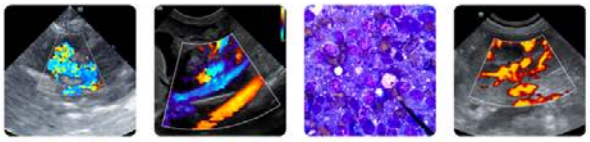


PATIENT

Kloe Lawlor

SPECIES

Canine

BREED

Beagle x

SEX

Spayed Female

AGE

13 Years

WEIGHT

14.4 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Erin Wicks

HOSPITAL NAME

Shores Veterinary Emergency Center

REFERRING VET

Dr. Law

INVOICE

72851

DATE

2/11/26

PRESENTING CLINICAL SIGNS

P ate breakfast like normal this morning and got her 12u insulin. this evening P started vomiting at 6pm and had no interest in dinner so did not get PM insulin. vomit was food/mucus then bile. P also vomited once in the lobby. P has been diabetic for 2 years and well controlled. gets BG curves Q6 months currently, last one was in October.

Previous Health Concerns diabetic, tumor right axillary region that is not getting removed b/c of diabetes

Current Medications: Novolin N 12 units BID (last dose 7 am, 7 pm dose withheld)

Abnormal PE/Chem/CBC/UA Results: Tense/hard to palpate, Tense on palpation, painful, unable to palpate organs Neutrophilia Elevated lactate Hyperglycemia at 209 Elevated BUN Hypercholesterolemia Elevated ALP Canine CPL result (ng/ml) 372.2 Radiographs: Moderately gas distended stomach, loss of serosal detail in right cranial quadrant, no obstructive pattern, irregular splenic margin, mild hepatomegaly

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The majority of the bladder wall appears normal in thickness with a smooth mucosal surface. In the mid caudal dorsal region of the urinary bladder there is some focal thickening and irregularity measuring approximately 0.74 cm x 2.0 cm, with a suspected polypoid like projection. Focal cystitis is suspected but an early mass lesion cannot be ruled out.

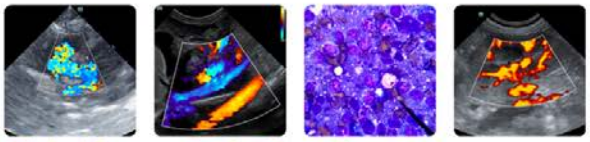
The left kidney has a normal shape and size (5.0 cm) with numerous small cortical cysts and a larger cyst in the caudal pole measuring 1.54 cm. Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (6.68 cm) with numerous small cortical cysts. 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 0.66 cm at the cranial pole and 0.70 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 large, measuring 1.15 cm at the cranial pole and 1.02 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.



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Spleen

The spleen is subjectively normal in size (2.03 cm in width at the level of the hilus) and the echotexture is homogenous. The splenic capsule is smooth with no visible irregularities. Rare discrete focal hyperechoic, perivascular parenchymal abnormalities are present. The appearance of these lesions is most consistent with benign splenic myelolipomas. The blood flow through the hilus and splenic parenchyma appears normal.

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 gallbladder wall appears somewhat prominent, measuring at 0.29 cm. Luminal contents are mild and likely incidental at this time. 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 relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. Duodenum wall measures 0.46 cm. Jejunum wall measures 0.44 cm. 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

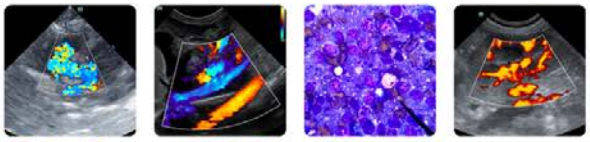
The right limb of the pancreas is prominent and mottled compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is some mildly reactive mesentery in the region.

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.

PRIMARY FINDINGS

- Focal irregularity in the dorsal urinary bladder wall – Findings could be consistent with focal cystitis/polypoid like lesion. An early transitional cell carcinoma cannot be ruled out.
- Age related changes visualized associated with both kidneys.



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- Prominent, mottled right limb of the pancreas – Findings are most consistent with chronic pancreatic remodeling +/- chronic pancreatitis.
- Large, heterogeneous liver – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy.
- Large right adrenal gland – Findings could be consistent with anatomic variation, unilateral hyperplasia or an early mass effect.

SECONDARY FINDINGS

- Peripheral hyperechoic parenchymal lesions visualized in the spleen – Findings are most consistent with benign myelolipomas. Recommend continued monitoring.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No significant abnormalities were visualized associated with the GI tract to explain the vomiting reported. The right limb of the pancreas is somewhat prominent. These findings are most consistent with chronic pancreatic remodeling +/- chronic pancreatitis. Recommend empirical treatment for chronic pancreatitis and acute gastroenteritis with close continued monitoring.

There is some focal irregularity in the dorsal wall of the urinary bladder. Recommend urinalysis and culture. If an infection is present, consider treatment and reevaluation of this region post-treatment. If no infection is present, further evaluation for possible transitional cell carcinoma should be considered (urine BRAF test, traumatic catheterization, continued monitoring with ultrasound, etc.).

The liver is large and heterogeneous. These findings are most consistent with a vacuolar hepatopathy/diabetic hepatopathy.

The right adrenal gland is large. The significance of this is uncertain. A discrete mass effect is not visualized, but this does not exclude the possibility of an early mass lesion involving the entire gland. I suspect this is not related to the current acute GI symptoms. Consider reevaluation once the patient is feeling better. If signs consistent with Cushing's are present, you could consider adrenal function testing. Additionally, recommend a blood pressure evaluation, looking for possible early pheochromocytoma. Consider reevaluation of the adrenal in 8-12 weeks, looking for any significant changes.

If GI symptoms are persistent despite empirical therapy, recommended follow up radiographs +/- repeat ultrasound, looking for a more focal lesion or the development of new lesions.

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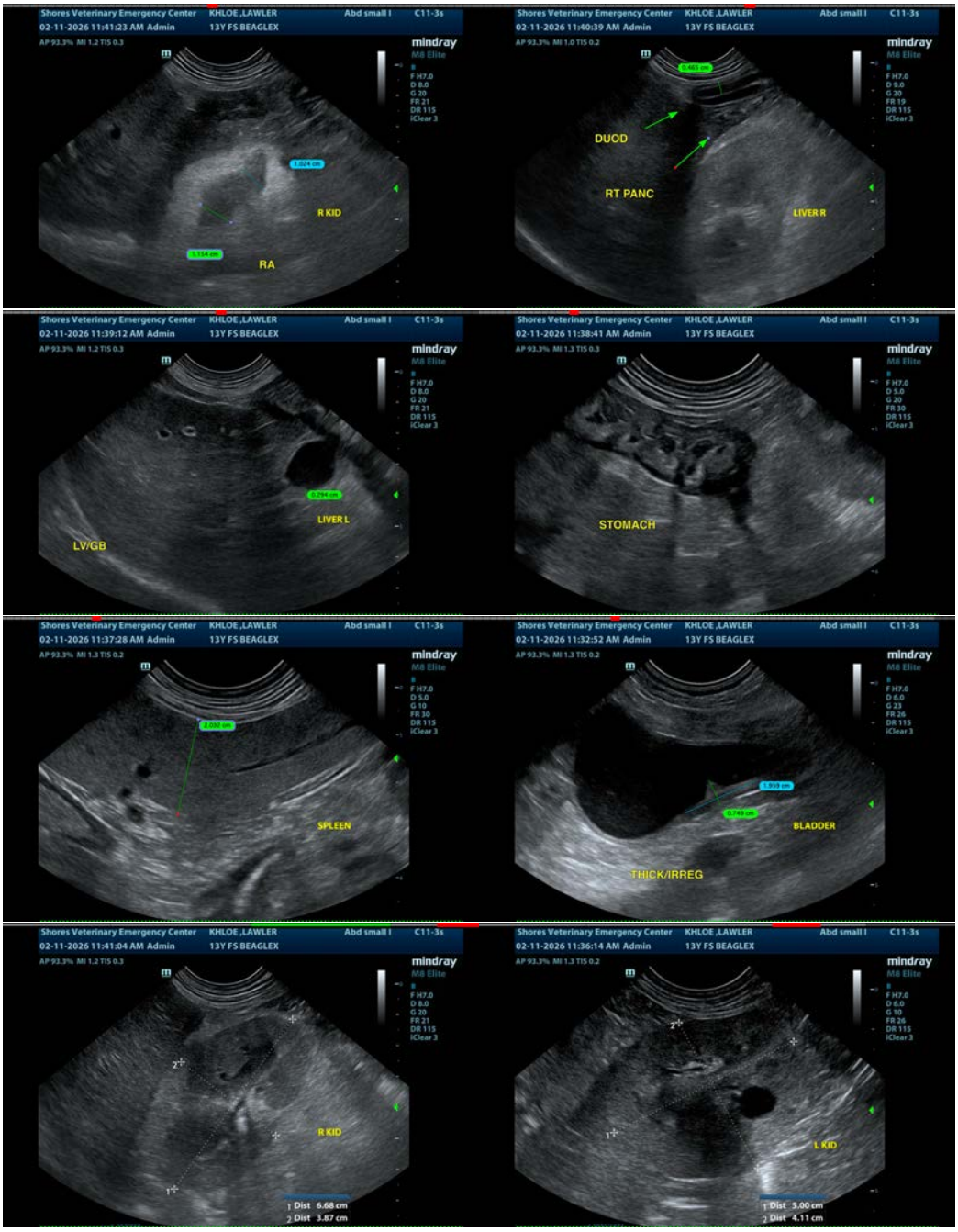

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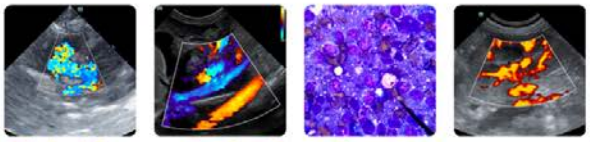

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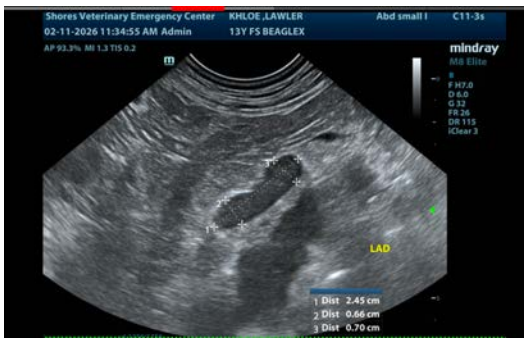

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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