



PATIENT

Bailey Schuler

SPECIES

Canine

BREED

Cocker Spaniel Mix

SEX

Neutered Male

AGE

8.5 Years

WEIGHT

14 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Hayley Heindel, CVT

HOSPITAL NAME

Mason Dixon AEH

REFERRING VET

Dr. de Cordon

INVOICE

20477

DATE

1/8/23

PRESENTING CLINICAL SIGNS

History: persistent v/d, pancreatitis

Abnormal PE/Chem/CBC/UA Results: ALT 168 Alkp 247 Albumin 1.4 Chol 85

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Prostate is normal in size, echotexture and echogenicity for a neutered male.

Left kidney is normal is size (5.24 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Right kidney is normal is size (5.5 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

Left adrenal gland is normal in size (1.94 cm long x 0.47 cm at cranial pole and 0.52 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (2.47 cm long x 0.46 cm at cranial pole and 0.6 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.



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

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The visible colon is normal in wall thickness and layering. Contents are consistent with normal formed feces and gas.

Pancreas

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The area of the pancreas contains irregular hyperechoic pancreatic remodeling.

Free Abdomen

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A very scant amount of anechoic free fluid was present, as well as diffusely mildly enhanced hyperechoic mesenteric fat. There is no apparent lymphadenopathy.

ULTRASONOGRAPHIC FINDINGS

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- Mucosal speckling – Mucosal speckling is often present with inflammatory bowel disease (IBD). It is not specific for type or severity of disease. Mild speckling change can occur as a normal patient variant in the post-prandial state.
- Hyperechoic pancreas – This finding is suggestive of pancreatic fibrosis, possibly secondary to chronic pancreatitis. A TLI is recommended to rule out exocrine pancreatic insufficiency (EPI), especially if clinical signs (weight loss, diarrhea, etc.) are present. Chronic smoldering pancreatitis cannot be ruled out, however, the diffusely enhanced mesenteric fat and scant amount of anechoic free fluid is believed, more likely, secondary to the suspected bowel disease and hyperalbuminemia vs ongoing active pancreatitis.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

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Hayley Heindel, CVT

Ideally, biopsies of the GI tract are recommended to definitively diagnose and therefore manage the infiltrative bowel process.

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If biopsies cannot be obtained safely due to low albumin or patient stability, etc., empirical therapies could include diet change to an ultra-low-fat diet, empirical deworming with a 5 day course of Panacur, cobalamin supplementation (unless cobalamin level is evaluated and supplementation is not warranted) a probiotic and prednisolone (if not contraindicated based on patient contraindications, comorbidities, etc.). Calcium monitoring, and supplementation, if necessary, is also recommended.

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Additionally, if not recently evaluated, to rule out concurrent proteinuria, as a source of the hypoalbuminemia, urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

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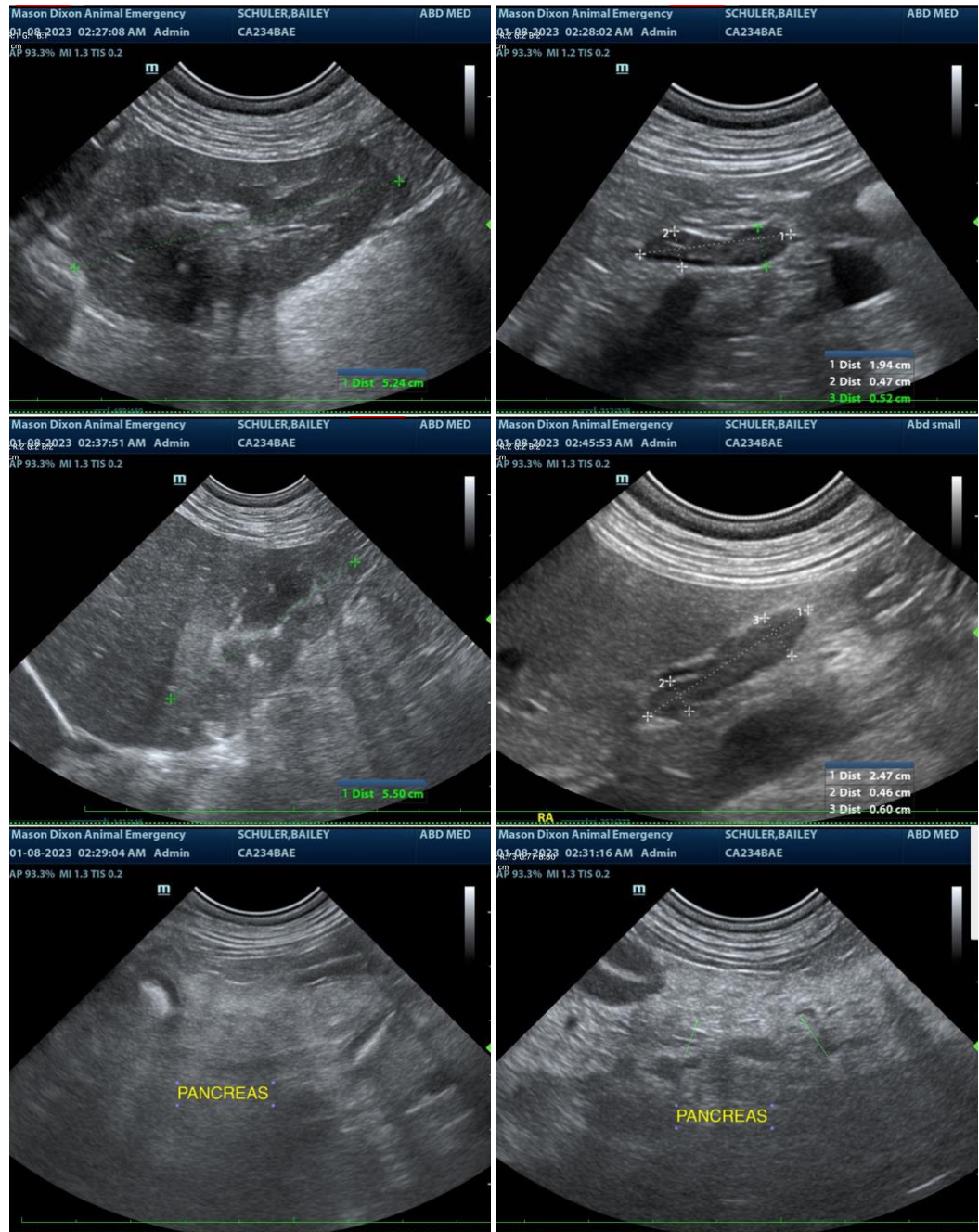
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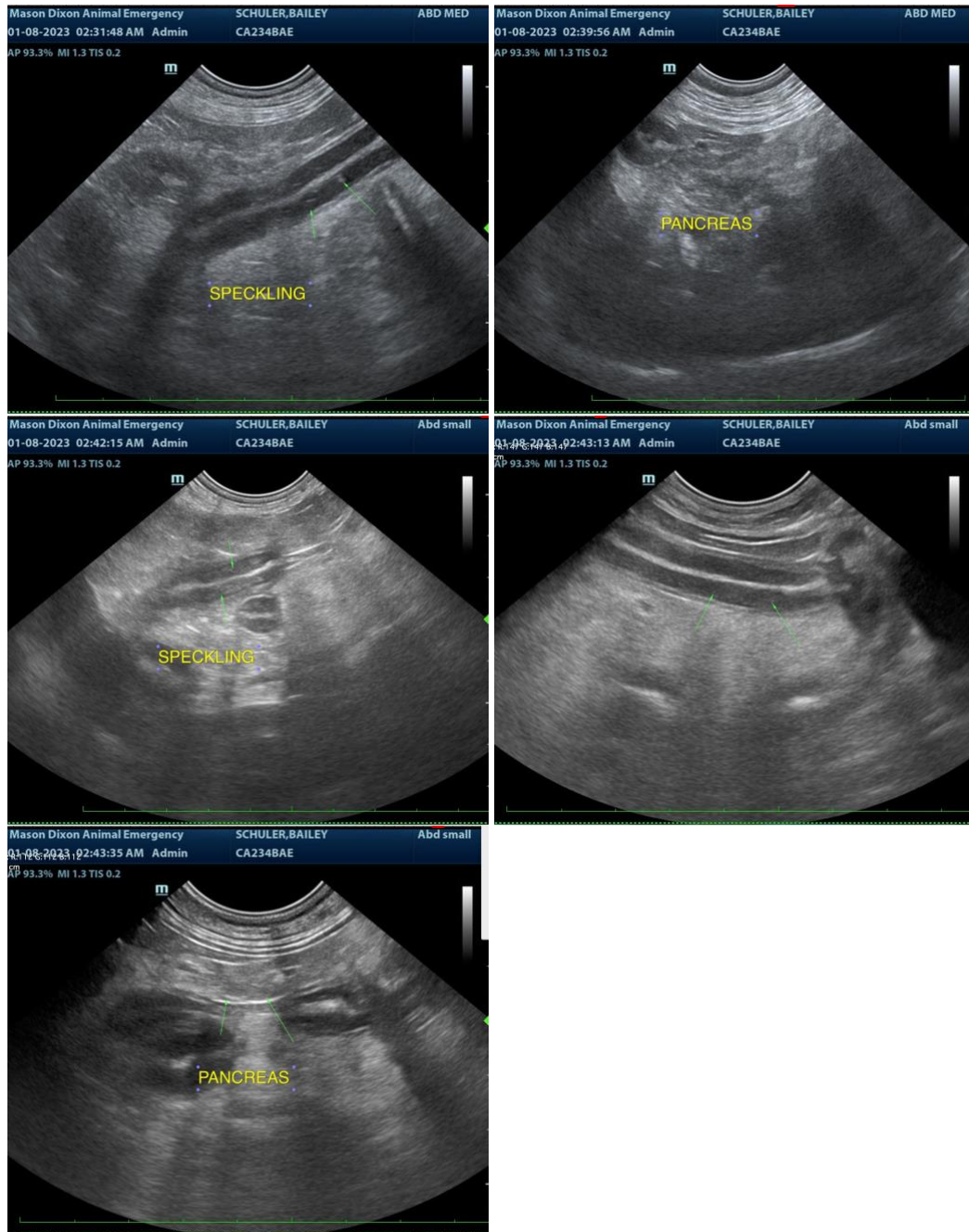
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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



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