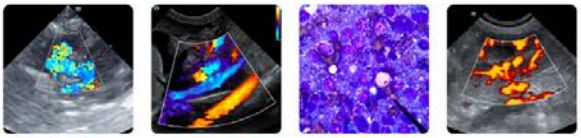


PATIENT

Abigail Lennox

SPECIES

Canine

BREED

Labrador Retriever

SEX

Spayed Female

AGE

8 Years

WEIGHT

49.8 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Meghan Morse, LVT, CVT

HOSPITAL NAME

Orchard Grove Animal Hospital

REFERRING VET

Dr. Ludmerer

INVOICE

72661

DATE

2/3/26

PRESENTING CLINICAL SIGNS

R/O causes of PLE such as end stage liver etc.

Current meds: Metronidazole

Abnormal PE/Chem/CBC/UA Results: CBC- NSF Chem- BUN 7, Calcium 7.1, TP 2.8, Alb 1.0, Glob 1.8, Alb/Glob 0.6, Chol 105, rest NSF Cortisol- 1.5 4dx negative

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 left kidney has a normal shape and size (5.85 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.

The right kidney has a normal shape and size (5.7 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 0.66 cm at the cranial pole and 0.56 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 1.01 cm at the cranial pole and 0.57 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.

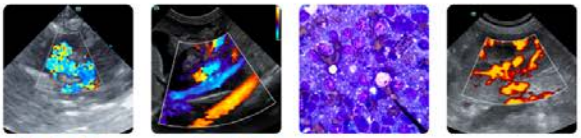
Spleen

The spleen is subjectively normal in size (1.43 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.

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. Luminal contents are mild and likely incidental at this time. The cystic and common bile ducts are normal/not visible.



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Gastrointestinal

The stomach contains mild shadowing ingesta and gas. 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. Shadowing ingesta and gas interfere with full evaluation of the stomach.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with mild to moderate fluid distension. Wall thickness is increased. Duodenum wall measures 0.51 cm. Jejunum wall measures 0.41 cm. Bowel loops follow a typical curvilinear path. There is mucosal fogging and mild mucosal speckling visualized associated with some sections of the small intestine. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The descending colon is distended with non-formed fecal material. Colon wall measures at 0.26 cm with intact wall layering.

Pancreas

The pancreas is mildly 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

There is a small amount of free abdominal fluid. No lymphadenopathy noted. The omentum is mildly diffusely hyperechoic.

ULTRASONOGRAPHIC FINDINGS

- Diffusely thickened small intestine with mild mucosal fogging and rare speckling – The bowel wall thickening could be consistent with inflammation, edema, or infiltrative neoplasia.
- Pancreatic changes most consistent with pancreatic remodeling.
- Prominent gastric wall with shadowing intraluminal contents – Correlate with the feeding history. If the patient was adequately fasted, this could represent delayed gastric emptying, ingested foreign material, etc. No evidence of an obstruction is visualized.
- Small volume free abdominal fluid.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small intestine appears diffusely thickened and fluid distended with evidence of wall edema, mucosal fogging, and some mild speckling. Findings are suggestive of a protein losing enteropathy. A focal lesion is not visualized but this cannot be definitively ruled out. The most likely differentials would be severe IBD, lymphangiectasia, or less likely intestinal neoplasia. Biopsies of the GI tract would be necessary to differentiate. If patient is stable enough, consider either surgical biopsies or endoscopic biopsies. If surgical biopsies are performed, recommend full evaluation of the GI tract, looking for any unseen focal lesions.

Recommend a liver function test and evaluation of a urine protein to creatinine ratio, looking for any concurrent hepatic or renal disease contributing to the low albumin levels reported.

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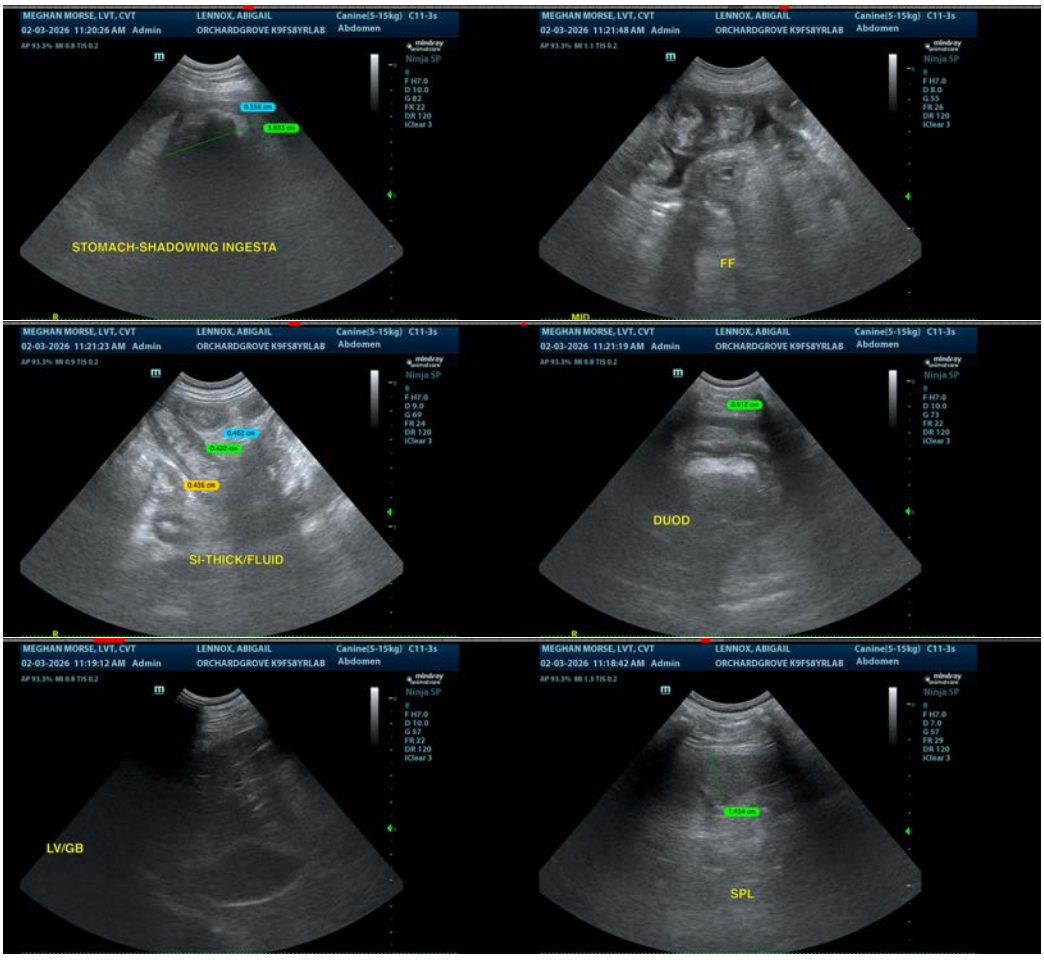
For initial empirical therapy, consider the following:

- Consider a prescription combination ultra low-fat and hydrolyzed protein prescription diet (Royal Canin has a diet with these characteristics).
- A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.
- Consider chronic probiotic therapy.

If the patient is unstable, biopsies are not an option, and dietary therapy is not effective, consider anti-inflammatory steroid therapy in efforts to stabilize the patient.



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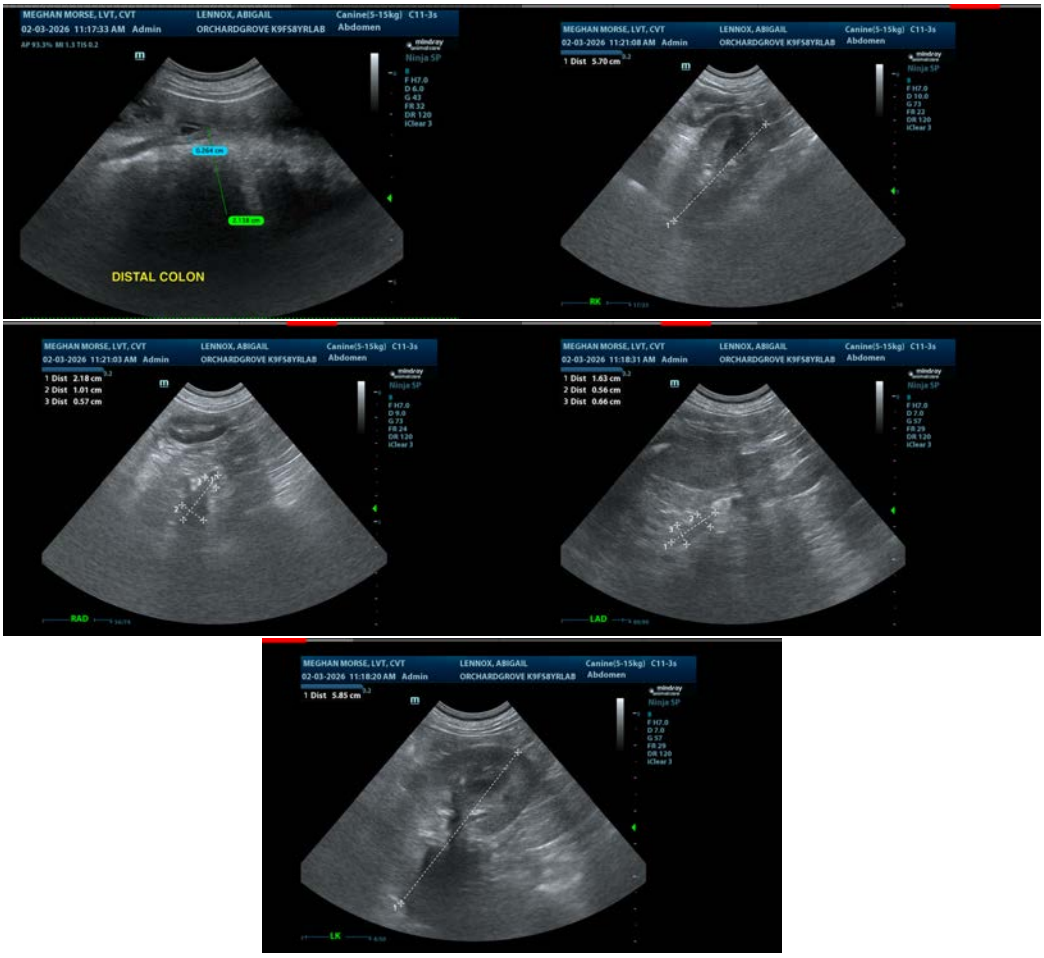

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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