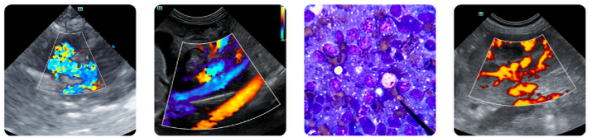


PATIENT

Lacy Galvin

SPECIES

Canine

BREED

Cocker Spaniel

SEX

Spayed Female

AGE

10 Years

WEIGHT

26 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Julia Baker, DVM

HOSPITAL NAME

Orange Blossom VI

REFERRING VET

Salina Samnani, DVM

INVOICE

35663

DATE

11/24/25

PRESENTING CLINICAL SIGNS

History: Patient presented 11/18 for syncope/weakness/collapse episodes. Patient is bradycardic. Thoracic radiographs show possible pulmonary mass effects. Heart murmur grade III. Painful on abdominal palpation. Bicavitary scan to better define systemic health. FNA of abdominal effusion and abnormal liver lobe taken today.

Abnormal PE/Chem/CBC/UA Results: Labwork attached

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is only mildly distended. Visible contents are anechoic. Urinary bladder wall is unable to be fully assessed for pathology without further distension. No visible masses or definitive cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface. In the face of urinary signs and/or suspected urinary bladder pathology, reassessment after complete filling is recommended.

Left kidney is normal in size (4.62 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 in size (5.25 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 (0.47 cm at cranial pole and 0.5 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.46 cm at cranial pole and 0.39 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

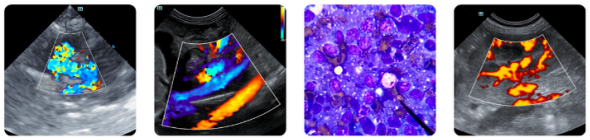
Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). Multifocal well-demarcated hyperechoic homogenous nodules are noted. Splenic vasculature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

Liver

Liver is normal to subjectively small in size with slightly undulating or scalloped capsular contour or margins. Patchy ill-defined areas of increased echogenicity are present with reduced visualization of vessels. No overt nodules or masses are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is unable to be visualized in these images.

Gastrointestinal



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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.

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

The pancreas that is observed 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.

Free Abdomen

There is a moderate to large amount of echogenic appearing free fluid.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Hepatic fibrosis pattern- This appearance is most consistent with chronic hepatitis with fibrosis and/or early cirrhosis. These changes can occasionally be seen with resolved past inflammatory episodes and should therefore be interpreted in combination with clinical signs and/or associated laboratory changes (including bile acids).
- A moderate to large amount of free fluid is of unknown origin. Differentials (unless already ruled out) could include increased hydrostatic pressure (cardiac disease and/or vascular or lymph blockage), decreased oncotic pressure (low albumin), vasculitis, paraneoplastic fluid, rupture/leakage of/from an organ (GI, GB, UB, other), blood (hemoabdomen), other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

As is reportedly already pending, sampling of the free abdominal fluid for analysis and cytology is recommended, if patient's coagulation status is appropriate.

Further work up of the hypoalbuminemia is recommended, beginning with bile acids if patient's total bilirubin is not increased.

Pending results of that, ruling out proteinuria is recommended if not already evaluated, via 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.

Pending results of above, 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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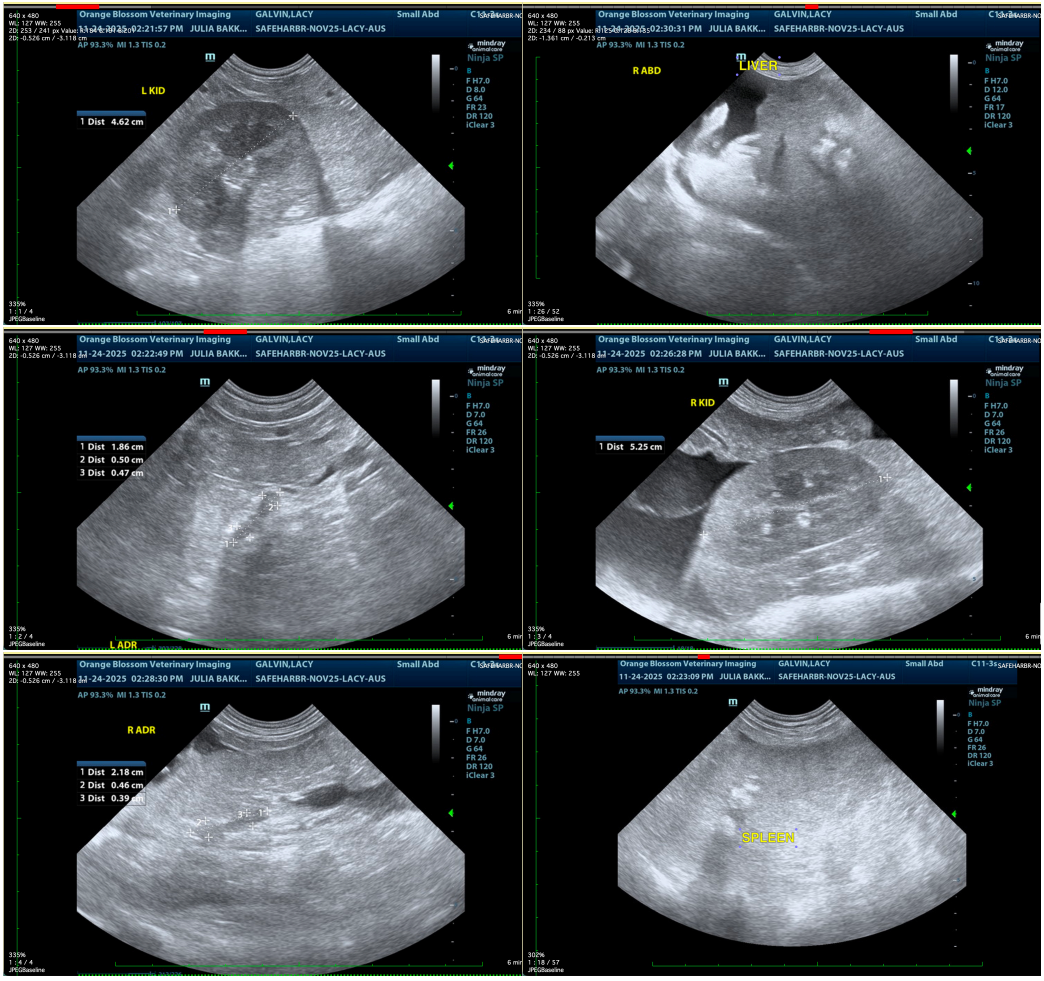
Pending results of above, a baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

The reported pulmonary changes are of unknown, if any, relation to the suspected liver changes, hypoalbuminemia, free fluid, etc., but likely warrant further investigation, including sampling of the suspected pulmonary mass as well, if patient's coagulation status is appropriate.

Other than supportive/symptomatic medical management of clinical signs, further diagnostic and treatment recommendations are largely dependent on results of the above.



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

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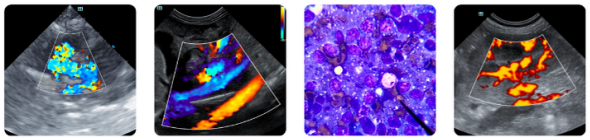

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