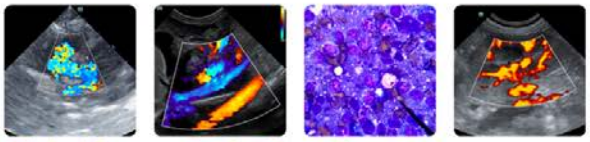


PATIENT

Bentley Fischer

SPECIES

Canine

BREED

Dachshund

SEX

Spayed Female

AGE

1 Year 3 Months

WEIGHT

13.7

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Agnes Rupley, DVM

HOSPITAL NAME

All Pets Medical Center

REFERRING VET

Agnes Rupley, DVM

INVOICE

75136

DATE

5/14/26

PRESENTING CLINICAL SIGNS

Presented 5/12 possible obstruction. Anorxia, vomited, passed piece of flip flop, then had diarrhea. Exam yesterday: BS 6/9. Pain on abdominal palpation. No mass or foreign body palpated. Tacky mucous membranes with slow CRT. Increased resp rate. CBC :mature neutrophilia, eosinophilia, low normal platelet count. CRP, Heartworm, Chemi/lyes normal. Urinalysis pH of 6.0 and sp gr 1.015. AFAST: dilated loops of intestine; hyperechoic kidneys. Fecal, Urine culture, and Leptospirosis PCR pending. Maropitant and IV fluids administered. 5/14/26: BAR. Afebrile. Urinating abundantly. No bm. Abdominal ultrasound today performed after IV fluids were administered. A small amount of free fluid noted today on abdominal ultrasound. Last video in the set is from the AFAST yesterday prior to fluid therapy. Doxycycline begun.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Images labeled "Pre-fluids Yesterday"

Images labeled "pre-fluids yesterday" reveal a largely normal liver and gallbladder, and the spleen that can be visualized appears normal.

Kidneys are bilaterally 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 kidneys are normal in size, measuring 4.2 cm on the left and 4.2 cm on the right. A hyperechoic band parallel to the corticomedullary border is present bilaterally.

The adrenals are not able to be well visualized.

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. 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.

Images labeled "Post-Fluids"

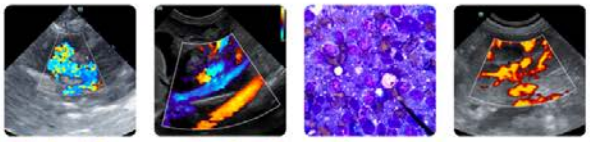
Urinary Bladder

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 normal in size but bilaterally irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed. Left kidney measures 4.0 cm. Right kidney measures 4.3 cm. A hyperechoic band parallel to the corticomedullary border is present bilaterally.

Adrenal Glands

The adrenal glands are unable to be visualized.



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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

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. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with 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 a very scant/trace amount of anechoic free fluid.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Ultimately, after evaluating both studies, mild to moderate bilateral kidney disease changes, most characterized by a significant medullary rim sign. The medullary rim sign is of unknown clinical significance and can be a normal variant, often idiopathic. Medullary rim sign can be present with renal disease including lymphoma, hypercalcemic nephropathy, Leptospirosis, tubular disease, other and should be interpreted in combination with other more specific indications of kidney disease such as isosthenuria, proteinuria, azotemia, etc. This is a common incidental finding in patients with diabetes mellitus.

- Scant/trace free fluid.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

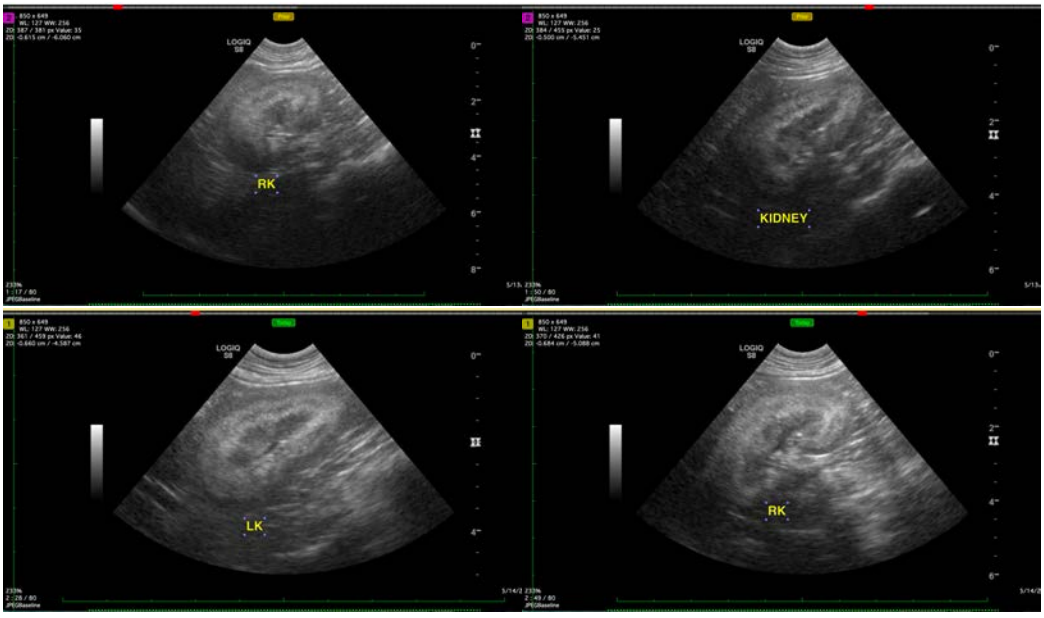
In neither study is there a definitive ultrasonographically visible explanation for patient's reported gastrointestinal signs, vomiting, and progressive diarrhea. Having said that, additional foreign material within the colon can't be definitively ruled out. If clinical signs persist after dietary indiscretion and passing of the previously noted foreign material, then further gastrointestinal workup recommendations, especially given the reported eosinophilia, include a routine fecal/giardia exam.

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.

Interpretation of the kidneys is difficult in the face of a normal chemistry panel, electrolytes, etc. However, given the reported urine specific gravity, if that was obtained before fluid therapy, early or emerging chronic kidney disease can't be ruled out, and the workup that is reported beginning with a urine culture, testing for Leptospirosis, etc. is appropriate. Monitoring of the kidney values, urinalysis, etc. may be appropriate ongoing to help determine if chronic kidney disease is present and the progression speed of it.



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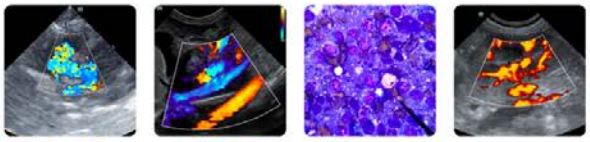

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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