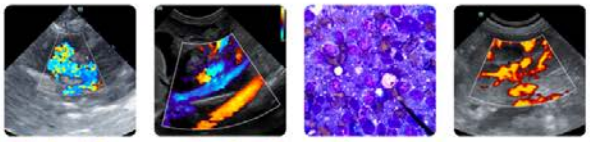


PATIENT

Sparky Gordon

SPECIES

Canine

BREED

Maltese x Poodle

SEX

Neutered Male

AGE

14 Years

WEIGHT

4.6 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Gabriel Ferrer, DVM

HOSPITAL NAME

Pulse: Pet Ultrasound

REFERRING VET

Dr. Jose Cruz

INVOICE

72304

DATE

12/3/25

PRESENTING CLINICAL SIGNS

Presented as a referral for an abdominal ultrasound to evaluate decrease appetite and Anemia. Pt has a 2 day history of decrease appetite and also discomfort on lumbar area. Diagnostics showed anemia and radiographs showed some radiopaque structure in the duodenum and some compression on L2-3. Pt has periodically diarrhea with mucus and blood (about every 5-6 weeks). Pt is currently feeding baby food beef and Hills Biome. Started prednisone orally and injection was given. Wanted to further evaluate abdomen.

Abnormal PE/Chem/CBC/UA Results: 4DX: positive for anaplasma, rest negative Radiographs and Bloodwork attached as supporting documents. CBC: HCT 34%, WBC: 17k, Neutr: 13k

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The prostate is normal in size (0.56 cm) and shape for this neutered male dog. The parenchyma is homogenous and the external margins are smooth. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (2.95 cm). Overall echogenicity is slightly hyperechoic with mildly reduced 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.

The right kidney has a normal shape and size (3.01 cm) with a small cystic lesion in the caudal pole measuring 0.34 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.

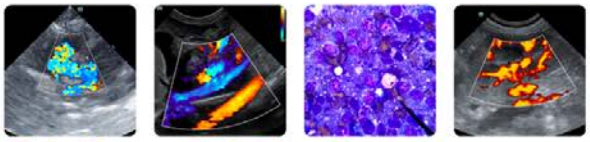
Adrenal Glands

The left adrenal gland is normal in size measuring 0.46 cm at the cranial pole and 0.50 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 0.50 cm at the cranial pole and 0.47 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 subjectively normal in size (0.70 cm), echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.



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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 focal hyperechoic shadowing material visualized within the lumen, most consistent with a large cholelith or an area of dependent mineralized debris measuring 0.39 cm. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains a large amount of fluid. 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 0.46 cm. Jejunum wall measures 0.35 cm. Visualized peristalsis appears appropriate. There are some areas of duodenum that appear somewhat corrugated and fluid distended.

The ileocecal junction was visualized and appears within normal limits. The colon appears fluid distended, and the descending colon appears mildly thickened with wall measuring at 0.21 cm with intact wall layering.

Pancreas

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, or subjective lymphadenomegaly. 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

- Age related changes visualized associated with both kidneys.
- Mineralization/cholelith visualized within the gallbladder. No evidence of wall thickening or significant liver enzyme elevations are present at this time.
- Large fluid distended stomach – Findings are suggestive of gastric ileus. An unseen obstruction cannot be definitively ruled out.
- Mild diffuse thickening of the small intestine with some areas exhibiting corrugation and fluid distention – Findings are most consistent with an enteritis pattern, although an unseen focal lesion or partial obstruction cannot be ruled out.

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- Non-formed fecal material with a thickened colon wall and intact wall layering – Findings are most consistent with colitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Based on the history and presentation, underlying gastrointestinal disease would be a significant concern. The colon appears mildly thickened with non-formed fecal material, and the small intestine has areas of fluid distention, corrugation, etc. Recommend empirical treatment for gastroenterocolitis as well as the following:

- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend chronic probiotic therapy.
- If not previously done, recommend parasite screening and empirical deworming.
- Consider infectious causes for chronic diarrhea.

If symptoms are persistent, biopsies of the upper and lower GI tract may be warranted. This should ideally be done off steroid therapy.

The stomach is significantly distended, most consistent with gastric ileus, although a partial outflow tract obstruction cannot be definitively ruled out. Options would include possible promotility therapy and/or decompression of the stomach with a nasogastric tube.

There is a large amount of mineralized debris most consistent with a cholelith in the gallbladder. Consider chronic Ursodiol therapy and continued monitoring for liver enzyme elevations, inflammation, wall thickening, etc.

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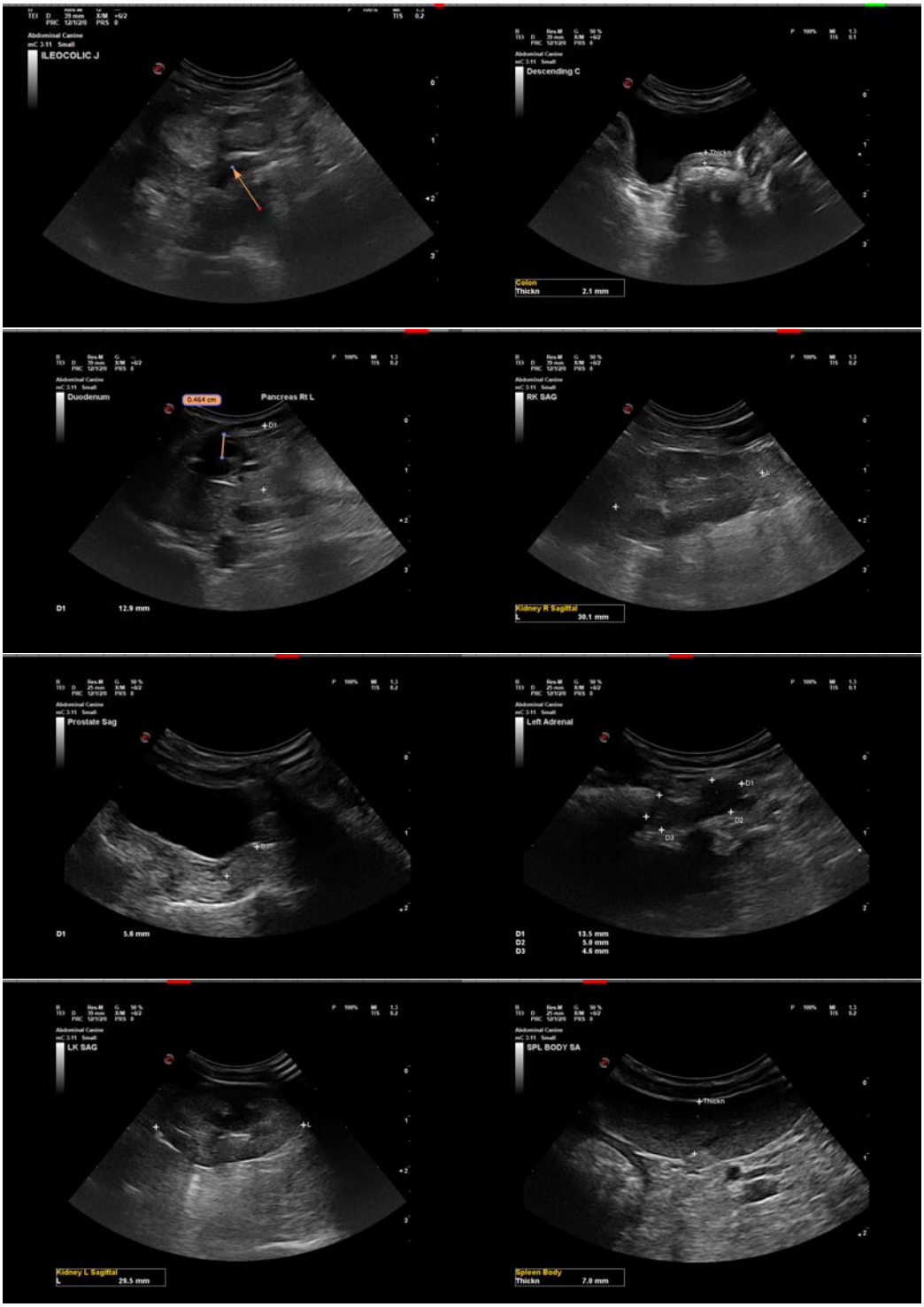

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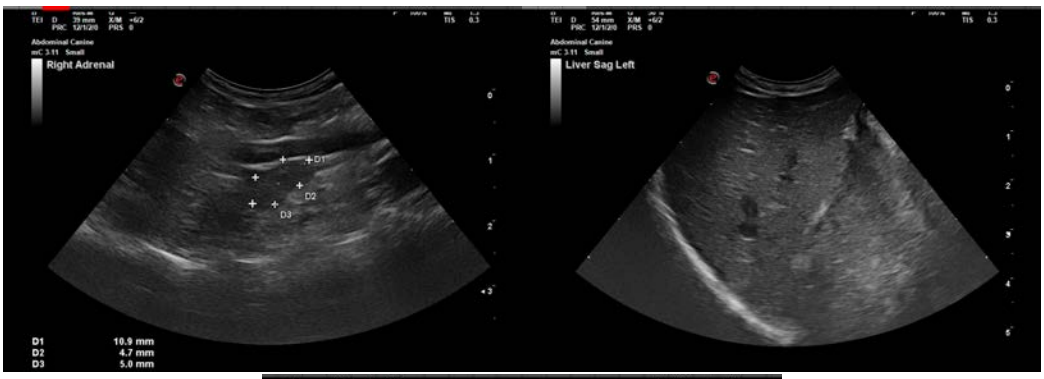

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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