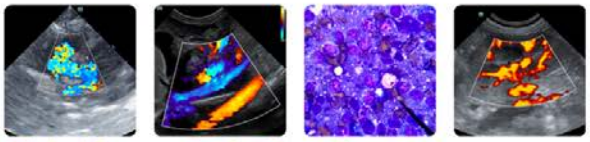


PATIENT

Piper Steckley

SPECIES

Canine

BREED

Yorkie x

SEX

Spayed Female

AGE

14 Years

WEIGHT

2 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Melissa Randolph

HOSPITAL NAME

Shores Veterinary Emergency Center

REFERRING VET

Dr. Logan Law

INVOICE

74138

DATE

4/1/26

PRESENTING CLINICAL SIGNS

P started to vomit on 3/27-3/29. P 3/27-3/29 had not been eating well. P seen at Rossmoyne ER on 3/30. Outpatient treatment with ondansetron injection and sq fluids. rx'd entyce. P ate small amount on 3/30, yesterday ate 3 meals, today P has had 2 meals. P had soft stool last night, normal stool today. Owner has noted increased flatulence. Owner notes weight loss. P has been pu/pd for a few weeks. P was seen again today at Rossmoyne ER for only slight improvement (to owner) since 3/30. blood work was done. P was seen at rdvm in FL on 3/2/26. P has monitoring blood work every few weeks. P lives part of year in PA and part of year in FL. prior health history of arthritis, pancreatitis, gastroenteritis, gastritis, CKD, hypertension, dental disease. P medications: meloxicam 2 pound dose prn , entyce Q 24 hr, telmisartan liquid 10 mg/ml 0.1 ml Q 24 hr, soliquin chew Q 24 hr, joint/hip chew Q 24 hr, cerenia Q 24 hr. P diet is i/d low fat stew and i/d low fat dry. Concern for Marked Azotemia - Acute on Chronic kidney disease, pre-renal azotemia; Pancreatitis - r/o acute flare, ongoing inflammatory process; Weight loss and cachexia - r/o chronic kidney disease, pancreatitis, neoplasia; Hypertension (historical finding) - r/o chronic kidney disease, idiopathic; other

Abnormal PE/Chem/CBC/UA Results: PE: subtle pain, abdominal discomfort; BCS 4/9, thin; reactive to abd palpation; Muscle atrophy, appears to have recent weight loss; Blood pressure 194/111 (Map 139) 3/2/26 Florida rDVM: abbreviated CHEM: BUN 71 H, creatinine 2.1 H CBC: RBC 5.2 L, Hct 35.6% L, WBC 3.7 L, neu 2.2 L, Mono 0.5 H UA: pH 5.0, protein + 15; sediment unremarkable 4/1/26 Rossmoyne ER: CBC: WNL; CHEM: BUN > 140 H, Creat 2.8 H, Amylase 2,010 H, Lipase 471 H; EPOC: Creat 3.17 H, Lactate 3.09 H, pO2 95.3 H, pH 7.329 L, TCO2 15.4 L, BEecf -10.0 L; Hct: 40% cPL: abnormal; Cortisol (baseline): 3.8 Shores 4/1 4 pm: BUN >140 H, creat 2.8 H; usg 1.017; u/a: Protein neg, pH 5.0, USG 1.017; Inactive sediment 4/2 4 am epoc: pH 7.299 L, Na 158 H, K+ 3.4 L, Cl 129 H, BUN 96 H, creat 2.36 H, glu 127 H, hct 35% L

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 bilaterally small, irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed. The left kidney measures 2.9 cm. The right kidney measures 3.0 cm.

Adrenal Glands

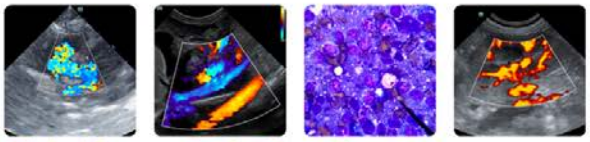
The adrenal glands are unable to be well visualized in these images.

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



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homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is mildly overdistended with a moderate amount of non-dependent, mildly aggregated/inspissated sludge. Hypo to anechoic cystic areas are noted between the gallbladder sludge and luminal wall. The wall is otherwise smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The stomach is moderately distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. If patient was appropriately fasted, delayed gastric emptying could be considered. Non-shadowing foreign material is considered less likely but cannot be definitively ruled out.

If clinical signs are consistent (vomiting, etc.), recommendations include supportive medical care, 24 hours fasting and re-image.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta/chyme. There is 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 no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Moderate bilateral chronic kidney disease changes.
- Emerging mucocele – 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. The non-dependent nature of this sludge combined with the cystic areas are suggestive, however, of possible emerging cystic mucosal hyperplasia or early gallbladder mucocele.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

It is difficult to determine based on imaging alone whether patient's reported clinical signs are secondary to potentially progressive chronic kidney disease or an acute on chronic insult such as an infection versus dehydration caused by another metabolic disease, etc. There is no definitive visible evidence of gastrointestinal or pancreatic disease, however they can't be ruled out. Therefore, if not recently evaluated, a urine culture could be considered.

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.

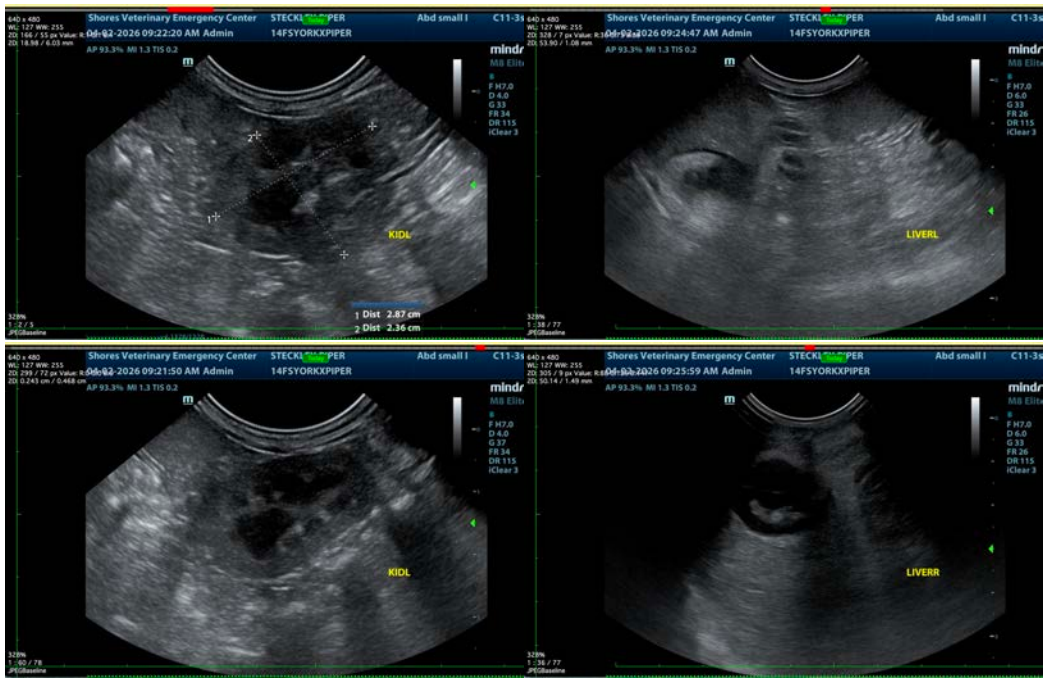
Contribution from the suspect emerging mucocele is of unknown significance but could be suspected as a contributing factor, especially in the face of cranial abdominal pain, liver enzyme changes, etc.

In addition to supportive/symptomatic medical management of clinical signs, continued and potentially increased medical management of chronic kidney disease, etc., and if tolerated empirical hepatic nutraceuticals including Ursodiol could be considered while monitoring the gallbladder for improvement.

Full consultation with a veterinary internist may also be helpful.

For an additional charge an internal medicine consult can be utilized through Sonopath.com. You can select the internal medicine drop down at http://spa.sonopath.com/.

One of the world's top internists & SonoPath associate Dr. Remo Lobetti BVSc, MMedVet, PhD, DECVIM can evaluate your case through SonoPath. https://sonopath.com/resources/sonopath-services/internal-medicine-teleconsultation-services



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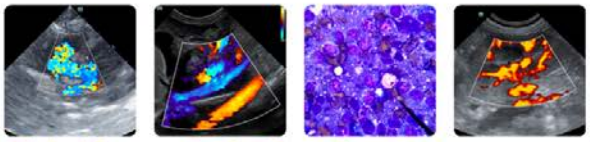

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Educational Teleconsultation Services™

SonoPath.com info@sonopath.com 1.800.838.4268

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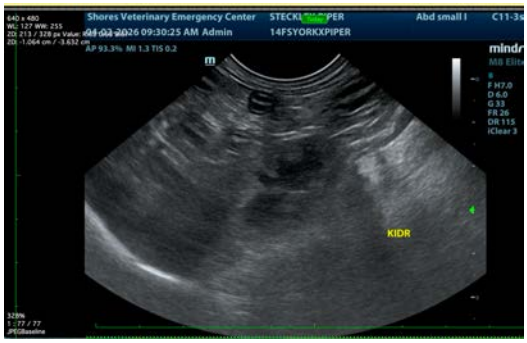

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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