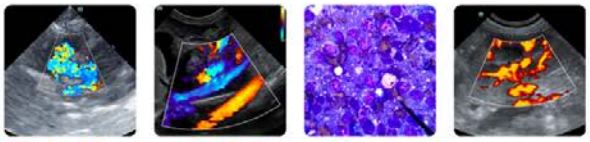


PATIENT

Fifi Wagner

SPECIES

Canine

BREED

Bichon x

SEX

Spayed Female

AGE

15 Years

WEIGHT

7.4 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Blue Pearl Wyomissing

REFERRING VET

Blue Pearl Wyomissing

INVOICE

72010

DATE

1/7/26

PRESENTING CLINICAL SIGNS

AUS to further evaluate recurring hematochezia and diarrhea. P was hospitalized for presumptive AHDS and AKI 12/26-12/26, discharged with mildly elevated kidney values and otherwise doing well at home until yesterday 1/5 when diarrhea started, turning into blood tonight 1/6. P is otherwise eating well and no vomiting. Meds: metronidazole, proviable

Abnormal PE/Chem/CBC/UA Results: ER Diagnostics: 12/27 - Chem: Alb 3.6, Glob 3.3, ALP 391, Creat 2, BUN 79.4, Phos 6.3, Tbili 0.8, Na 149, K 4.3 - PCV/TS: 51/8.2 - CPL: 213 (N) - UA: 1.032, cocci 1+/hpf - CBC: HCT 53.6, Neuts 7.36k, PLT 358k - AXR: no obvious masses or obstructive pattern noted - PCV/TS: 41/6 - EPOC: Creat 3.29, BUN 67, K 4.6, Na 138 12/28 - EPOC: Creat 3.15, BUN 52, K 4.1, Na 143, Glu 89 - PCV/TS: 35/5.8 12/28 3pm: - PCV/TS 35/6 - EPOC: Creat 3.09, BUN 44, K 4.1, Na 147, Glu 84 12/29 - EPOC: Creat 2.09, BUN 28, K 3.9, Glu 87 - PCV/TS: 37/6.2 12/29 - EPOC: CREAT 1.96, BUN 25 - pcv/ts: 35/5.6

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots, as well as dependent mineral “sand” (crystals) debris. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses are observed. Small/pinpoint cystoliths within the sand debris can’t be ruled out. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia or infarcts observed. Left measured 4.73 cm. Right measured 5.07 cm. Non-obstructive linear multifocal hyperechoic diverticular foci with acoustic shadowing are noted bilaterally.

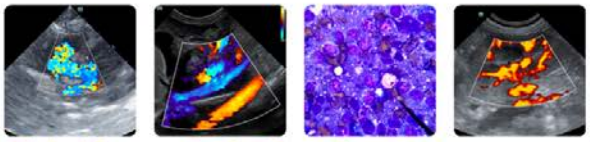
Adrenal Glands

The right adrenal gland is normal in size (0.39 cm at cranial pole and 0.60 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.41 cm at cranial pole and 0.39 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively normal in size (1.1 cm thick at the hilus) with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). Multifocal well-demarcated hyperechoic homogenous nodules are noted. Splenic vasculature appears normal.



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Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is mildly heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is mildly overdistended with a moderate amount of non-dependent, mildly aggregated/inspissated sludge. Hypo to anechoic cystic areas are noted between the gallbladder sludge and luminal wall. The wall is otherwise smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen is mildly distended with primarily fluid as well as some echogenic non-shadowing luminal contents and gas consistent with normal chyme. There is no evidence of obstruction, foreign material, or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

Pancreas is prominent (enlarged) in size and mildly irregular in shape with a slightly undulating contour. Parenchyma is coarse in echotexture and heterogenous to hypoechoic in echogenicity.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

PRIMARY FINDINGS

- Chronic low-grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.
- Emerging mucocele – Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. The non-dependent nature of this sludge combined with the cystic areas are suggestive, however, of possible emerging cystic mucosal hyperplasia or early gallbladder mucocele.
- Mildly Heterogenous Liver – These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.

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SECONDARY FINDINGS

- Hyperechoic splenic nodules – most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.
- Age related kidney changes with non-obstructive dystrophic mineralization bilaterally.
- Moderate amount of echogenic urinary bladder mineral/sand debris with concurrent pinpoint cystoliths suspected.

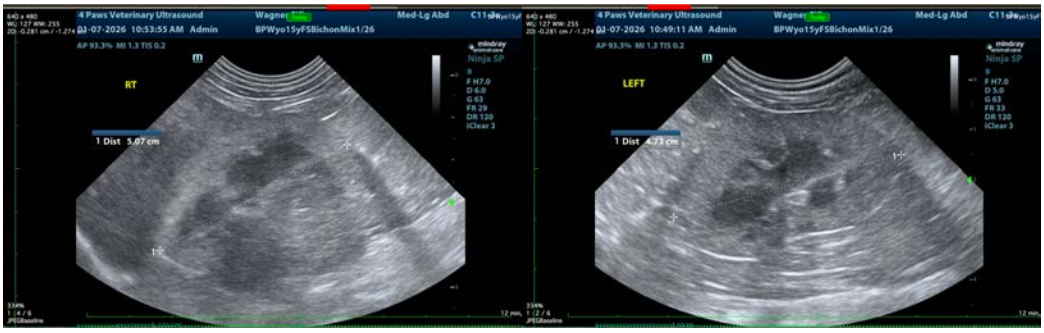
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given patient's recent history of azotemia combined with the newly reported gastrointestinal signs, a baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

Pending results of above, if not recently evaluated, general fecal/giardia exam is recommended, as is +/- a fecal enteropathogen PCR panel to Texas A&M GI Laboratory for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

In the meantime, in addition to indicated medical management for the suspected chronic kidney disease, urinary tract infection, hypertension, proteinuria, etc., supportive/symptomatic medical management of clinical signs is recommended, including a probiotic (such as visbiome or proviable), empirical deworming with a 5-day course of Panacur and, if tolerated, a transition in diet, based on trial-and-error response, beginning possibly with a gastrointestinal biome diet vs a hydrolyzed protein diet vs other. Some patients respond to one brand/version of a hydrolyzed protein diet better than another brand, so several brand attempts may be required.



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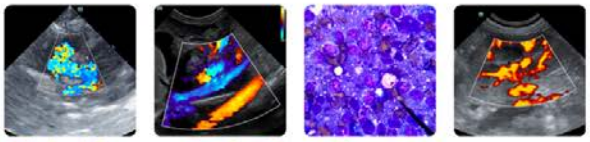

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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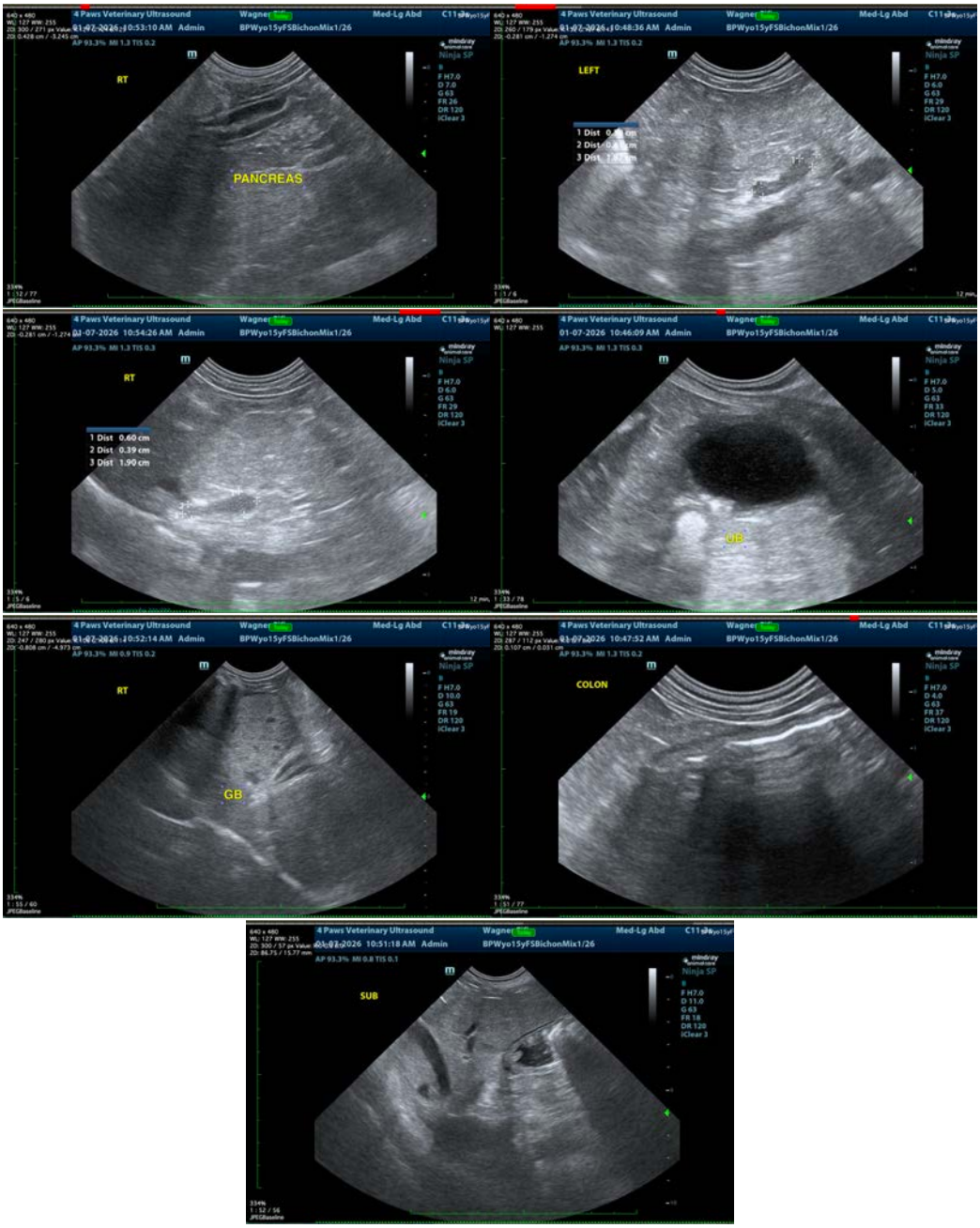

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM info@sonopath.com