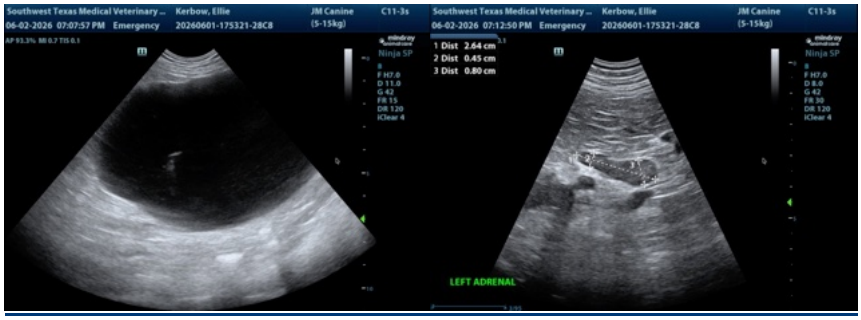
The gallbladder contains echogenic, suspended and dependent unorganized debris. This is not yet to the level of an organized mucocele, however early/developing mucocele cannot be ruled out. This dependent sediment is often an incidental finding, or may be associated with concurrent endocrine disease such as hyperadrenocorticism or diabetes mellitus.

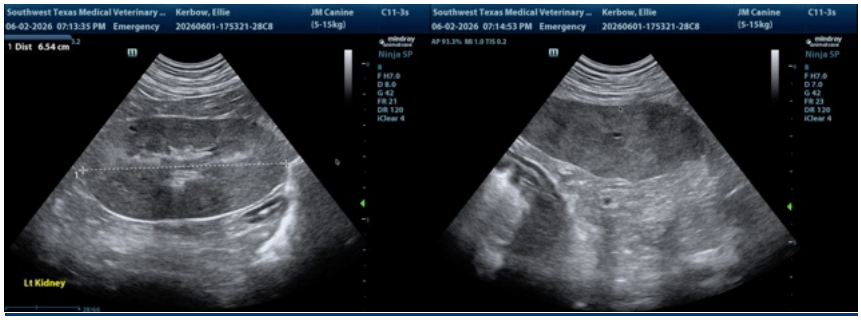
## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Fine needle aspirates of the spleen and liver with cytology are recommended. A coagulation profile and platelet estimate prior to sampling are indicated to ensure the absence of coagulopathy. Occasionally some tissues are poorly exfoliative, or cytology is non-specific, in which case biopsy with histopathology may be required for a definitive diagnosis.

A urinalysis and urine culture via cystocentesis are recommended to evaluate the urinary tract changes for potential urinary tract infection.

Given the gastrointestinal signs consider a gastrointestinal panel (TLI, PLI, B12, folate) via Texas A&M gastrointestinal laboratory is indicated to further evaluate for potential chronic enteropathy. Ultimately, gastrointestinal biopsies may be required for a definitive diagnosis. Also consider a spec CPLI to further evaluate the pancreas for occult inflammation or pancreatitis.



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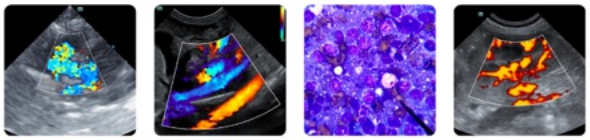

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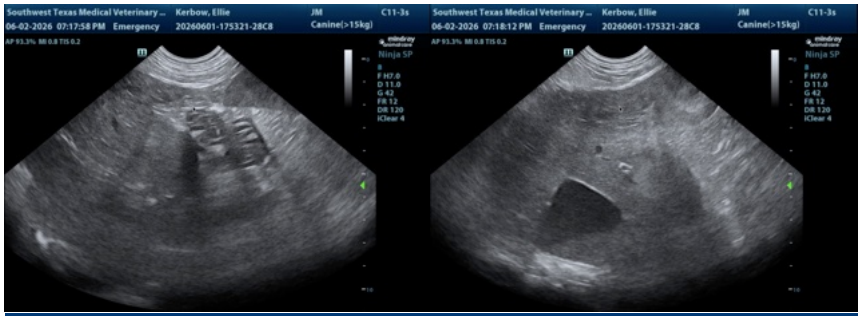


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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.

Bradley Harris, DVM, DACVECC, DACVIM (cardiology)

info@SonoPath.com