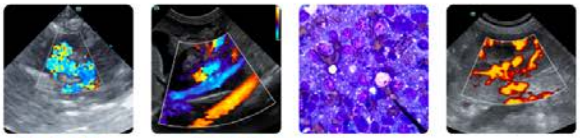


SonoPath www.thefocalzone.com info@thefocalzone.com 289.808.2608

PATIENT

Harvey O'Brian-Barton

SPECIES

Canine

BREED

Labradoodle

SEX

Neutered Male

AGE

6 Years

WEIGHT

62 lbs

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Centerville Animal Hospital

REFERRING VET

Dr. Sandhu

INVOICE

73088

DATE

2/19/26

PRESENTING CLINICAL SIGNS

Presented 1 month ago for: Acute diarrhea, Lethargy, Decreased appetite, Weight loss, Similar episode occurred last year. Fecal test: Negative Bloodwork: Severe hypoproteinemia, hypoalbuminemia, and low B12. Assessment: Suspected protein-losing enteropathy (PLE) based on history, clinical signs, and lab results. Initial Management: Transitioned to Royal Canin Gastrointestinal Low Fat, Later transitioned to Hill's z/d Low Fat due to suspected chicken allergy. Medications started: Prednisone, Tylosin, Weekly B12 injections, Proviable probiotic. Initial Response to Treatment: Significant clinical improvement. Increased albumin and total protein levels, improved energy levels, Appetite improved, Weight gain noted, stools have occasional normal form. Last 2 weeks seems to decline again

Current Medications: Prednisone (15mg BID), Tylosin (200 mg BID) , B12 injections weekly for last 6 weeks, Proviable probiotic

Abnormal PE/Chem/CBC/UA Results: Labs attached

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The prostate is not visualized.

The left kidney is normal in size and structure, with smooth capsule and normal corticomedullary definition and ratio. Medullary structure differed distinctly from that of the cortex. No evidence of pelvic dilation was present. Left kidney measures 7.17 cm.

The right kidney is minimally visualized. There is overlying gas filled GI tract in the area of the kidney. Visible portions of the kidney appear to have normal size and shape. Provided right renal measurement cannot be verified. Right kidney measures approximately 6.26 cm.

Adrenal Glands

The left adrenal gland is visualized on still image only. It appears to have generally normal shape, position and echogenicity. It is subjectively small for a patient of this breed and size. Left measures 2.07 cm in length x 0.50 cm at the caudal pole and 0.56 cm at the cranial pole.

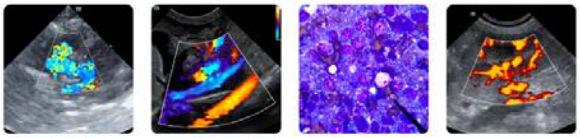
The right adrenal gland is not distinctly visualized.

Spleen

The spleen was normal with age appropriate homogeneous parenchyma and a smooth capsule with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

Liver

The liver is subjectively normal in size with normal contours and structure. There is age appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion.



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The gallbladder is normally distended with anechoic bile. The gallbladder wall is mildly thickened and diffusely hyperechoic. There is no visualized common bile duct distention.

Gastrointestinal

The stomach contains ingesta. It measures at a normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate. No masses or focal lesions were observed.

Multiple small intestinal loops appear subjectively thickened with a hyperechoic mucosa. Some loops have hyperechoic foci within the mucus, consistent with mucosal patches. There is gas and some ingesta throughout intestine.

Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The pancreas is not distinctly visualized.

Free Abdomen

No clinically significant lymphadenopathy or abnormalities noted. No free fluid noted.

ULTRASONOGRAPHIC FINDINGS

- Thickened small intestines with hyperechoic mucosa and mucosal patches.
- Hyperechoic gallbladder wall – Possible cholangitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Gall bladder changes with concurrent ELE are most consistent with cholangiohepatitis. Despite normal ultrasonographic appearance, liver FNA is indicated. Acute toxic insult, infectious or inflammatory hepatitis (leptospirosis, other bacterial, viral, auto-immune other), and neoplasia among other things remain possibilities. Primary small intestinal disease can predispose to ascending gallbladder infections, and this may be the case in this patient. Cholangiohepatitis may be sterile or infectious. Cholecystocentesis for cytology and culture should be considered. There is a low but present risk of causing bile peritonitis with this procedure. Empiric antibiotic therapy is not unreasonable and antibiotics that are effective against gram-negative, aerobic, enteric bacteria and excreted into the bile are recommended. Amoxicillin, amoxicillin-clavulanic acid, cephalosporins, and fluoroquinolones are suggested first choices. Metronidazole (7.5 mg/kg PO, IV q 12 hrs) may be added for extra anaerobe coverage. Consider treatment with liver supportive medications (SAM-E, milk thistle, Vitamin E, ursodiol) and GI support as needed.

Small intestinal changes are most consistent with infiltrative disease of the small intestine with inflammatory bowel disease or other chronic enteropathy being the top differentials. GI lymphoma cannot be ruled out but is less likely. No overt neoplastic criteria were present in the bowel given that curvilinear layering is still intact. Ultrasound cannot differentiate between small cell lymphoma and inflammatory bowel disease, and GI biopsies are recommended for definitive diagnosis, especially if there is a poor response to empirical efforts or recurrence of clinical signs after initial control. Endoscopic biopsy is less invasive but may miss lesions due to inability to obtain samples from all sections of the GI tract, especially the jejunum which is the most common site of development of disease. Surgical biopsies are more likely to be diagnostic but are more invasive. A GI panel

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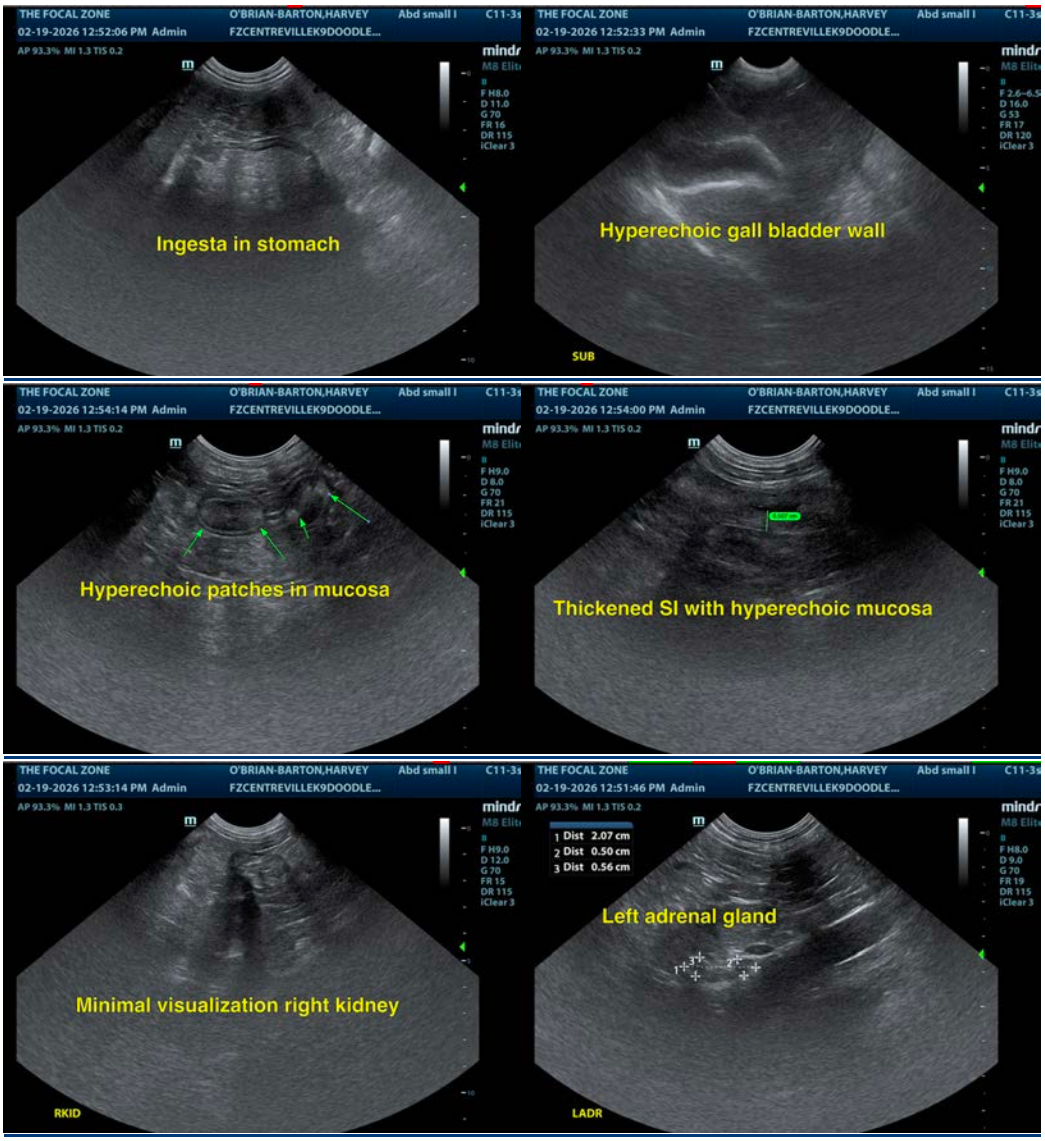
(TLI/PLI/cobalamin/folate) will help determine the severity of SI dysfunction, and need for vitamin supplementation. A baseline cortisol +/- ACTH stimulation test is recommended to rule out hypoadrenocorticism.



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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.

Dr Brittany Sinclair, BVSc(hons), DACVECC

info@SonoPath.com