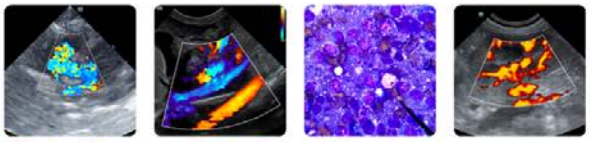


PATIENT

Bijou Harris

SPECIES

Canine

BREED

Mini Schnauzer x

SEX

Spayed Female

AGE

13.5 Years

WEIGHT

8.1 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Iacovides

HOSPITAL NAME

Tuxedo Animal Hospital

REFERRING VET

Dr. Chartrand

INVOICE

73961

DATE

3/24/26

PRESENTING CLINICAL SIGNS

Presented 3/13 for hyporexia since introduction of urinary food (had calcium oxalate stone removed last year). Had been regurgitating a few times over past 3 weeks. Timing is random and can happen 12h after eating. Kibble like material in vomitus although not sure it's kibble. Possible sensitive abdomen when owner dries her off with towel. Owner reports today: that she hasn't done this in a week and is eating better now with more canned and lest kibble

Meds: Stilbesterol 0.5mg once a week. Food: royal canine urinary and satiety and w/d canned

Abnormal PE/Chem/CBC/UA Results: Grade 2/6 murmur Slow weight loss bcs 4/9 normal tpr normal abdominal palpation

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. There is a very small amount of subtle hyperechoic dependent debris, possibly consistent with mild sandy debris. 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 (4.85 cm) with numerous shadowing non-obstructive nephroliths. 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 (4.91 cm) with numerous shadowing non-obstructive nephroliths. 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.

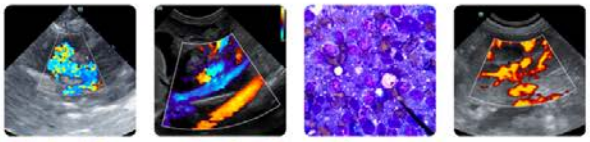
Adrenal Glands

The left adrenal gland is borderline “plump”, measuring 0.52 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 0.56 cm at the cranial pole and 0.55 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 (1.31 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.



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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 hypoechoic nodule at the periphery of the liver on the right side, which mildly deviates the hepatic margins.

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of 0.32 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. 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 0.43 cm. Jejunum wall measures 0.33 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. 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

- Mild sandy/mineralized debris in the dependent portion of the urinary bladder – This is very mild and likely incidental at this time.
- Borderline “plump” left adrenal gland with a normal right adrenal gland – Findings could represent anatomic variation or early hyperplasia.
- Bilateral non-obstructive nephroliths – The hyperechoic mineralized foci observed at the corticomedullary junction of the left/right kidney are consistent with small, non-obstructive nephroliths.
- Pancreatic changes most consistent with chronic pancreatic remodeling. Mild pancreatitis cannot be ruled out.

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- Large, heterogeneous liver with a hypoechoic nodule visualized on the right side – 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 nodule could represent a benign or early neoplastic lesion. It deviates the hepatic margins somewhat.

- Moderate gallbladder debris – The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting but seems unlikely to be causing a current issue. Recommend continued monitoring.

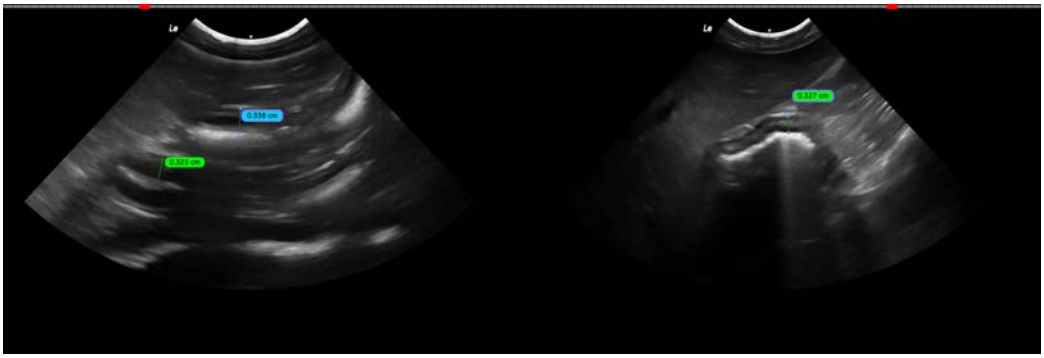
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A lesion responsible for the symptoms described is not clearly visualized. The liver is large and heterogeneous with a hypoechoic nodule on the right side. The appearance could be consistent with a vacuolar hepatopathy, although other hepatopathies are possible. Correlate with current lab work and consider workup for liver disease if this is a significant concern. The hypoechoic nodule is relatively small but does deviate the hepatic margins somewhat. Options would include continued monitoring or a fine needle aspirate (provided coagulation parameters are normal).

Consider 3-view thoracic radiographs +/- barium swallow to evaluate the esophagus for causes of regurgitation. Upper GI endoscopy could also be considered.

No significant focal lesions are visualized associated with the GI tract, although this does not rule out the possibility of underlying gastrointestinal disease. If this is strongly suspected, further workup possibly starting with a hypoallergenic diet, a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate, etc. could be considered.

Recommend full biochemical evaluation, CBC and urinalysis to evaluate for metabolic causes of these symptoms.



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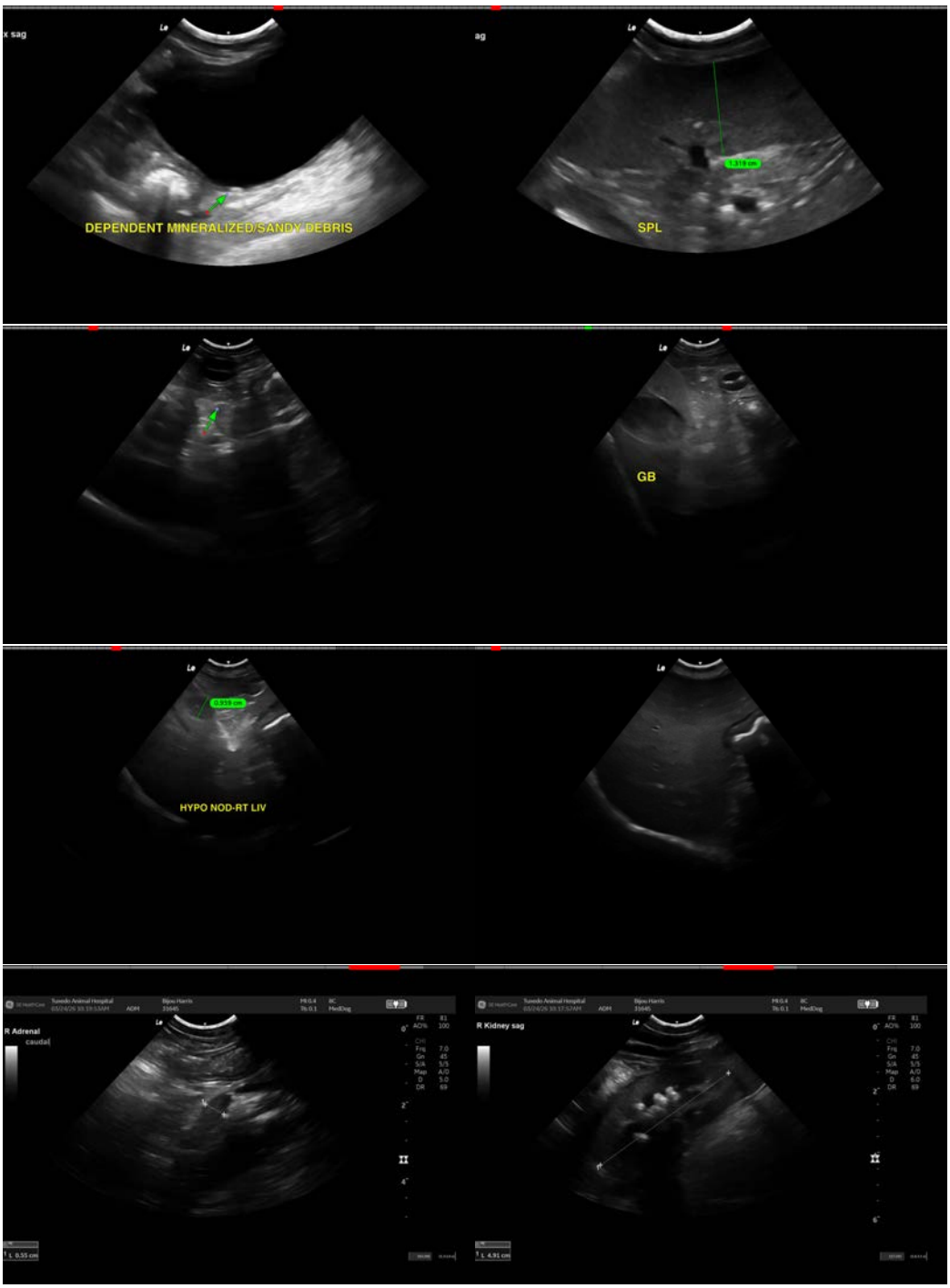

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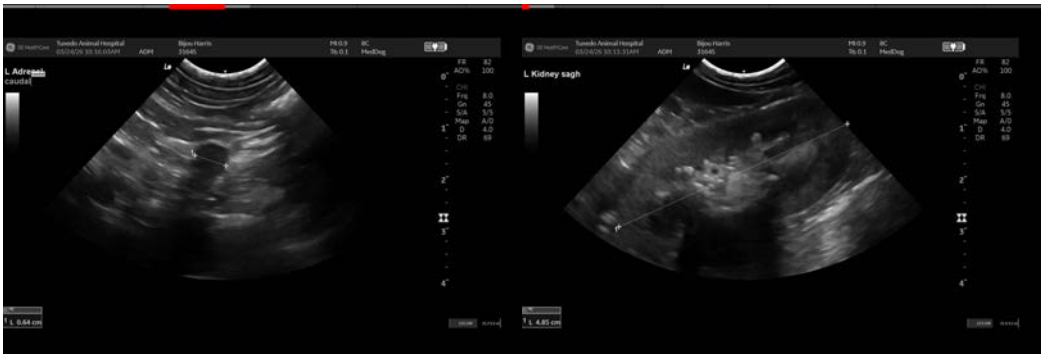

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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