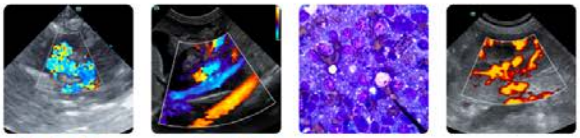

PATIENT

Bruiser Moore

SPECIES

Canine

BREED

Miniature Poodle

SEX

Neutered Male

AGE

12 Years

WEIGHT

5.8 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Kathleen Byrnes

HOSPITAL NAME

Chatham Veterinary Services

REFERRING VET

Dr. Scott

INVOICE

72755

DATE

2/5/26

PRESENTING CLINICAL SIGNS

P presented for not eating nor drinking. Sleeps all day. Offered chicken over the weekend since he wasn't eating but would vomit it back up. Has chronic history of GI upset and pancreatitis

Currently on fluids, mirtazapine, cerenia, gabapentin, proviable

Abnormal PE/Chem/CBC/UA Results: 1/28/26 ALKP 277, Amy 1528, Lip 1864, Panc Lipase 1090

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 (0.73 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 (3.09 cm) with occasional non-obstructive nephroliths, an example of which measures 0.28 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, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.13 cm) with occasional non-obstructive mineralizations. 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, 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 0.35 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 0.29 cm at the cranial pole and 0.36 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 (0.85 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 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

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vasculature and biliary tract appear normal. There are numerous ill-defined nodules in the parenchyma, examples measure 0.99 cm and 0.61 cm.

The gall bladder lumen is significantly distended. Some areas of the wall appear mildly thickened with adherent debris. There is a large amount of primarily non-organized echogenic debris. There is no evidence of bile duct dilation.

Gastrointestinal

The stomach contains mild fluid and gas. The gastric wall appears slightly prominent with intact wall layering, measuring at 0.39 cm. 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. Jejunum wall measures 0.39 cm. Visualized peristalsis appears appropriate. The small intestine appears mildly diffusely thickened with some areas exhibiting mild corrugation, suggestive of enteritis.

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, 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

- Heterogeneous liver with ill-defined hypoechoic nodules – 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. The hypoechoic nodules have the appearance most consistent with benign regenerative nodules, although early neoplastic lesions cannot be ruled out.

- Large gallbladder debris with some debris adhered to the gallbladder wall – 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 fluid distended stomach with a slightly prominent gastric wall with intact wall layering – findings could be consistent with gastritis.

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- Mildly thickened small intestine with some areas exhibiting mild corrugation – Findings are most consistent with inflammatory type change/enteritis/IBD.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

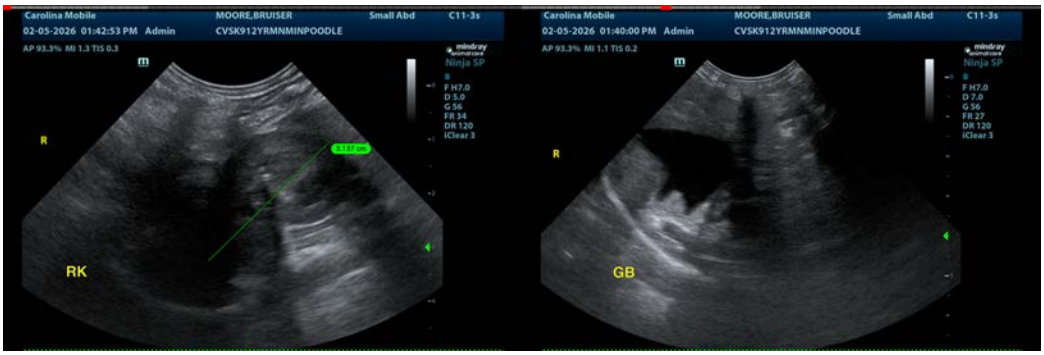
The changes observed on today's scan are relatively mild. There is some mild fluid distention of the stomach with a slightly prominent gastric wall, and similarly the small intestine appears diffusely thickened with some areas of mild corrugation. Small intestinal findings are most consistent with inflammatory type change, enteritis/IBD, etc., although other differentials are possible. No evidence of significant pancreatitis was observed, but if pancreatic specific values are significantly elevated, empirical treatment for pancreatitis is warranted. Additionally, consider 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.
- Recommend symptomatic therapy for acute gastroenteritis/pancreatitis.

If symptoms are persistent, repeat evaluation may be warranted, as eventually more significant evaluation such as GI biopsies or similar could be considered.

The liver is somewhat heterogeneous with ill-defined hypoechoic nodules. At this time this has a somewhat benign appearance, but given that the patient is not feeling well, further evaluation could include a liver function test and a fine needle aspirate of the liver (provided coagulation parameters are normal).

There is a large amount of debris visualized associated with the gallbladder without the appearance of significant surrounding inflammation. Recommend starting chronic Ursodiol therapy and continued monitoring of the gallbladder and liver values.



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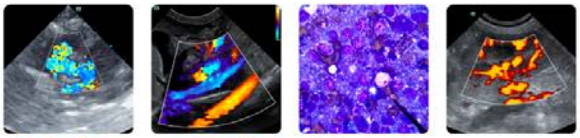

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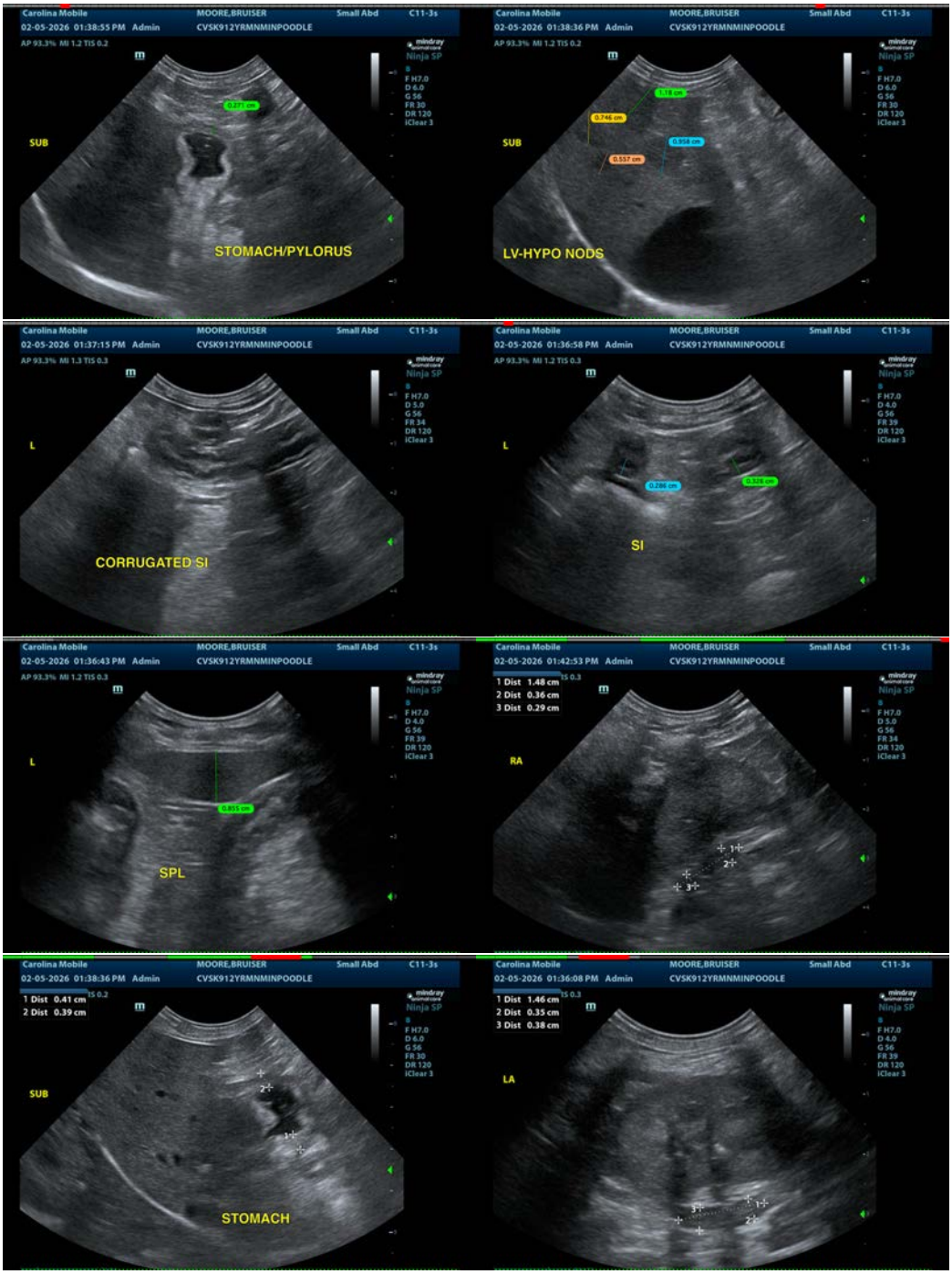

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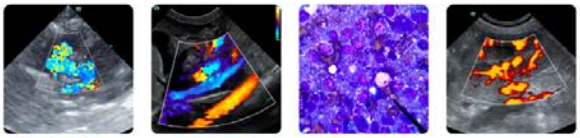

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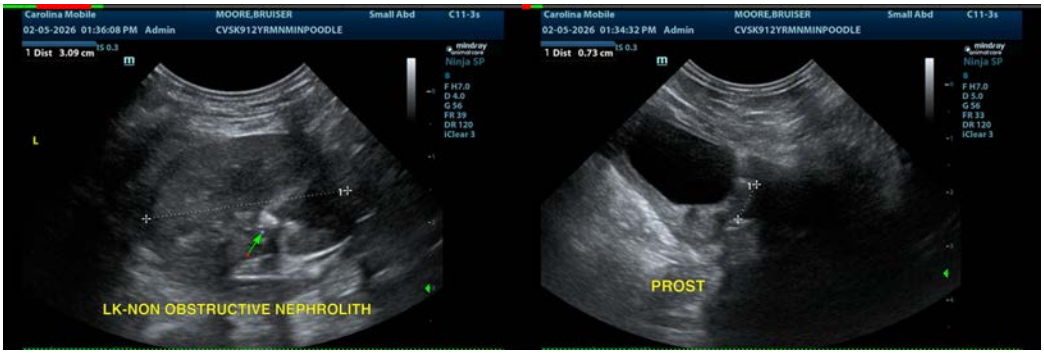

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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