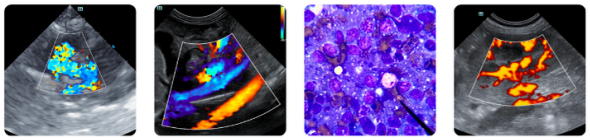


PATIENT

Sophie Schi

SPECIES

Canine

BREED

Coton De Tulear

SEX

FS

AGE

12 years 4 months

WEIGHT

2.1 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Jill Rankin

HOSPITAL NAME

West Springs Vet Hospital

REFERRING VET

Dr. Caitlyn

INVOICE

11531

DATE

3/20/2026

PRESENTING CLINICAL SIGNS

- 12yo FS Coton presented for chronic vomiting and wt loss. Elevated Cystatin B suggesting kidney inflammation, mild changes in liver values, and abnormal protein levels (low albumin, high globulin).
- Due to the progressive signs and bloodwork findings, I recommended an abdominal ultrasound to investigate for underlying causes such as inflammatory bowel disease, polynephritis, hepatitis, or neoplasia.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is under distended with primarily anechoic contents and occasional echogenic non-shadowing debris. The non-fully distended state is likely at least, partially exacerbating the thick irregular appearance to the wall. Apical urinary bladder wall is diffusely thick (0.37 cm). Mucosa is hyperechoic and irregular. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.

Kidneys are overall normal in 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 pyelectasia or infarcts observed. Left kidney measures 2.5 cm and contains non-obstructive linear multifocal hyperechoic diverticular foci with acoustic shadowing are noted. *The kidney is not fully visualized in a sagittal view, it's partially oblique/transverse, altering the measurement. Right kidney measures is small/normal in size, measuring 3.2 cm, and contains a 0.5 cm in diameter non-obstructive nephrolith is noted in the right kidney.

Adrenal Glands

The adrenal glands are unable to be visualized in these images.

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.

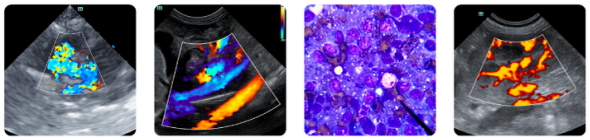
Liver

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.

The 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

Fundic mucosal hypertrophy with hyperechoic mucosa and some mucosal remodeling is noted. There is no loss of mural detail. Layering is normal. There is mild luminal fluid accumulation. No evidence of



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masses/nodules or foreign material present. *In some views, the wall measures 0.74 cm thick, and while in most views layering is intact trending in appearance toward the benign gastritis, adjacent to the stomach is irregular, amorphous, ill-defined echogenic tissue density that is likely edematous fat mesentery and omentum, some free fluid +/- pancreas. Although in one view, it appears to be a focally thicker part of the stomach.*

The visible small intestine demonstrates areas of moderate to severely thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. 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. 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. *The tissue density described above adjacent to the stomach, could represent an edematous pancreas and surrounding tissue.

Free Abdomen

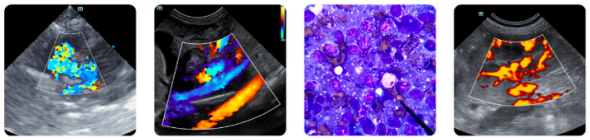
There is a moderate amount of free fluid noted in these images.

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.

PRIMARY FINDINGS

- Moderate Inflammatory bowel disease (IBD) pattern – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No loss of layering or distinct characteristics of malignancy are present. Therefore, differentials cannot be further ranked without tissue sampling.
- Gastritis – Consistent with irritation secondary to dietary indiscretion or intolerance, infection (bacterial, viral, other), parasitic or protozoal disease, toxin, other metabolic disease such as pancreatitis, other. Microulceration cannot be ruled out.
- Concurrent chronic low grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs, but I'm more suspicious that the fluid and edematous changes described above are benign and likely secondary to reported hypoalbuminemia but should be interpreted in combination with the actual degree of hypoalbuminemia which I'm uncertain of.
- Mildly reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

SECONDARY FINDINGS



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Age related kidney changes with non-obstructive dystrophic mineralization noted in the left kidney, and one larger but non visibly obstructive nephrolith noted in the right kidney.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated, especially given patient's reported hypoalbuminemia, **Urinalysis –** 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.

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

GI panel –
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.

Fecal PCR panel –
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.

Further recommendations regarding patient's reported liver enzyme changes are largely dependent on the pattern of liver enzyme changes i.e. primarily hepatocellular injury versus cholestatic, etc.

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 considered.
- 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.

If the hypoalbuminemia is not significant enough to results in the free fluid and/or diagnosis is not obtained, additionally smapling of the free abdominal fluid for analysis and cytology could be considered if patient's coagulation status is appropriate.

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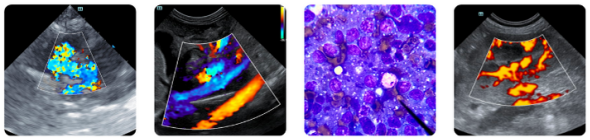

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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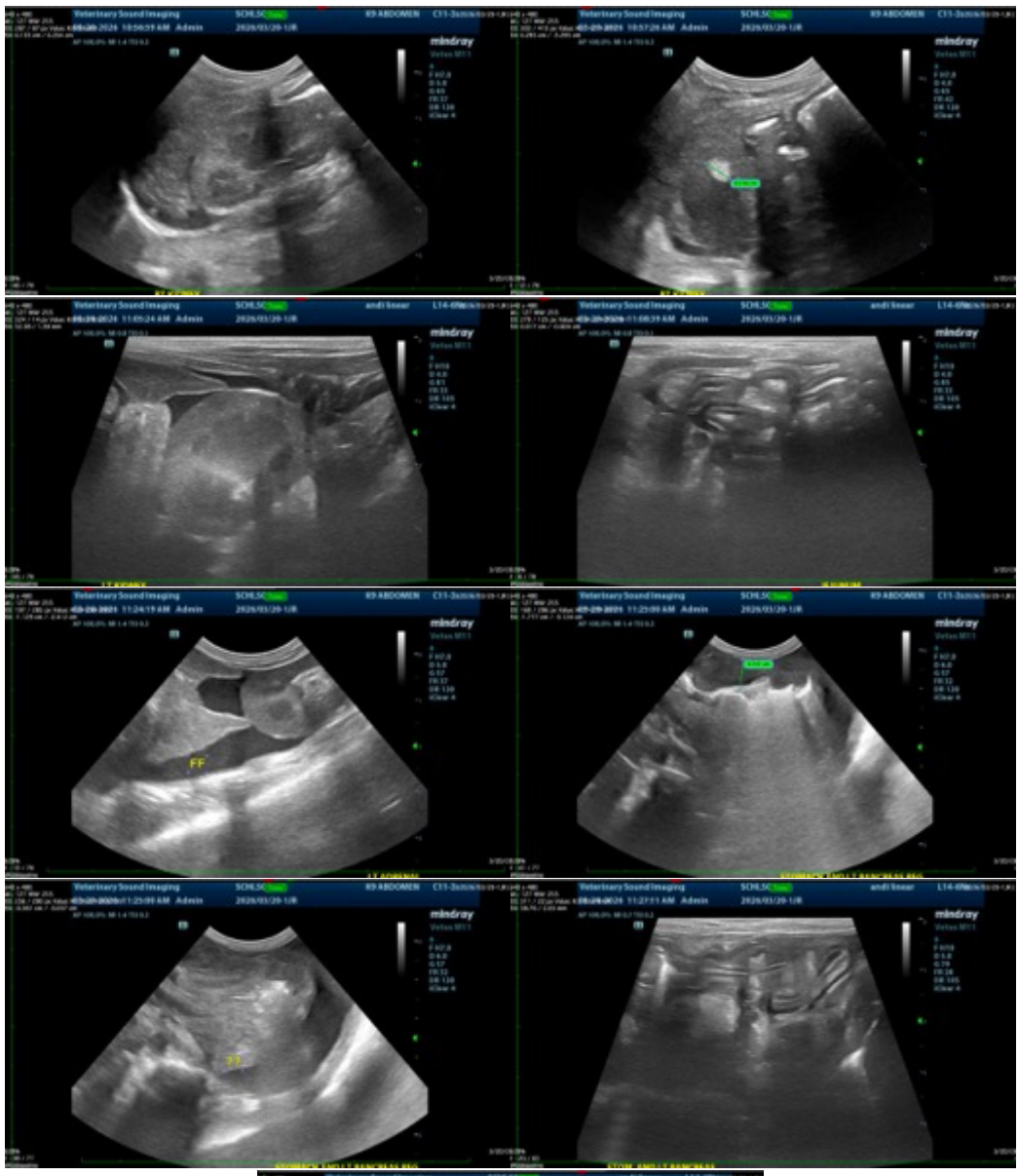
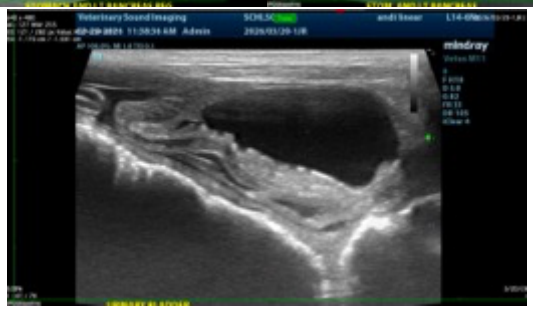
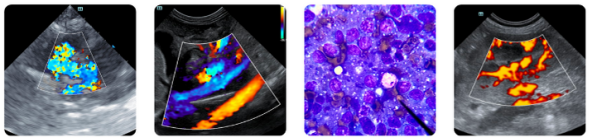




The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not



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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