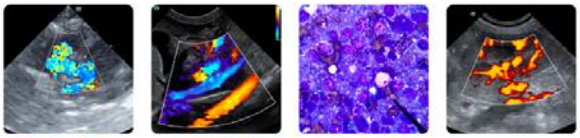


SonoPath www.thefocalzone.com info@thefocalzone.com 289.808.2608

PATIENT

Zoey Cote

SPECIES

Canine

BREED

Havanese

SEX

Spayed Female

AGE

15 Years

WEIGHT

5.7 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Simcoe Animal Hospital

REFERRING VET

Dr. Lancashire

INVOICE

71574

DATE

11/5/25

PRESENTING CLINICAL SIGNS

Here for 2nd opinion. vomiting bile/foam since early August almost daily - appetite has been decreasing and increasing since then, but appetite is almost gone for almost a week - decreased energy, uninterested in normal activities - wt loss Current Medications Prednisolone 10mg/mL - 0.55mL SID in AM ; Famotidine 5mg BID

Abnormal PE/Chem/CBC/UA Results: Previous labwork done at other clinic (we are a second opinion) - increased sodium Radiographic Findings Not done with us but we do have copies - I will send records we received with BW and radiographs Primary Question to Be Answered in This Exam Is there a reason for the vomiting and weight loss?

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The majority of the bladder wall appears to have a smooth mucosal surface and normal thickness. Towards the trigone region there is a small irregular, almost polypoid-like lesion measuring 0.77 cm x 0.45 cm.

The left kidney has a normal shape and size (4.27 cm) with pinpoint non-obstructive nephroliths and a small cortical cyst. 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 (4.12 cm). 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, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

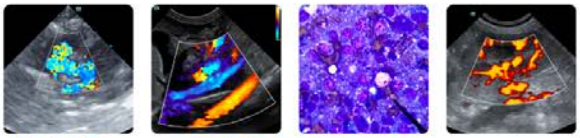
Adrenal Glands

The left adrenal gland is normal in size measuring 0.38 cm at the cranial pole and 0.41 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 1.04 cm at the cranial pole and 0.41 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 but slightly irregular in shape, measuring 1.1 cm at the hilus. The blood flow through the hilus and splenic parenchyma appears normal. There is a hypoechoic, almost cystic/cavitated appearing lesion visualized in the mid body at the border of the spleen measuring 0.51 cm x 0.73 cm.



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Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. 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 mild gas/fluid. It measures at a normal thickness of 0.55 cm 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 0.41 cm. Jejunum wall measures 0.27 cm. There is very subtle mucosal speckling visualized associated with the duodenum. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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 area of the pancreas is normal and isoechoic to surrounding 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. There is no evidence of a diffuse lymphadenopathy. A prominent pancreaticoduodenal lymph node is visualized measuring 0.70 cm x 0.66 cm. The omentum is slightly hyperechoic in the cranial abdomen.

ULTRASONOGRAPHIC FINDINGS

- Mild irregularity/polypoid looking lesion visualized near the trigone of the urinary bladder – Findings could be consistent with a benign polypoid lesion or an early neoplastic lesion.
- Age related changes visualized associated with both kidneys.
- Small, hypoechoic cystic/cavitated appearing lesion at the margins of the spleen – 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.
- Moderate gallbladder debris – The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting but seems unlikely to be causing a current issue. Recommend continued monitoring.

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- Very mild mucosal speckling visualized associated with the duodenum – Bright mucosal speckling has been postulated to represent dilated lacteals or focal accumulations of mucus, cellular debris, etc.. in the mucosal crypts.

- Prominent pancreaticoduodenal lymph node – Findings are most consistent with a reactive lymph node. An early neoplastic lymph node cannot be ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

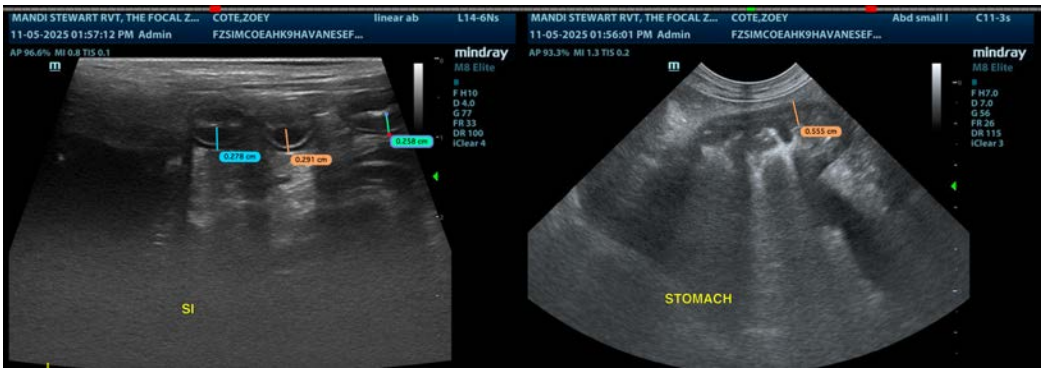
The majority of these changes are mild and of uncertain significance. A definitive cause for the vomiting reported is not visualized. Recommend repeat full biochemical profile including a urinalysis +/- culture.

There is a small irregularity visualized near the trigone region of the urinary bladder. This could represent a small polypoid lesion, an early neoplastic lesion, etc. Correlate these findings with urinalysis findings. A urine BRAF test could be considered. If this is positive, this would increase the likelihood of a neoplastic lesion. A negative BRAF test is non-diagnostic, and additional evaluation would be warranted.

Both kidneys have changes consistent with chronic age related renal disease.

There is a small, hypoechoic nodule visualized at the periphery of the spleen. This appears almost cystic/cavitated. A fine needle aspirate could be considered, although there could be some mild risk for hemorrhage due to its thin-walled nature. If sampling is pursued, recommend passing through splenic tissue prior to sampling to reduce the risk for hemorrhage. Alternately, continued monitoring would be warranted (recheck in 2-3 months).

On some views there is very mild mucosal speckling visualized associated with the duodenum. I would typically call this normal, but in this individual, it is possible that steroid use is masking some lesions. You could consider a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate, looking for evidence of chronic gastrointestinal disease. If this is strongly suspected, then consider upper GI endoscopy to further evaluate and obtain biopsies.



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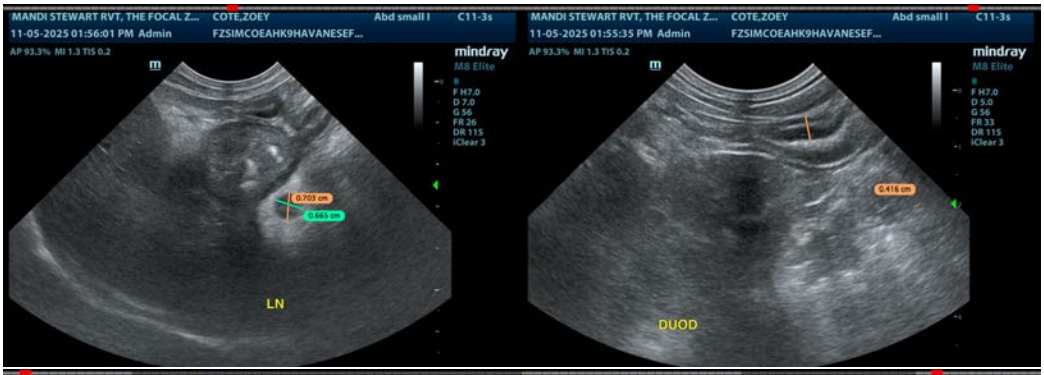

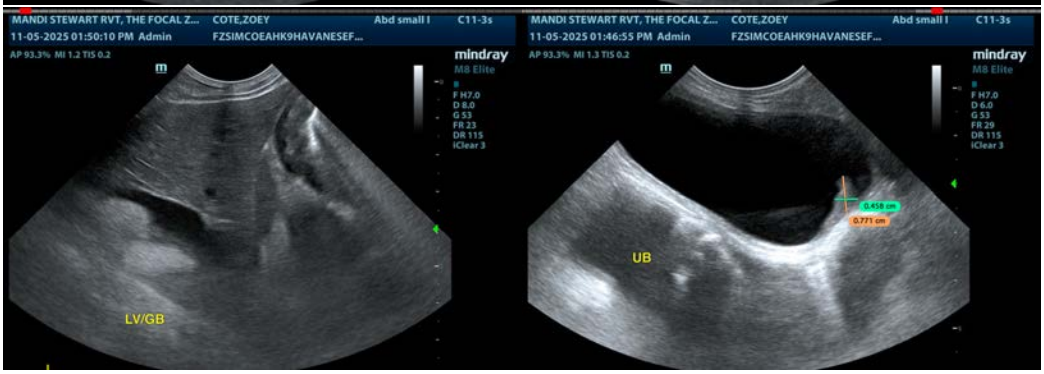

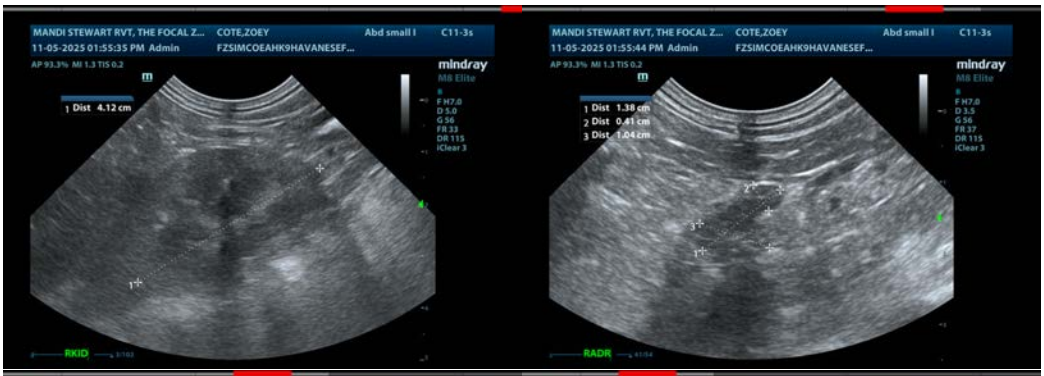

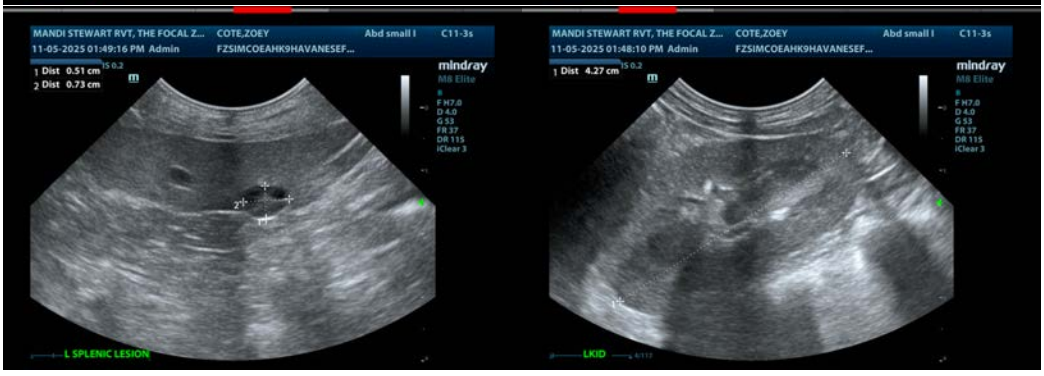

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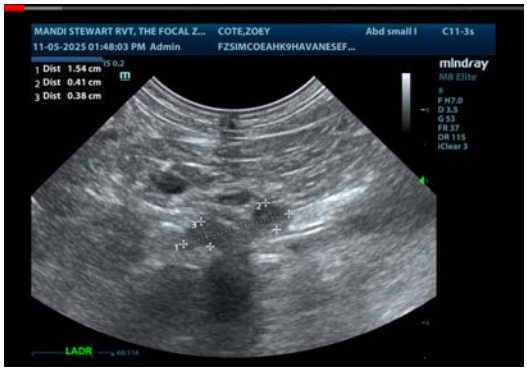

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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