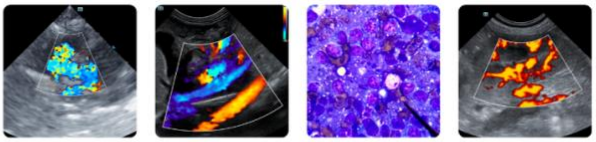


PATIENT

Elsa Bignell

SPECIES

Canine

BREED

Labrador Retriever

SEX

Spayed Female

AGE

9 Years 4 Months

WEIGHT

39.95 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Brian Barnes

HOSPITAL NAME

Westview Veterinary Hospital

REFERRING VET

Dr. Brian Barnes

INVOICE

14893

DATE

04/06/26

PRESENTING CLINICAL SIGNS

Slowing down.

Current Medications: Prednisone 5mg for allergies. Viaderm cream at home. Indoor/Outdoor: The owner reports a sudden and random onset of urinary signs. The patient has been burping recently. The owner notes the patient seems to have some hearing loss. Allergies are an ongoing issue, currently managed with a low dose of prednisone. The patient was born with a significant overbite.

Abnormal PE/Chem/CBC/UA Results: Few hyaline Renal cast on U/A, USG1.022, 1.027, 1.042 ALP 1537 (N 23-212) Steroid use Routine geri screen

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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.

Left kidney is normal in size (6.87 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.

Right kidney is normal in size (7.12 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

Adrenal glands are small (flattened contour). Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. The left adrenal gland measured 0.27 cm at the cranial pole and 0.54 cm at the caudal pole. The right adrenal gland measured 0.34 cm at the cranial pole and 0.31 cm at the caudal pole.

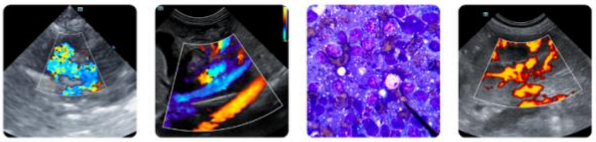
Spleen

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 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.

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.



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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 intestine demonstrates areas of mildly 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.

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

- Mild/emerging inflammatory bowel disease 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. This change is very subtle/mild and could be in part normal patient variant in a senior dog and should be interpreted in combination with patient's clinical history especially given reported allergies which could also be affecting the bowel.
- Patient's subjectively flat/small adrenal glands are likely secondary to steroid history. Other pathologic cause however can't be definitively ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is not a definitive ultrasonographically visible intra-abdominal explanation for patient's reported 'urinary signs'. Further workup/investigation and treatment of those signs is largely dependent on more specific information regarding the signs i.e. polyuria, polydipsia, pollakiuria, incontinence etc.

Having said that, given steroid history, if not recently evaluated, a urine culture could be considered.

In the meantime, additional evaluation of the GI tract including evaluation of absorption and digestion could be considered via 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.

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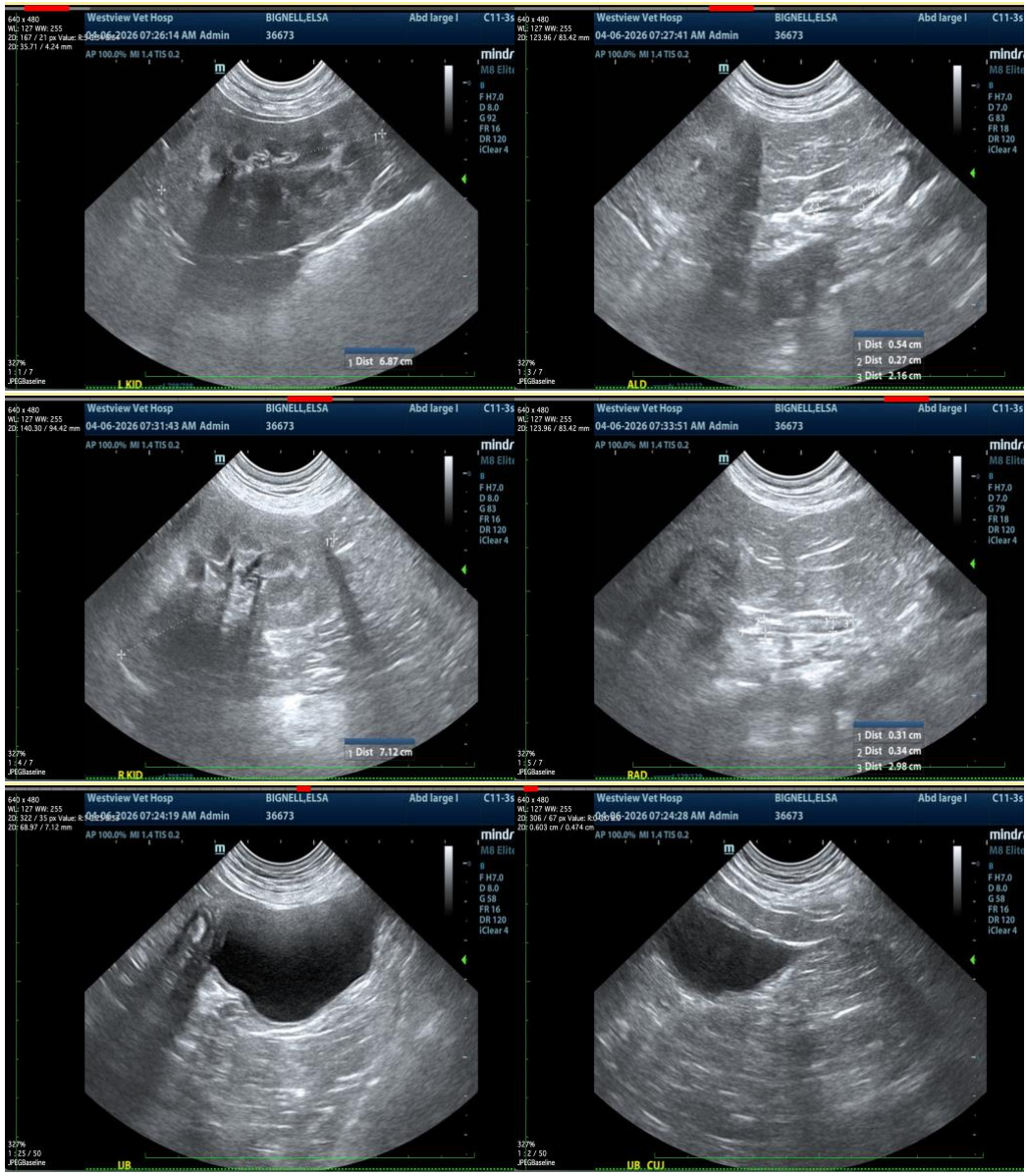
Otherwise, further gastrointestinal workup or treatment recommendations are largely dependent on patient's history. Having said that, given the reported vomiting as well as the reported allergies, if tolerated, a transition in diet is recommended, based on trial-and-error response.

Some options to consider include a gastrointestinal biome diet vs a hydrolyzed protein diet (sometimes several trials with different brands are necessary) vs a fiber response/colitis diet vs a bland, easy to digest or low-fat diet vs other.



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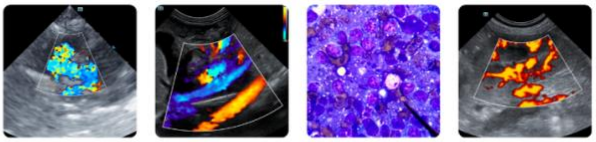

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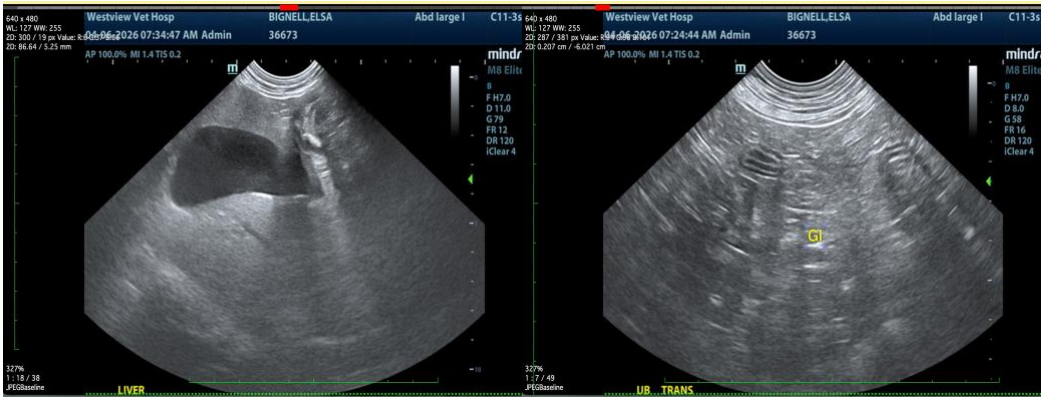

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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