



PATIENT

Shelby Shurlow

SPECIES

Canine

BREED

Australian Shepherd

SEX

Spayed Female

AGE

9 Years

WEIGHT

48.8 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Amy Mayhew, LVT

HOSPITAL NAME

SVS Imaging MI

REFERRING VET

Dr. Kenny Rangin-
Pinecrest AH

INVOICE

20513

DATE

1/9/23

PRESENTING CLINICAL SIGNS

History: D+ chronic

Abnormal PE/Chem/CBC/UA Results: See attached.

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.

Left kidney is normal is size (6.92 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. A chronic infarct is noted in the cranial pole of the left kidney.

Right kidney is normal is size (6.54 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 (0.49 cm at cranial pole and 0.48 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.54 cm at cranial pole and 0.47 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is generally normal in size and shape with a smooth capsular contour. However, parenchyma is diffusely nodular in appearance, characterized by multifocal small discrete hypoechoic nodules of varying sizes. 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. Several small discrete hyperechoic nodules are noted. 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 mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

Small intestine is diffusely mildly thick with a relatively thick mucosa compared to other layers. Normal wall layering is preserved; however, the mucosa is more echogenic than normal and contains



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hyperechoic striations perpendicular to the lumen. The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

The visible colon is normal in wall thickness and layering. The colon contains soft to liquid stool.

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Pancreas

The observed pancreas appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

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Free Abdomen

The mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

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Free abdominal fluid is noted.

ULTRASONOGRAPHIC FINDINGS

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Primary Findings

- Lymphangiectasia with free fluid – Small bowel findings are most consistent with lacteal dilation. These findings can be observed with protein-losing enteropathies caused by either primary lymphangiectasia or primary infiltrative inflammatory disease with secondary lymphangiectasia. Infiltrative neoplasia is possible but considered less likely. Histopathology is necessary to definitively determine underlying cause. The free fluid is likely secondary to the hypoalbuminemia.

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- Reactive mesenteric lymph nodes- infiltrative neoplastic disease cannot be ruled out but is considered less likely.

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- The nodular spleen may represent a benign aging nodular hyperplasia or extramedullary hematopoiesis, however, infiltrative neoplasia, including both early hemangiosarcoma or round cell neoplasia cannot be excluded.

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- Liver nodules – Differentials for discrete liver nodules include primarily benign changes such as nodular hyperplasia, fibrosis of old hematomas, granulomas, myelolipomas etc.; however, while considered less likely, primary hepatic neoplasia, infiltrative round cell neoplasia and metastatic disease can mimic benign lesions and cannot be definitively ruled out.

Secondary Findings

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Pinecrest AH

- Chronic infarct in the caudal pole of the left kidney

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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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



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warranted) a probiotic and prednisolone (if not contraindicated based on patient contraindications, co-morbidities, etc.). Calcium monitoring, and supplementation, if necessary, is also recommended.

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If not already evaluated, to rule out concurrent proteinuria, 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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Pending above results, given this patients reportedly concurrent increase in ALT, if another reason for the hypoalbuminemia is not discovered, bile acid testing should be considered if bilirubin is normal.

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Additionally , a fine needle aspirate of the spleen is recommended if patients coagulation status is appropriate.

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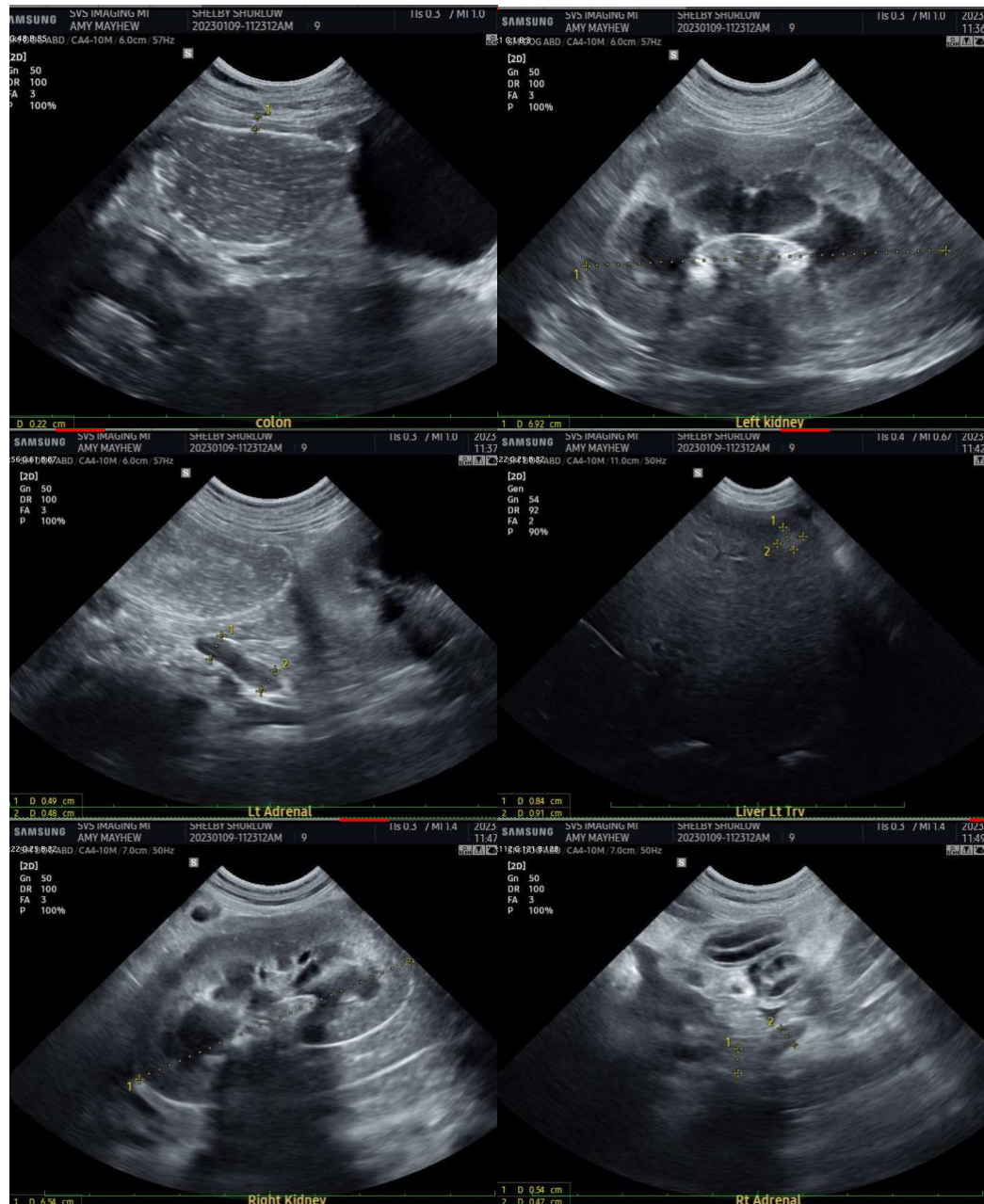
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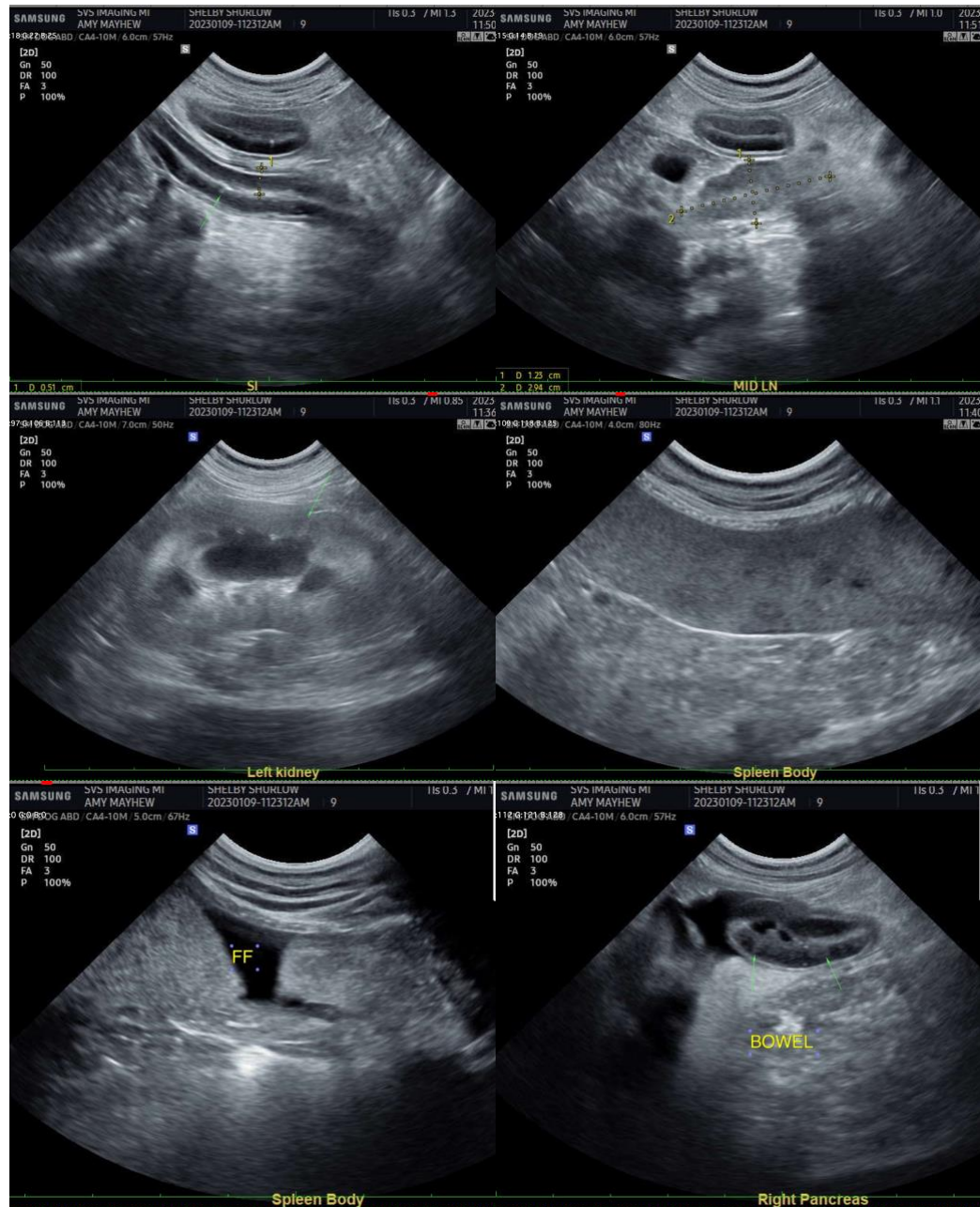
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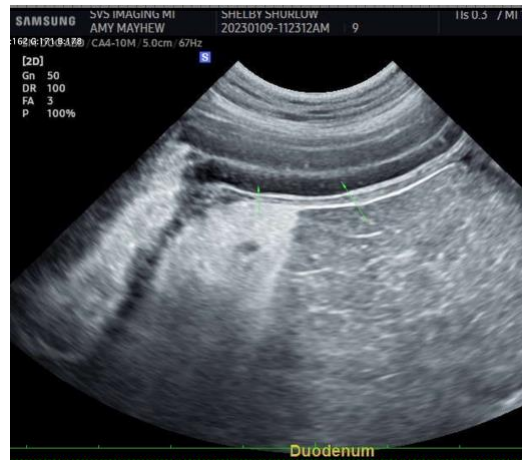
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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