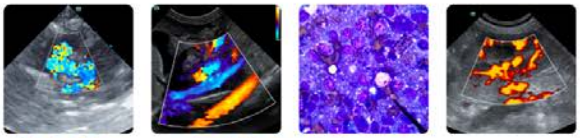

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PATIENT

Electra Slivka

SPECIES

Canine

BREED

Poodle

SEX

Spayed Female

AGE

13 Years

WEIGHT

16.2 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Kathleen Byrnes

HOSPITAL NAME

Northwood Animal Hospital

REFERRING VET

Dr. Slivka

INVOICE

73743

DATE

3/17/26

PRESENTING CLINICAL SIGNS

P presented for US due to 2-3 week history of weight loss, decreased appetite and soft stool. some coughing about 3 weeks ago that resolved

Rad report- possible small volume peritoneal effusion, Mild diffuse bronchial pattern lungs.

Abnormal PE/Chem/CBC/UA Results: WBC 50.9 Neu 44283, Bands 509, Monocytes 4072, PLT 870 Glu 51 Crea 0.4, BUN 4, Ca 7.8, TP 4.3, Alb 1.5, ALP 687, Lipase 310 Path review of CBC Inflammatory leukogram, thrombocytosis

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 (4.86 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 (4.75 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 0.61 cm at the cranial pole and 0.64 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 0.54 cm at the cranial pole and 0.52 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 (1.0 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 vasculature and biliary tract appear normal. There is a poorly defined hyperechoic mass effect visualized in the cranioventral region of the liver measuring 2.63 cm x 2.78 cm.

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The gall bladder lumen is mildly distended. The wall of the gall bladder is thickened, measuring at 0.21 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 mild 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 thickness is increased. Bowel loops follow a typical curvilinear path. Some areas have reduced detail of wall layering. Duodenum wall measures 0.52 cm. Jejunum wall measures 0.42 cm. There is mild mucosal speckling visualized associated with some loops of small intestine. Visualized peristalsis appears appropriate. The region of the proximal duodenum appears thickened and irregular with some areas exhibiting reduced detail of wall layering, measuring up to 0.80 cm. There is abnormal tissue visualized adjacent to this section of duodenum, possibly consistent with a mass effect or focal abnormal area in the right cranial pancreas.

Sections of colon are visualized with non-formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

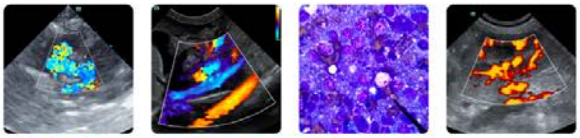
The right limb of the pancreas is prominent and mottled compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is reactive mesentery in the region of the right cranial pancreas.

Free Abdomen

There is a small amount of free abdominal fluid. No significant lymphadenopathy. The omentum is diffusely hyperechoic, particularly in the cranial abdomen.

ULTRASONOGRAPHIC FINDINGS

- Prominent, irregular, mottled right limb of the pancreas with surrounding reactive mesentery. Findings could be consistent with focal pancreatitis. A mass effect in the region cannot be ruled out.
- Large, heterogeneous liver with an ill-defined hyperechoic mass effect – 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 hyperechoic mass effect has somewhat of a benign appearance, possibly consistent with an adenoma or other primary hepatic mass lesion. A neoplastic lesion is possible.
- Thickened gallbladder wall – Findings are most consistent with edema, although mild cholecystitis cannot be ruled out.
- Diffusely thickened small intestine with some areas exhibiting mildly reduced detail of wall layering and mucosal speckling. The proximal duodenum in particular appears thickened with some irregularity – Findings could be consistent with severe inflammatory type change,



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although there is concern for the possibility of early neoplastic change +/- lymphangiectasia.

- Pleural and peritoneal effusion.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small intestine appears diffusely thickened with some areas exhibiting reduced detail of wall layering and mild mucosal speckling. Findings could be consistent with severe inflammatory change and lymphangiectasia, although the proximal duodenum appears more significantly thickened and could be concerning for a possible early neoplastic lesion. The pancreas in this region also appears abnormal, so concurrent focal duodenitis secondary to pancreatitis could be a consideration. I suspect this region of duodenum is not readily reachable for a fine needle aspirate.

The right limb of the pancreas does appear inflamed and hypoechoic, most consistent with mild pancreatitis, although there is some irregularity in the right cranial aspect near the pyloroduodenal junction, which could be consistent with a focal pancreatic abnormality or even a mass effect in the region.

The liver is large and heterogeneous with an ill-defined hyperechoic mass effect. The significance of this is uncertain, although if this is a benign lesion this could be somewhat incidental at this time. The location of this lesion is not reachable for a fine needle aspirate.

Given the appearance of today's exam, I'm most concerned about a significant enteropathy causing protein loss and a protein losing enteropathy. This could be secondary to severe IBD and lymphangiectasia, although there are some irregularities to the proximal duodenum, which could be concerning for an early neoplastic process. Typically, biopsies are necessary to differentiate. Consider the following for stabilization:

- Recommend a combined prescription ultra low-fat and hydrolyzed protein prescription diet (Royal Canin has this combination).
- 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.
- Probiotic therapy.
- Recommend a urinalysis +/- urine protein to creatinine ratio to rule out any concurrent proteinuria contributing to the hypoalbuminemia reported and pre- and post-prandial bile acids to assess for abnormal liver function.
- Recommend empirical treatment for pancreatitis and gastroenteritis.

If the patient doesn't stabilize with these steps (in addition to supportive care and thoracocentesis if necessary), then you may need to consider an anti-inflammatory dose of steroids (0.5 mg/kg per day of Prednisone). If the patient can be stabilized, you could consider a contrast CT scan to further evaluate the liver lesion and the proximal duodenum, and/or surgical biopsies with the knowledge that the Prednisone could somewhat mask the appearance of these lesions.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement (disregard if this has already been done).

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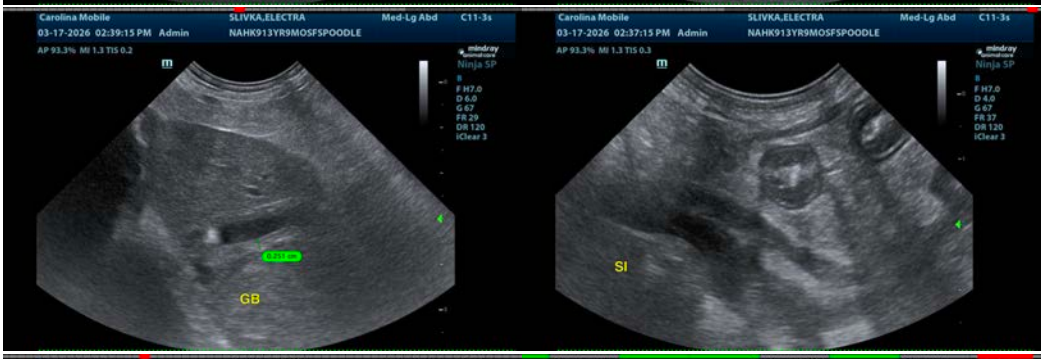

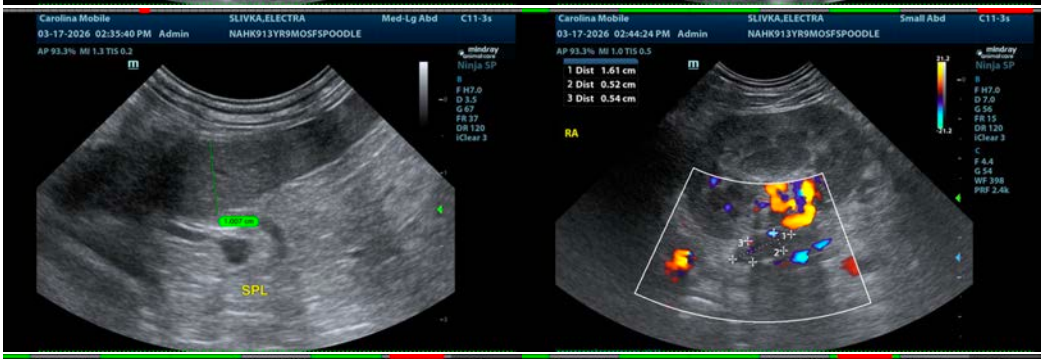

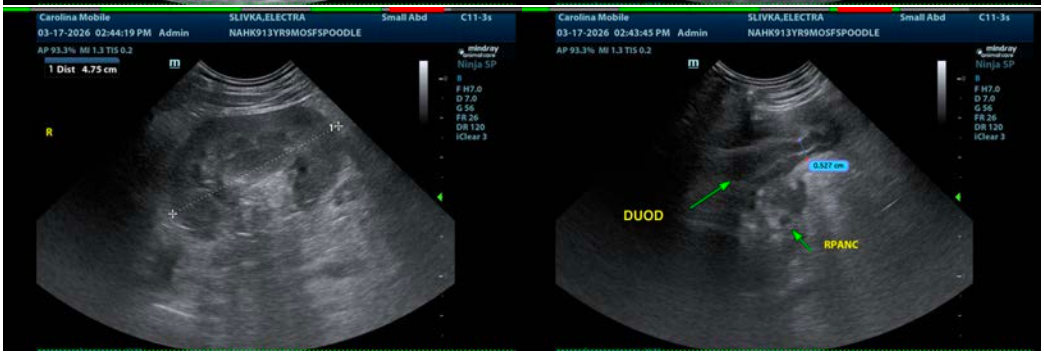

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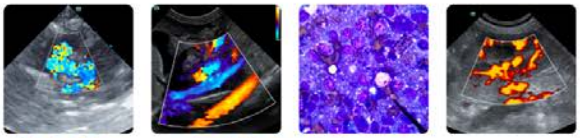

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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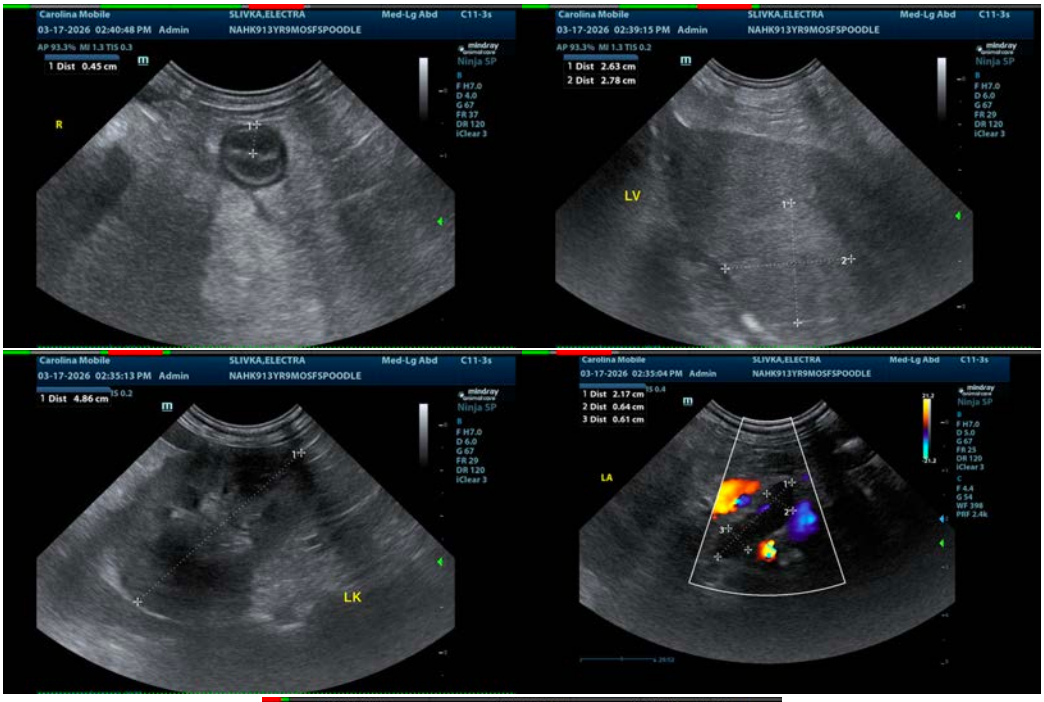

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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