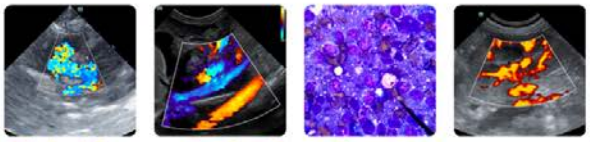


PATIENT

Dougie Cueto

SPECIES

Canine

BREED

Fox Terrier

SEX

Neutered Male

AGE

14 Years

WEIGHT

18 lbs

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Megan Cassels-Conway, DVM

HOSPITAL NAME

Central Broward Animal Hospital

REFERRING VET

Megan Cassels-Conway, DVM

INVOICE

71959

DATE

11/19/25

PRESENTING CLINICAL SIGNS

Presented for 2nd opinion for chronic diarrhea for over 2 months. Currently on Royal Canin GI LF, fortiflora and tylan powder with diarrhea controlled. Recurs every time tylan is stopped. Liquid diarrhea with increased frequency. Previously treated with metronidazole with no response. Past 4 days appetite mildly decreased, panting and seems uncomfortable. PU/PD per owner chronically. Chronic hypercalcemia of at least 2 years duration. History of urinary cystoliths.

Abnormal PE/Chem/CBC/UA Results: 11/19/25 CBC/chem/T4/UA pending GI profile to Texas A&M pending Cadet BRAF pending 11/14/25 Fecal keyscreen pcr undetected 9/7/25 CBC WNL Chem: Ca 13.1, ALT 172, ALP 248 T4 WNL UA: 1.013, 1+ protein, 3+ epithelial cells 4dx: NEG iCa: 1.63 (1.25-1.5) Fecal O&P 9/9/24 CBC mild monocytosis Chem Ca 12.8

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall appears mildly diffusely thickened and irregular, with a focal mass effect/polypoid lesion near the trigone measuring 0.40 cm x 0.83 cm. There is dependent mineralized debris/small calculi visualized in the dependent portion of the urinary bladder. On some views this is also visualized in the trigone region/proximal urethra, possibly consistent with mobile debris.

The visualized areas of prostate and surrounding tissue appear normal. Unfortunately, the prostate is not fully visualized likely due to its intrapelvic location. Correlate with rectal exam findings.

The left kidney has a normal shape and size (4.49 cm) with numerous pinpoint non-obstructive nephroliths. Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.74 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

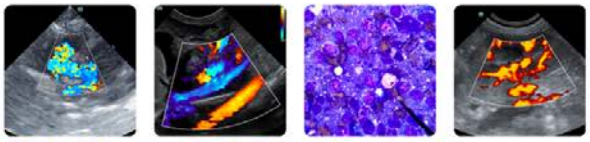
Adrenal Glands

The left adrenal gland is normal in size measuring 0.30 cm at the cranial pole and 0.48 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.55 cm at the cranial pole and 0.48 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is normal in size and shape. The blood flow through the hilus and splenic parenchyma appears normal. There is a hypoechoic nodule visualized in the head of the spleen measuring 0.73 cm in diameter.



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Liver

The liver is large in size, and normal in echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.7cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. Duodenum wall measures 0.29 cm. Jejunum wall measures 0.35 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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

Pancreas

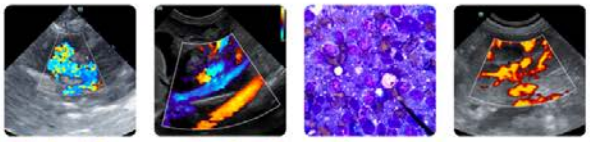
The pancreas is prominent and mottled compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. A mesenteric lymph node is visualized measuring 0.36 cm. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Mildly thickened/irregular urinary bladder wall with dependent mineralized debris and a focal mass/polypoid-like lesion – Findings are most consistent with cystitis. Recommend a urine culture. The lesion could represent a benign (polypoid) or early neoplastic transitional cell carcinoma lesion.
- Decreased corticomedullary distinction in both kidneys with numerous pinpoint non-obstructive nephroliths.
- Small, hypoechoic splenic nodule – There is a non-cavitated, hypoechoic splenic nodule visualized. Differentials include lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.



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- Pancreatic changes most consistent with chronic pancreatic remodeling +/- chronic pancreatitis.
- Large, heterogeneous liver – The appearance is most consistent with a vacuolar hepatopathy or similar. Other hepatopathies are possible.
- Large amount of debris visualized in the gallbladder – A large amount of debris is evident in the gall bladder with no evidence of a mucocele or associated inflammation at this time. This could represent an early mucocele or cholestasis, with minimal evidence of associated inflammation at this time. Continued monitoring of labwork and ultrasound are warranted for progression of this lesion. Ursodiol therapy could be considered.
- Mildly thickened small intestine – The mild small intestinal wall changes may be a normal variant in this patient or could be consistent with an inflammatory process (e.g., inflammatory bowel disease).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized associated with the GI tract to explain the chronic diarrhea reported. Based on the response to Tylosin, an antibiotic responsive diarrhea/dysbiosis would be suspected. Royal Canin has a combination hydrolyzed protein prescription diet/ultra low-fat diet. Consider a diet trial. You can also experiment with fiber supplementation, as this helps some individuals and makes some individuals worse.

Recommend probiotic therapy spaced at least two hours from any antibiotic therapy. If dysbiosis is strongly suspected, a fecal transplant could be considered.

The urinary bladder appears somewhat thickened and irregular with a focal lesion in the trigone region. This could represent a benign or neoplastic lesion. Recommend a urine culture. If an infection is present, recommend 2-4 weeks of treatment and reassessment of the mass lesion to see if it's persistent. If there is no infection present, then consider a urine BRAF test. If this is positive, this would increase the likelihood of a possible neoplastic lesion.

There is a small hypoechoic nodule in the spleen. Options moving forward would include a fine needle and continued monitoring with ultrasound.

If the PLI evaluation (on your pending GI panel) is significantly elevated, consider treatment for chronic pancreatitis.

There is a large amount of debris visualized in the gallbladder. There is no evidence of a significant mucocele at this time but consider chronic Ursodiol therapy and continued monitoring for the development of a mucocele.

Recommend a PTH/PTHrP to further evaluate the hypercalcemia reported. This is likely contributing to the stones/debris visualized in the kidneys and bladder. Additionally recommend a digital rectal exam to palpate for any anal gland nodules and evaluation for any other mass lesions that could be associated with the hypercalcemia reported.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement (disregard if this has already been done).

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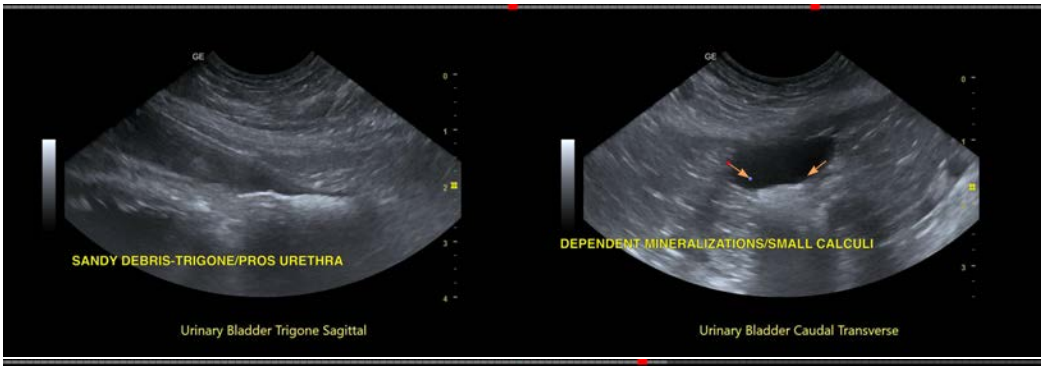

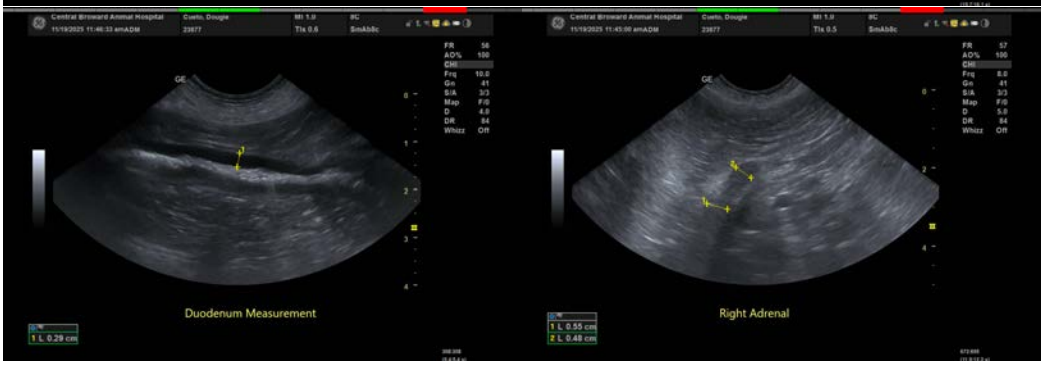

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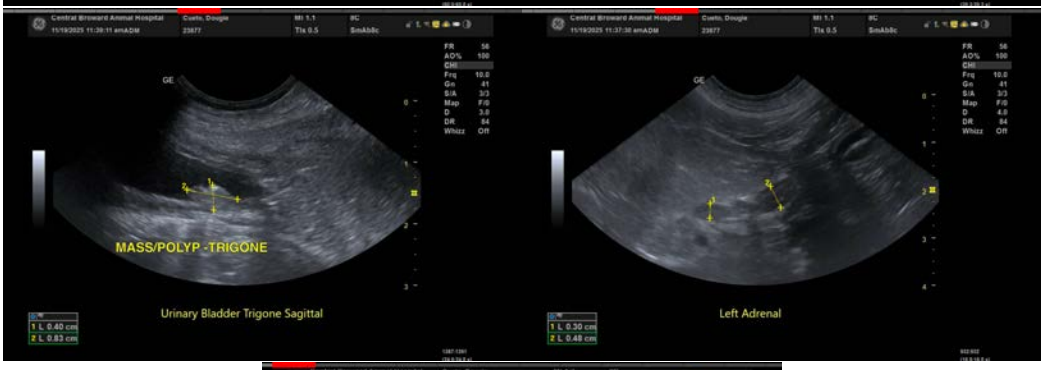

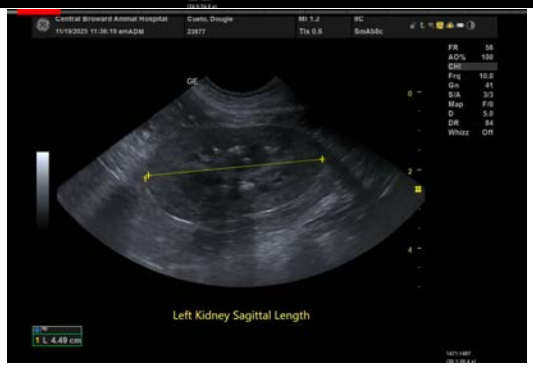

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)

info@sonopath.com