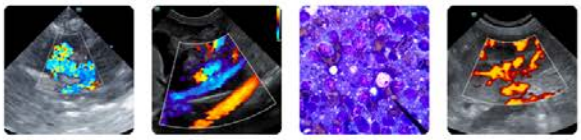


DATE

12/4/25

PATIENT

Berkley Rifino

SPECIES

Canine

BREED

Tibetan Spaniel

SEX

Spayed Female

AGE

3/30/13

WEIGHT

19.6 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Timonium Animal Hospital

REFERRING VET

Dr. McMichael

INVOICE

72351

PRESENTING CLINICAL SIGNS

Patient History: Significant weight loss (9#) over the past 6 months. Diarrhea for the past few weeks. No changes in appetite overall. Fecal negative. Bloodwork and radiographs at ER (will send separately)- Mild increase in left atrium and lack of cardiac waist. No evidence of pulmonary edema or CHF. Grade 4/6 holosystolic heart murmur. Painful on cranial abdominal palpation h/o Cushings disease. Currently on Trilostane 15mg once daily. Cortisol level at ER (11/29). Baseline cortisol 7.

Current Medications: Trilostane 15mg once daily, Proviable fiber supplement twice daily, Metronidazole 125mg PO q 12 hrs for 5 days, Visbiome once daily, Panacur- prophylatic deworming
Labwork Results: Labwork attached, reported as: normal. electrolytes normal. Liver/renal values normal. CBC mild neutrophilia
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed by: Stephanie Warga RDCS, RVT.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The 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.

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 infarcts observed. Small non-obstructive nephroliths and non-obstructic dystrophic mineralization are noted bilaterally, as is trace pyelectasia. Left kidney measures 4.9 cm. Right kidney measures 4.6 cm.

Adrenal Glands

Adrenal glands are plump/swollen in size. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. Left measures 0.64 cm at the cranial pole and 0.78 cm at the caudal pole. Right measures 0.84 cm at the cranial pole and 0.68 cm at the caudal pole.

Spleen

The 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 enlarged with mildly irregular margins. Parenchyma is moderately 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 moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

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.

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.

The colon appears mildly thick, primarily noted in the proximal or early descending colon where it measures 0.50-0.60 cm thick. Layering is subtly hazy/less distinct than normal in that area. The lumen is empty.

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. This change is subtle and most appreciated in the right limb.

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

- 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.

- Moderate colonic wall thickening could represent a benign colitis i.e., parasitic, infectious, dietary related, other benign inflammatory, or early or emerging infiltrative neoplastic disease can't be ruled out without tissue sampling.

- Chronic low-grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.

SECONDARY FINDINGS

- The bilateral adrenomegaly is consistent with patient's reported history of medically managed hyperadrenocorticism.

- Moderately 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.

- Mild gallbladder debris - 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. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

- Age related kidney changes with non-obstructive, small nephroliths and non-obstructive dystrophic mineralization bilaterally, and trace pyelectasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Further gastrointestinal workup recommendations include a routine fecal/giardia exam if not recently evaluated.

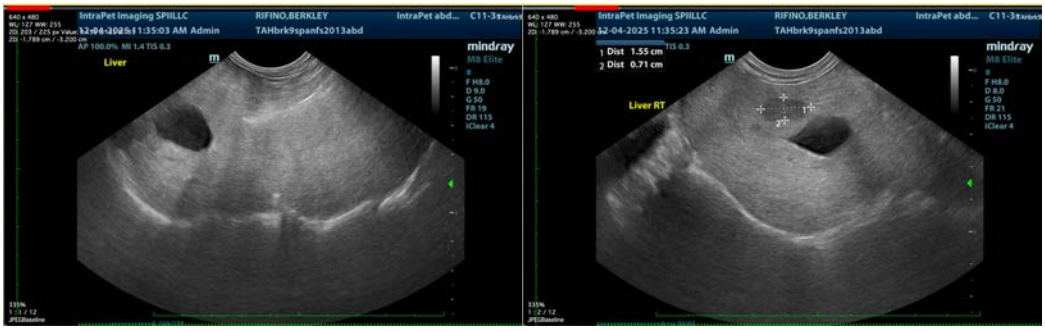
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

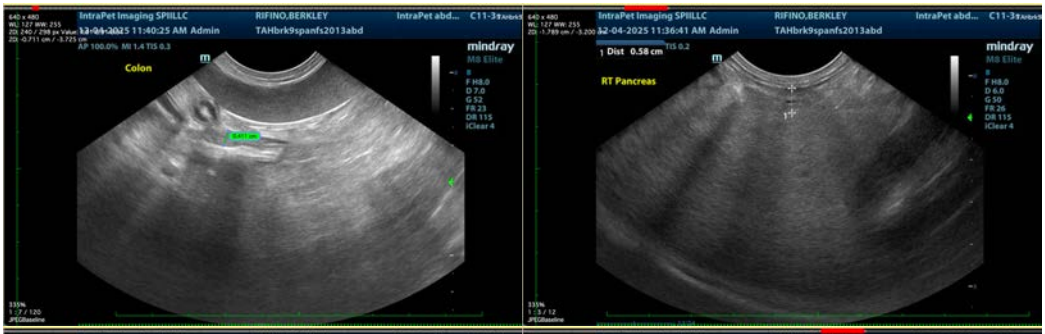
A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

In the meantime, 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.

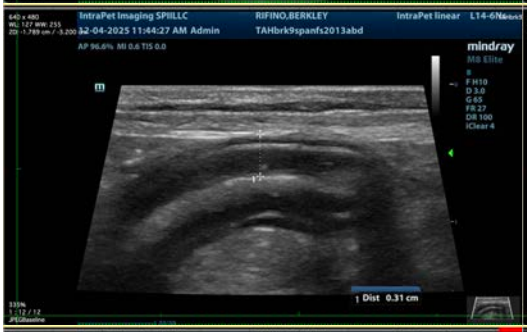
Additionally, especially if patient's appetite is not normal, temporary discontinuation of Trilostane could be considered until patient's sick clinical signs have resolved, and clinical signs of hyperadrenocorticism have returned, at which time it could be restarted. Incidentally, many patients are more successfully clinically managed on twice daily dosing, but maintaining the same total daily mgs, so a lower dose, but twice daily.

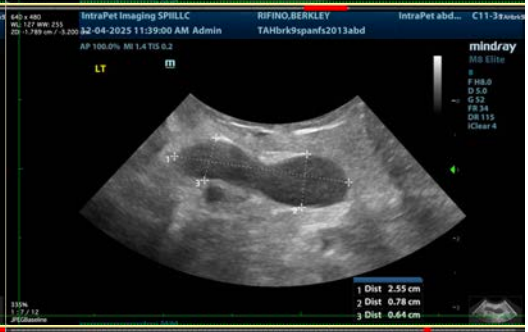
Ultimately, if a diagnosis is not obtained and clinical signs persist, sampling of the GI tract, including the colon, may be necessary for definitive diagnosis and therefore to further guide medical management.

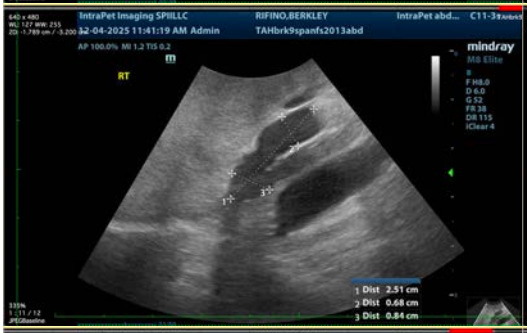


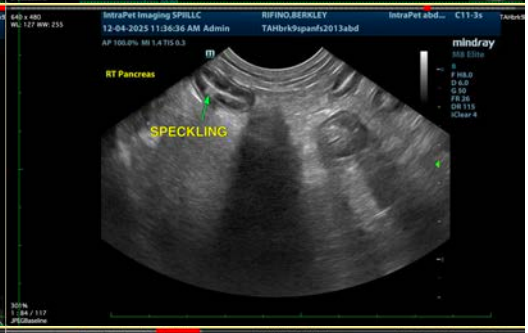

IntraPet Imaging SPIILLC
RIFINO,BERKLEY
IntraPet abd... C11-3s
TAHbrk9spanfs2013abd
mindray
Colon

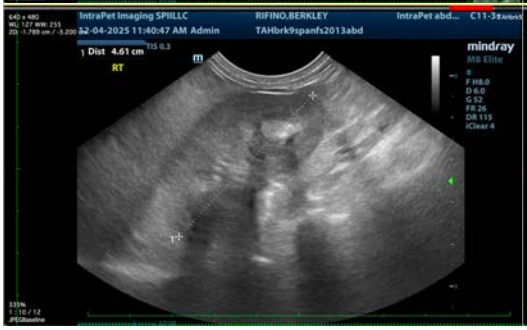
IntraPet Imaging SPIILLC
RIFINO,BERKLEY
IntraPet abd... C11-3s
TAHbrk9spanfs2013abd
mindray
1 Dist 0.58 cm
RT Pancreas

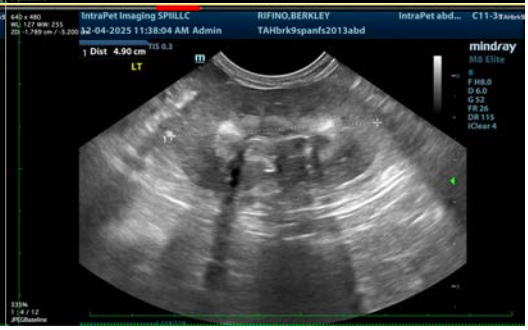

IntraPet Imaging SPIILLC
RIFINO,BERKLEY
IntraPet linear LT4-6Ns
TAHbrk9spanfs2013abd
mindray
1 Dist 0.31 cm

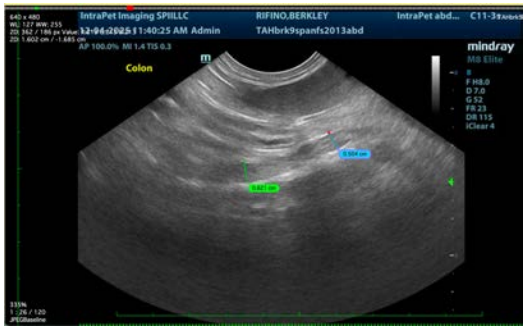

IntraPet Imaging SPIILLC
RIFINO,BERKLEY
IntraPet abd... C11-3s
TAHbrk9spanfs2013abd
mindray
LT
1 Dist 2.55 cm
2 Dist 0.78 cm
3 Dist 0.64 cm


IntraPet Imaging SPIILLC
RIFINO,BERKLEY
IntraPet abd... C11-3s
TAHbrk9spanfs2013abd
mindray
RT
1 Dist 2.51 cm
2 Dist 0.68 cm
3 Dist 0.84 cm


IntraPet Imaging SPIILLC
RIFINO,BERKLEY
IntraPet abd... C11-3s
TAHbrk9spanfs2013abd
mindray
RT Pancreas
SPECKLING


IntraPet Imaging SPIILLC
RIFINO,BERKLEY
IntraPet abd... C11-3s
TAHbrk9spanfs2013abd
mindray
1 Dist 4.61 cm
RT


IntraPet Imaging SPIILLC
RIFINO,BERKLEY
IntraPet abd... C11-3s
TAHbrk9spanfs2013abd
mindray
1 Dist 4.90 cm
LT



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