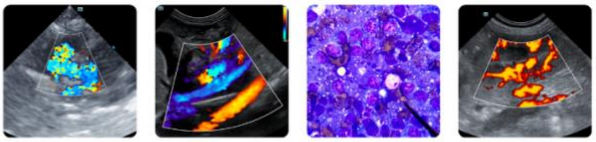


PATIENT

Roxy Bawroski

SPECIES

Canine

BREED

Pitbull Mix

SEX

Spayed Female

AGE

9 Years

WEIGHT

51 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Jessy Butcher

HOSPITAL NAME

VEG

REFERRING VET

Dr. Falk

INVOICE

16189

DATE

05/14/26

PRESENTING CLINICAL SIGNS

Presenting due to continued GI symptoms after work up and treatment. Had ultrasound 2 weeks ago, please see report.

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 (6.6 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.

The right kidney is unable to be visualized in these images.

Adrenal Glands

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

Spleen

Spleen is subjectively large in size with a mildly swollen but smooth capsule. Parenchyma is normal and homogenous in echogenicity and echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged (swollen contour) with a diffusely mildly coarse architecture and subtly increased portal markings. Mildly mixed echogenic changes are noted diffusely. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

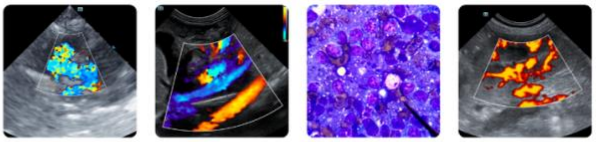
Gallbladder is non-distended in size. The gallbladder wall is thick and edematous characterized by an intramural hypo to anechoic rim or “double rim effect or halo sign”. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with a small to moderate amount of echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is 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 mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material, or infiltrative disease; however, visualization is partially inhibited by gas.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.



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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

No definitively visible lymphadenopathy is visible in these images. There's a large amount of free fluid and markedly enhanced hyperechoic mesentery and fat throughout the abdomen.

This study is significantly limited by artifact from gastrointestinal gas as well as obscured by free fluid and enhanced mesentery throughout the abdomen. Bowel changes up to and including even an obstruction while thought not likely based on the lack of visible distention, can't be ruled out. Other subtle changes including pancreatic parenchyma changes, lymphadenopathy, etc., can't be definitively ruled out.

ULTRASONOGRAPHIC FINDINGS

- A large amount of free fluid- 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.
- Diffusely enhanced hyperechoic mesentery and fat throughout the abdomen. These changes suggest ongoing peritonitis/inflammation without a cause able to be visibly determined. Diffuse gastrointestinal disease, ongoing pancreatitis versus other are differentials with pancreatic parenchymal changes as well as specific bowel wall changes, etc., difficult to fully visualize/assess in these images at this time.
- Gallbladder halo- GB wall edema is a non-specific change and can be seen with any underlying etiology (i.e. vasculitis, hypoalbuminemia, CHF, other) that results in edema, as well as immune-mediated disease, anaphylactic shock, other. Cholecystitis cannot be ruled out.
- Splenomegaly- can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.
- An obvious cause for the subtle liver changes is not identified in these images. Microscopic disease such as Leptospirosis, bacterial cholangiohepatitis, chronic active hepatitis, copper-associated hepatotoxicity, other hepatotoxicity, other reactive hepatopathy, infiltrative neoplasia, etc. cannot be definitively ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated, a general metabolic health screen (CBC, chemistry panel with electrolytes and urinalysis) is recommended.

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

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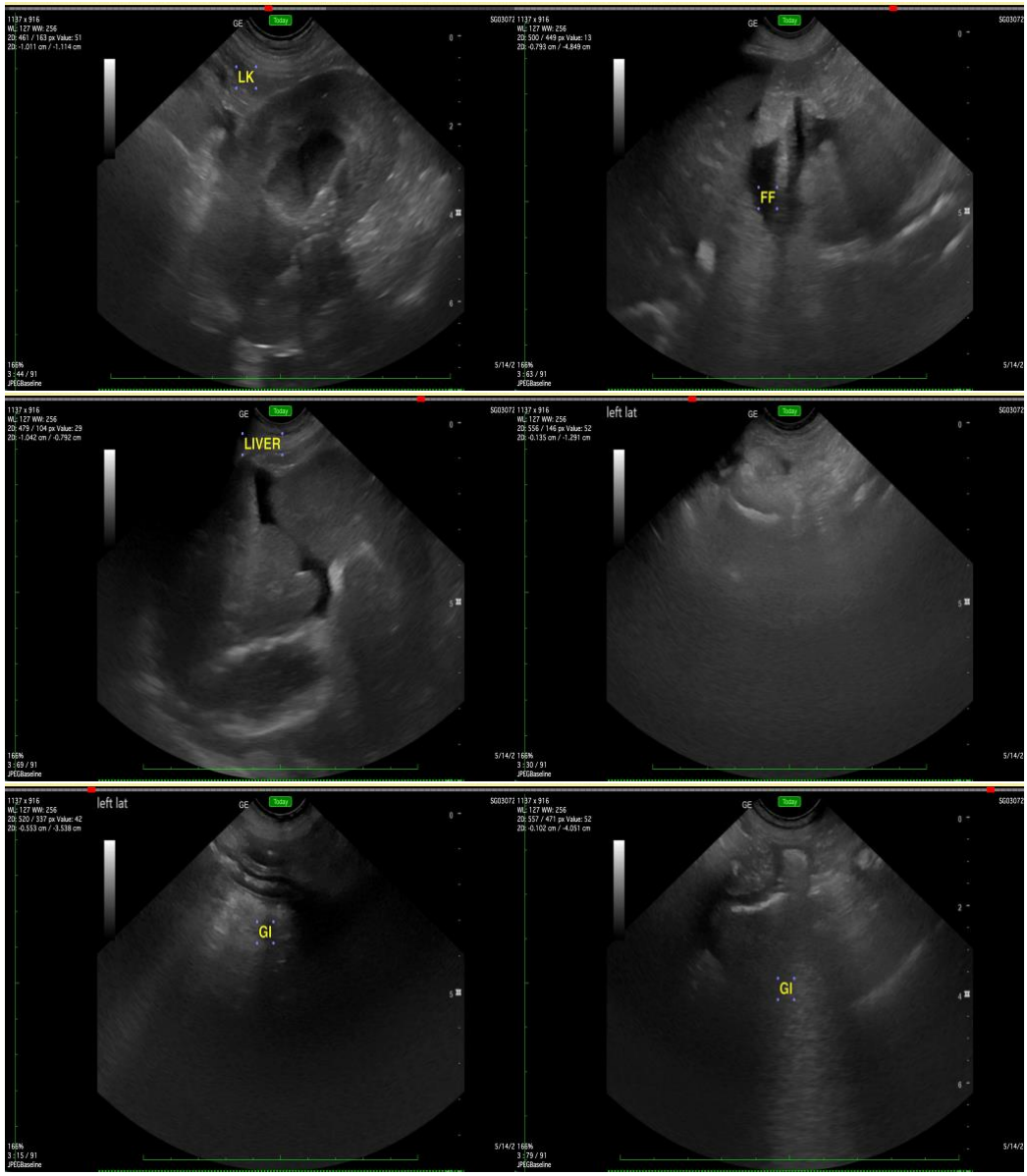
Fine needle aspirates of the spleen and liver as well as sampling of the free abdominal fluid are recommended if patient's coagulation status is appropriate.

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.

Pending results of above, a baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

Advanced imaging such an abdominal contrast CT scan could potentially be considered if a diagnosis is unable to be obtained.



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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