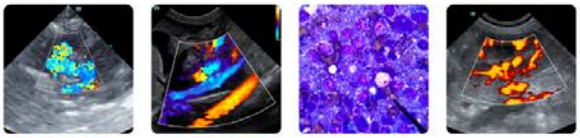


SonoPath www.thefocalzone.com info@thefocalzone.com 289.808.2608

PATIENT

Casey Belleville

SPECIES

Canine

BREED

Min Pin

SEX

Neutered Male

AGE

12 Years

WEIGHT

7.75 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Burford Veterinary Hospital

REFERRING VET

Dr. Fernandes

INVOICE

73522

DATE

3/10/26

PRESENTING CLINICAL SIGNS

Chronic intermittent GI signs. Significant weight loss and muscle wasting. Reduced appetite but grazing on his i/d low fat food. Vomited once at home a few weeks ago after meds given. Currently passing dark brown diarrhea. History of 2 possible seizure episodes in December. BW then revealed severe hypoalbuminemia, QAR, Skin tent less than 1 second, abdomen soft on palpation, did eructate several times and lick lips with palpation, no obvious mass. Has been on Metronidazole, Cerenia, Codeine, gabapentin and Trazodone for US

Abnormal PE/Chem/CBC/UA Results: Total Protein 35 (LOW) 50-74 g/L Albumin 18 (LOW) 27-44 g/L Hemoglobin 205 (HIGH) 121-203 g/L Hematocrit 63 (HIGH) 36-60 %

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with primarily anechoic contents. There is a 1.3 cm in diameter echogenic density that could represent some sludge or debris, although a tissue density/polyp, nodule, much less likely infiltrative neoplasia, is noted near the dependent apex portion of the bladder. Otherwise, no masses, inflammatory changes or cystoliths are observed and 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.

The right kidney is normal is size (4.4 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.

The left kidney is normal is size (4.0 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

The right adrenal gland is normal in size (1.5 cm at cranial pole and 0.56 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

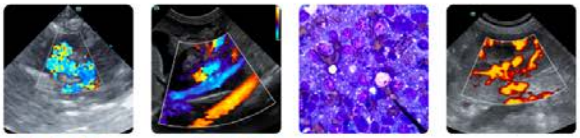
The left adrenal gland is normal in size (0.37 cm at cranial pole and 0.76 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

The spleen is subjectively normal in shape and size but has a markedly mottled, coarse, heterogeneous parenchyma diffusely, characterized by almost a striped appearance with hyperechoic, what in some views appears to be mineral densities, throughout the spleen. Nodules or other pathologic change, however, can't be rueld out. Splenic vasculature appears normal.

Liver

The 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.



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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 visible colon is normal in wall thickness (< 0.2 cm) and layering. It is mildly diffusely distended with soft stool.

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 no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Moderate 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.
- The splenic changes appear, in my opinion, to be marked splenic mineralization, which is a benign change but can be associated with endocrinopathies such as hyperadrenocorticism versus other. Having said that, given the degree of change, in some views a nodular or moth-eaten appearance can't be definitively ruled out. Therefore, more pathologic infiltrative disease including infiltrative neoplasia can't be ruled out without tissue sampling.
- 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.
- The urinary bladder density, as described above, could represent sludge or tissue.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

Fine needle aspirates of the spleen are recommended if patient's coagulation status is appropriate.

Given patient's gastrointestinal history and the hypoalbuminemia, combined with the mucosal speckling, a protein losing enteropathy could be considered, and further gastrointestinal/hypoalbuminemia 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.

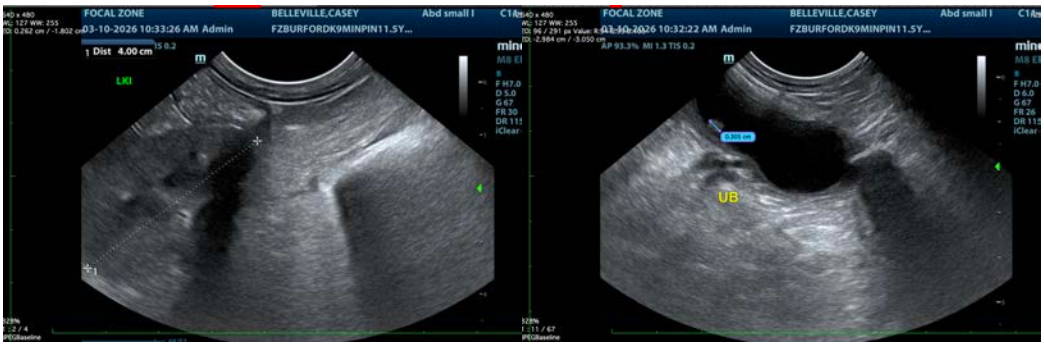
A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

Additionally, given patient's seizure history, bile acids could be considered if patient's total bilirubin is not increased.

In the meantime:

- Supportive/symptomatic medical management of clinical signs is recommended, including anti-emetics, gastroprotectants (+/- sucralfate, especially with any history of hematemesis), an appetite stimulant and fluid therapy if indicated, etc.
- Additionally, empirical deworming with a 5-day course of Panacur is recommended.
- A full course of empirical Helicobacter triple therapy could be considerd.
- A probiotic, such a visbiome or proviable, may be helpful.
- Finally, if tolerated, a transition in diet could be considered, based on trial-and-error response with some options to consider including a gastrointestinal biome diet vs a hydrolyzed protein diet (sometimes several trials with different brands are necessary) vs an easy to digest, bland or low-fat diet vs other.



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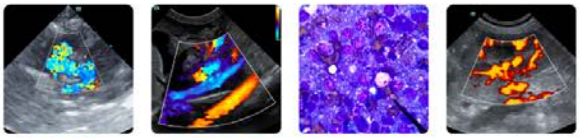

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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