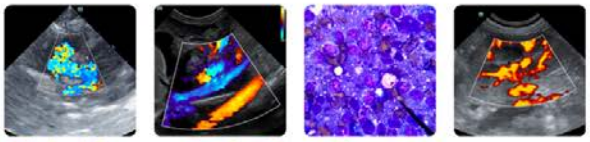


PATIENT

Skye Taplin

SPECIES

Canine

BREED

Catahoula Leopard Dog

SEX

Spayed Female

AGE

10 Years 6 Months

WEIGHT

65.6 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Amanda Crook – SDEP Clinical Sonographer

HOSPITAL NAME

River's Edge Pet Medical Center

REFERRING VET

Dr. David Gray

INVOICE

73814

DATE

3/19/26

PRESENTING CLINICAL SIGNS

Patient presented Tuesday night ADR hyperemic painful on the right side near a mass that now had enlarged and had peripheral edema around it abdomen slightly distended increased respiratory rate blood work and x-rays at that time for the most part within normal limits mildly dehydrated concerned about mast cell as a differential started antihistamines subcu fluids Cerenia and gave a dose of Buprenex to get the patient comfortable owners to start Pepcid

Patient returned to next morning still hyperemic more swelling around the mass on the right side chest wall still hyperemic rechecked films chest abdomen and blood work no major changes repeated diphenhydramine started IV fluids fine-needle aspirate of the mass now that antihistamines has been started in house review possible mast cell pathology review by OSU degranulated mast cells likely no organisms seen in the sampling started steroids Cerenia Buprenex vitamin K and Unasyn

Abnormal PE/Chem/CBC/UA Results: CBC chemistry mild inflammatory mild dehydration pancreatic lipase okay coags not done yet fine-needle aspirate of the mass on the right side of the chest wall positive for degranulated mast cells no organisms noted Current Medications: Cerenia diphenhydramine Dex SP Unasyn IV fluids vitamin K Pepcid Buprenex Radiographic Findings: Mild to moderate loss of detail in the abdomen (See attached)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is significantly 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.

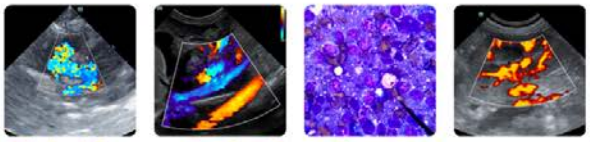
The left kidney has a normal shape and size (5.67 cm) with mild pyelectasia at 0.70 cm. Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (6.52 cm) with mild pyelectasia at 0.20 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 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 0.55 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 0.95 cm at the cranial pole and 0.56 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 normal in size and shape. The blood flow through the hilus and splenic parenchyma appears normal. There are at least two hypoechoic nodules in the spleen. A larger nodule slightly deviates the splenic capsule, measuring 1.29 cm x 2.23 cm. A smaller more hypoechoic nodule is visualized measuring 0.63 cm x 0.55 cm.

Liver

The liver is subjectively normal in size, and 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 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.

Gastrointestinal

The stomach contains a large amount of fluid and some shadowing ingesta. 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. On some views, the gastric wall appears mildly thickened, measuring at 0.77 cm, with intact but reduced detail of wall layering. An outflow tract obstruction is unlikely but cannot be definitively ruled out.

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. Jejunum wall measures 0.28 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 pancreas is visible/mildly mottled in the left limb. 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. There are occasional slightly prominent mesenteric lymph nodes. The omentum is mildly hyperechoic in the cranial abdomen.

Other

The right auricle and pericardium were visualized and were unremarkable. No obvious pathology is visualized. If cardiac function evaluation is desired a full echocardiogram is warranted.

PRIMARY FINDINGS

- Mild bilateral pyelectasia – Pyelectasia of the kidney(s)could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.

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- Two hypoechoic splenic nodules – There are several, non-cavitated, hypoechoic splenic nodules visualized. Differentials include lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.

- 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 fluid distended stomach with a small amount of shadowing ingesta and questionable wall thickening – Possible differentials include delayed gastric emptying or a partial outflow tract obstruction. Gastric wall thickening could represent image artifact, gastritis, or less likely neoplastic infiltration.

SECONDARY FINDINGS

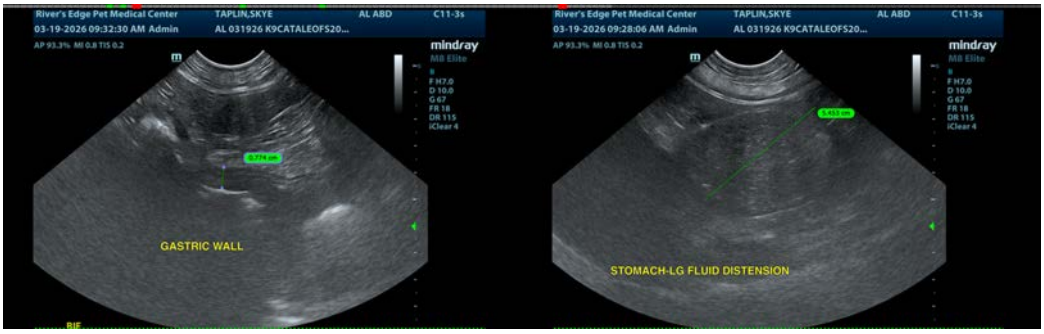
- Large, distended urinary bladder – No evidence of an obstruction is clearly visualized. Recommend walking and catheterization if the patient will not urinate.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There are two hypoechoic nodules visualized in the spleen. Recommend a fine needle aspirate to assess for the possibility of mast cell disease.

The liver is slightly heterogeneous. No focal lesions are observed. A fine needle aspirate could be considered if this is a major concern.

The stomach is severely fluid distended with a small amount of shadowing ingesta. A definitive focal obstruction is not visualized but cannot be ruled out. On some views there are areas of gastric wall that appear mildly thickened. This could be consistent with image artifact, gastritis, gastric ulceration, etc. Consider empirical treatment for gastric ulceration and ileus. Correlate with abdominal radiographs, looking for any evidence of an obstruction.



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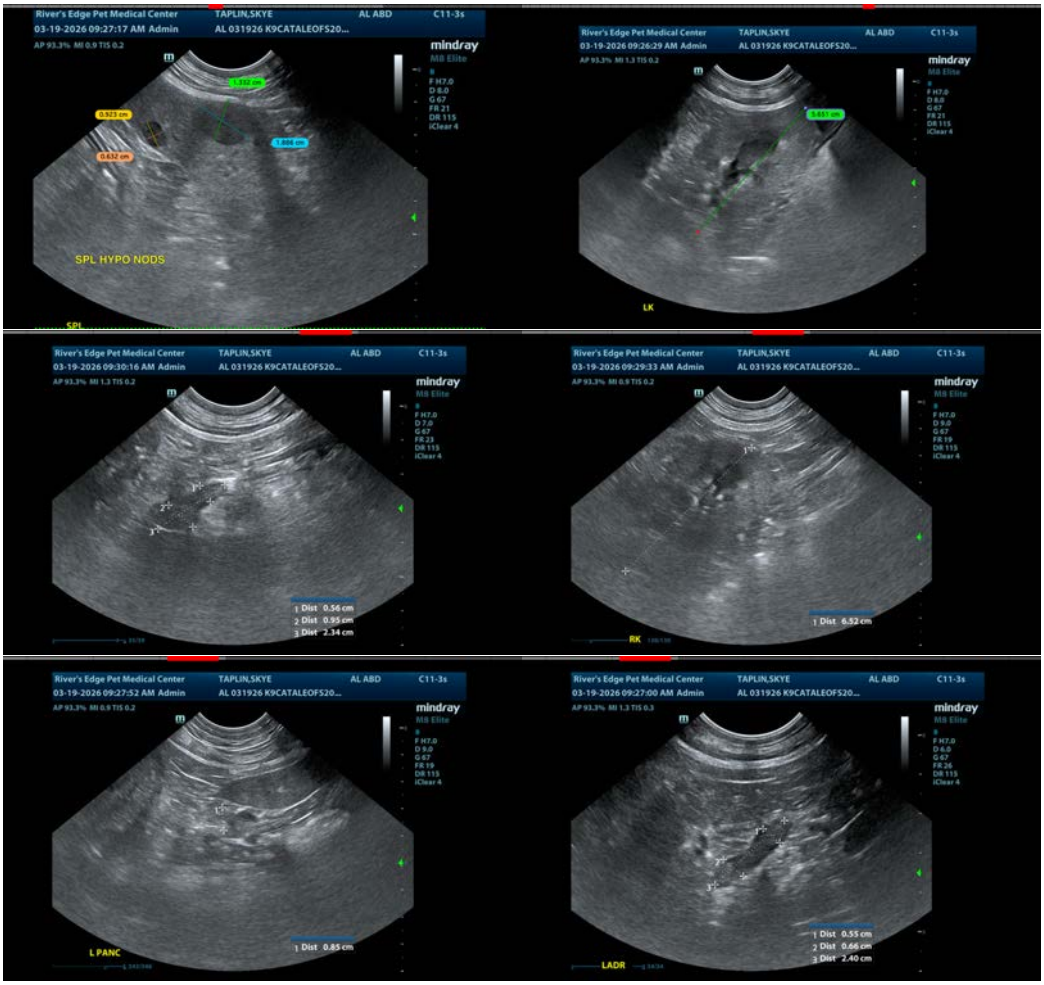

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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