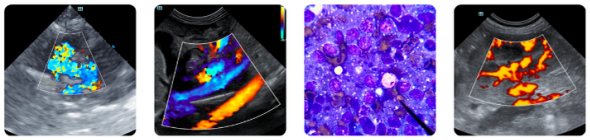


PATIENT

Loki Traynor

SPECIES

Canine

BREED

Havanese

SEX

MN

AGE

11 years

WEIGHT

7.1 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Gira

HOSPITAL NAME

Signal Hill AC

REFERRING VET

Dr. Sweet

INVOICE

11770

DATE

4/22/2026

PRESENTING CLINICAL SIGNS

The patient had surgery on April 14th, where 5 full-thickness biopsies were taken from the small intestine. He was started on prednisone at 1 mg/kg immediately after the surgery. He responded well clinically with an increased appetite. His albumin improved from an initial value of 11 to 16 over the several days following surgery. However, his white blood cell count began to rise progressively post-operatively, reaching 100. Clinically, he is still doing well, is not febrile, and is gradually improving each day. The current concern is for a septic abdomen or localized peritonitis as a cause for the high white blood cell count.

Current Medications: Prednisone: 1 mg/kg, started on April 14th post-operatively.

Previous Diagnostics: Surgical Biopsies (April 14th): 5 full-thickness biopsies were taken from the small intestine.

Other Medical Problems: Chronic diarrhea, Hypoalbuminemia

Abnormal PE/Chem/CBC/UA Results: Bloodwork: Albumin was initially 11 and improved to 16 post-operatively. The white blood cell count has progressively risen to 100 post-operatively. CBC attached

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.

Prostate is unable to be well visualized in these images.

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 pyelectasia, mineral or infarcts observed. Left kidney measures 4.84 cm, and the right kidney measures 5.27 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.45 cm at cranial pole and 0.56 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

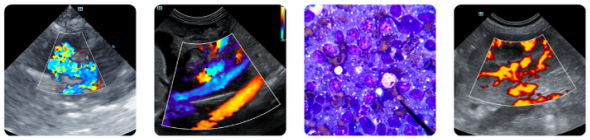
The left adrenal gland is normal in size (0.64 cm at cranial pole and 0.67 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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 lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

Small intestine is diffusely mildly thick with a relatively thick mucosa compared to other layers. Normal wall layering is preserved; however, the mucosa is more echogenic than normal and contains hyperechoic striations perpendicular to the lumen. The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

The visible colon is normal but the lumen is moderately distended, diffusely, 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 a large amount of echogenic appearing free fluid and subtly enhanced hyperechoic mesenteric fat.

There is no apparent pathologic lymphadenopathy noted in these images.

PRIMARY FINDINGS

- Lymphangiectasia – Small bowel findings are most consistent with lacteal dilation. These findings can be observed with protein-losing enteropathies caused by either primary lymphangiectasia or primary infiltrative inflammatory disease with secondary lymphangiectasia. Infiltrative neoplasia is possible but considered less likely. Histopathology is necessary to definitively determine underlying cause.
- 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.
- 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.

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SECONDARY FINDINGS

- Mild age-related kidney changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

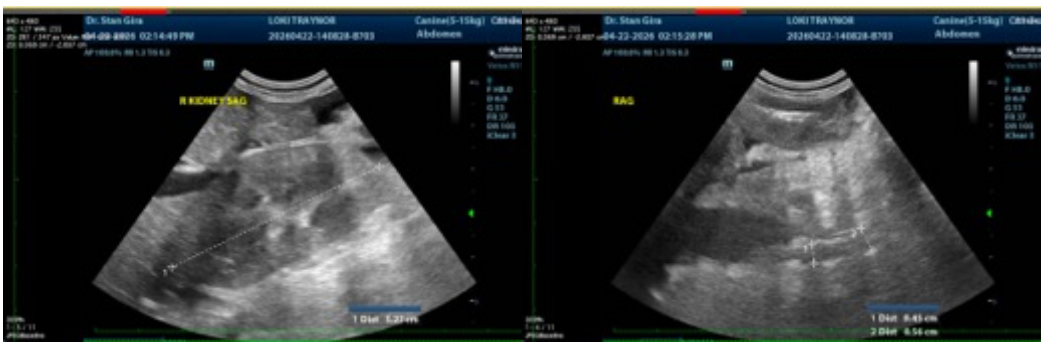
Given patient's reported hypoalbuminemia, recent surgery combined with diffuse gastrointestinal disease, all which could contribute to free fluid and enhanced mesentery and fat, it's difficult to differentiate that cause versus more sinister dehiscence septic abdomen, etc. Having said that, I would expect a more focal change around a bowel loop, trying to seal off at the hiscence if that were the case, which I do not see. So that knowledge, combined with patient's reported clinical picture make dehiscence and/or septic abdomen less likely, in my opinion. This statement however should be interpreted in combination with patient's albumin level. Due to the difference in geographic areas, from which I receive cases, it's difficult to interpret lab work without provided units, reference ranges, or even highs versus lows.

The CBC changes similarly are a little bit confusing to me as the most recent CBC values are markedly different from the previous CBCs, assuming that one is an error sample, and the leukocytosis is real, one differential other than a roaming infection, is a leukemoid reaction from the steroids. A pathology review of the CBC could be considered. Additionally, as is reportedly already in place, sampling of the free abdominal fluid for analysis and cytology is recommended if patient's coagulation status is appropriate.

In the meantime, continued supportive/symptomatic medical management of clinical signs and management of lymphangiectasia is recommended. Including:

- Diet change to an ultra-low fat diet.
- Empirical deworming with a 5-day course of Panacur.
- Cobalamin supplementation, unless cobalamin level is evaluated and supplementation is not warranted.
- +/- continued prednisolone if not contraindicated based on patient contraindications, comorbidities, etc.
- Additionally, calcium monitoring and supplementation, if necessary, may be warranted.

Finally, if patient's coagulation status is otherwise appropriate, antithrombotic such as clopidogrel or low dose aspirin may be warranted.



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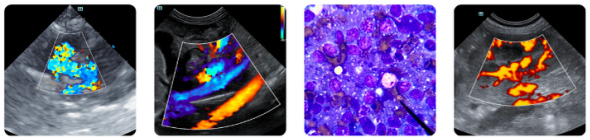

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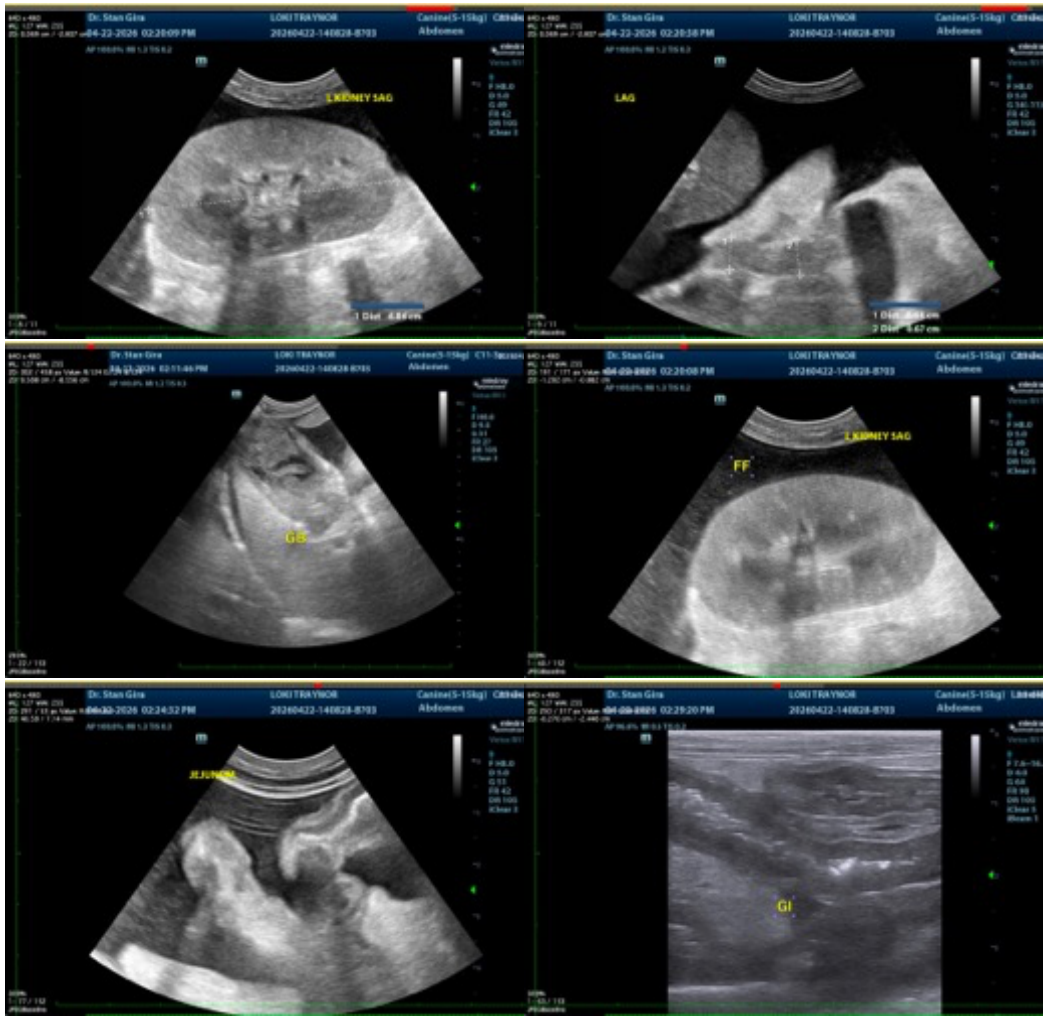

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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