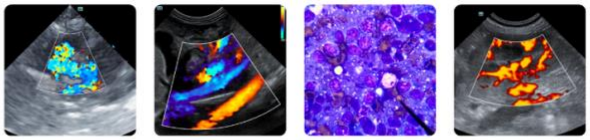


PATIENT

Bernie Fraser

SPECIES

Canine

BREED

Shih Tzu

SEX

Neutered Male

AGE

11 Years 6 Months

WEIGHT

7.1 kg

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Maher

HOSPITAL NAME

Eagleson Veterinary Clinic

REFERRING VET

Dr. Boules

INVOICE

16376

DATE

05/20/26

PRESENTING CLINICAL SIGNS

Presented for recheck following visit 2 days ago for vomiting and diarrhea. Patient was discharged on gabapentin, metronidazole, and probiotic. Client reports patient is still not eating and continues to have diarrhea despite treatment at home.

Abnormal PE/Chem/CBC/UA Results: Previous bloodwork showed elevated pancreatic lipase: 326 (0-200) CBC: mild anemia, monocytosis. Chem: elevated globulin; mild ALP; TBIL 20 (0-15).

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 kidneys have a smooth capsule and with hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. Pinpoint areas of cortical mineralization. The left kidney measured 4.22 cm in length. The right kidney measured 4.91 cm in length.

Adrenal Glands

Both adrenal glands were visualized and recognized as having normal shape, size, position and echogenicity for this breed and age. The visible phrenic vasculature was unremarkable. The left adrenal gland measured 1.75 cm in length and 0.51 cm at the caudal pole and 0.46 cm at the cranial pole. The right adrenal gland measured 0.91 cm in length and 0.55 cm at the caudal pole and 0.59 cm at the cranial pole.

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

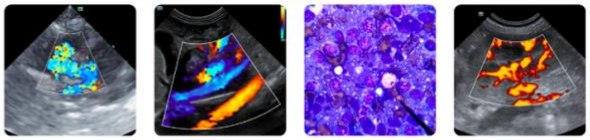
The liver is subjectively of normal size, with slightly irregular/rounded liver margins. Parenchyma is diffusely mildly coarse, with multifocal variably sized hyperechoic nodules noted throughout the parenchyma. No specific masses are visualized.

Gall bladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally.

Gastrointestinal

The stomach contains minimal luminal contents. 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.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall



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layering maintaining the typical 1:3 muscularis: mucosa layer ratio. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was not visualized. The colonic wall is mildly thickened and slightly hypoechoic, with maintenance of wall layering.

Pancreas

The visible pancreas was observed to be largely isoechoic to surrounding omental fat.

Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

Free Abdomen

No masses or free fluid were noted.

ULTRASONOGRAPHIC FINDINGS

- Mild colonic thickening consistent with acute colitis.
- Coarse liver with hyperechoic nodules and slightly irregular margins- likely chronic aging change.
- Degenerative renal changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Mild colonic wall thickening is consistent with reported signs of acute colitis. No underlying cause of GI signs was identified on ultrasound. Consideration for dietary indiscretion, infectious etiologies (bacterial, viral, parasitic), food sensitivity/allergy or mild inflammatory bowel disease is reasonable. While not sonographically evident, pancreatitis cannot be completely ruled out. Empiric treatment for GI signs including anti-nausea, appetite stimulant and fluid support as clinically indicated is warranted. A diet trial with hydrolyzed protein or select protein diet could be considered if food sensitivity is suspected clinically. If signs are persistent or recurrent, additional diagnostics to be considered include baseline cortisol +/- ACTH stimulation test, GI panel (TLI/PLI/cobalamin/folate), fecal pathogen panel, thyroid testing, bile acid profile, and thoracic radiographs to rule out occult neoplasia, cardiac disease and esophageal disease as potential causes. Ultimately GI biopsy may be required for more definitive diagnosis if the patient is not responsive to medical treatment.

Liver changes are a common benign age-related change, but infiltrative disease (lymphoma, MCT, other) cannot be definitively ruled out. In the face of elevated liver enzymes, fine needle aspirate is recommended to further characterize parenchymal changes, and bile acid profile to assess liver function, especially if any weight loss is noted or for baseline cytological assessment. Ultimately liver biopsy is often required for more definitive diagnosis. Empiric treatments (SAM-E, milk thistle, Vitamin E, ursodiol if bilirubin elevated or gallbladder sludge) could be tried and liver enzymes re-evaluated, especially if liver FNA does not show significant pathology before more invasive liver sampling is pursued.

Renal changes are likely age-related degeneration. Correlate clinical significance with semi-annual blood work/urinalysis findings and clinical signs.

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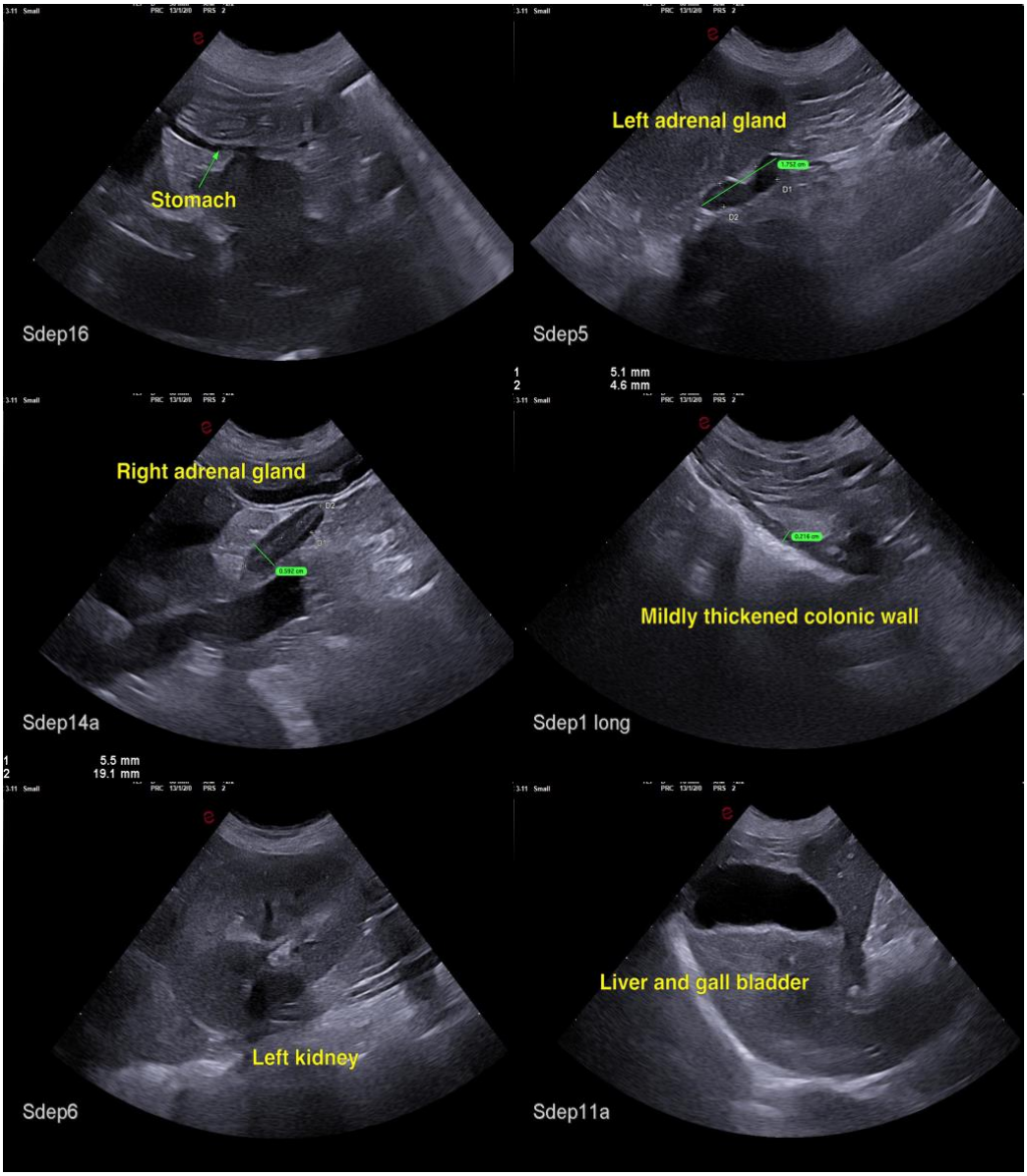

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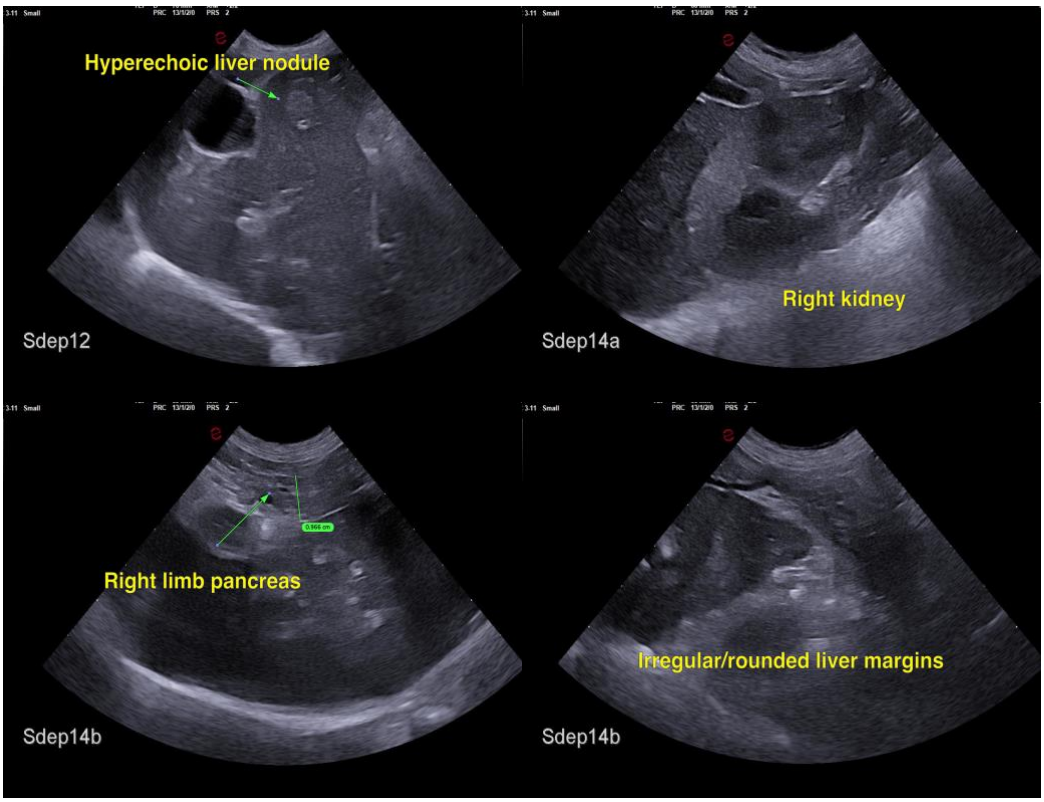

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC

info@SonoPath.com