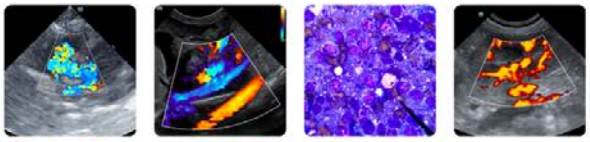


PATIENT

Shiloh Lees

SPECIES

Canine

BREED

Beagle

SEX

Neutered Male

AGE

13

WEIGHT

27.6 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Shane Stafford

HOSPITAL NAME

West Newton Animal Clinic

REFERRING VET

Dr. Shane Stafford

INVOICE

73428

DATE

3/5/26

PRESENTING CLINICAL SIGNS

Shiloh is a 13-year-old MN Beagle with a history of osteoarthritis, hypothyroidism (currently well controlled), chronic non-regenerative anemia, Sudden Acquired Retinal Degeneration Syndrome (SARDS), and possible prior seizure activity. The owner reports he is generally stable but has intermittent floor-licking behavior after eating and a history of stool irregularities, which may indicate gastrointestinal discomfort or dietary sensitivity. Recent laboratory testing showed proteinuria with a urine protein:creatinine ratio (UPC) now increased to 0.71 on pooled morning samples, raising concern for persistent protein loss and possible early renal disease. Given his chronic anemia and GI signs, abdominal ultrasound and consideration of a Texas A&M GI panel were discussed to further evaluate gastrointestinal function (including B12 status). Due to possible seizure history, minimal sedation protocols are planned for diagnostics.

Abnormal PE/Chem/CBC/UA Results: PE: Stiff gait with sensitivity to palpation of the hips and crepitus noted in the knees consistent with osteoarthritis. Dental disease present. Weight loss was noted as well. CBC: Non-regenerative anemia (RBC 4.39, HCT 29.2, Hgb 9.8) with low reticulocytes consistent with chronic disease/inflammation. Platelets elevated (537 K/µL). Chemistry: Mild hypoproteinemia (TP 5.1) with mild hypoalbuminemia (2.6). Marked elevations in pancreatic/GI enzymes including amylase (3918) and lipase (1027). Urinalysis/UPC: Mild proteinuria (1+) with UPC 0.3 (borderline proteinuria). Prior sample showed dilute urine. Findings raise concern for possible early renal protein loss; monitoring recommended. Note has had a chronic anemia for years

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 (1.17 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.

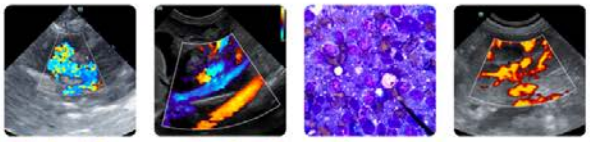
The left kidney has a normal shape and size (5.01 cm) with a small cortical cyst. Overall echogenicity is slightly hyperechoic with mildly reduced corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (5.32 cm) with pyelectasia at 0.32 cm. Overall echogenicity is slightly hyperechoic with mildly reduced 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 region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.

The region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.



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Spleen

The spleen is subjectively normal in size (1.72 cm), echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. There are pinpoint hyperechoic foci in the parenchyma, most consistent with dystrophic calcification.

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.

Gastrointestinal

The stomach contains mild/moderate 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. Correlate with the current feeding habits. If the patient was non-fasted, this could represent ingesta. Alternately, this could represent ingested foreign material, medication, etc.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal to moderate fluid/ingesta. 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 0.40 cm. Jejunum wall measures 0.30 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 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

- Age related changes visualized associated with both kidneys.
- Shadowing ingesta visualized within the gastric lumen – Correlate with feeding history. This could represent normal ingesta in a non-fasted patient. Alternately, ingested foreign material or similar could be present. No evidence of an obstruction is noted.

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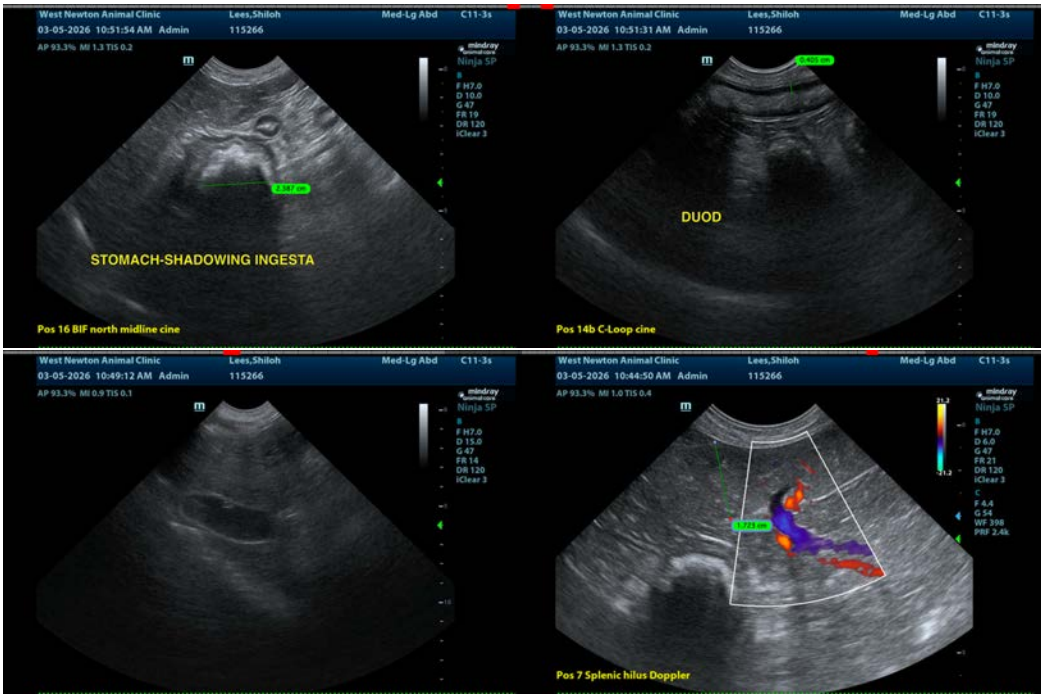
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized on today's exam to explain the anemia or GI signs reported. Unfortunately, you can still have a significant enteropathy with minimal ultrasonographic changes. If this is strongly suspected, 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.

No evidence of pancreatitis is visualized. Rarely, you can have small focal areas of inflammation that are not always readily apparent, but there is no significant evidence for this on today's exam.

If the GI panel is supportive of underlying gastrointestinal disease, you could consider upper GI endoscopy to screen the stomach for any gastric ulceration and to obtain biopsies from the proximal GI tract. The combination of low albumin and borderline low globulin levels is concerning for GI albumin loss and a possible protein losing enteropathy.



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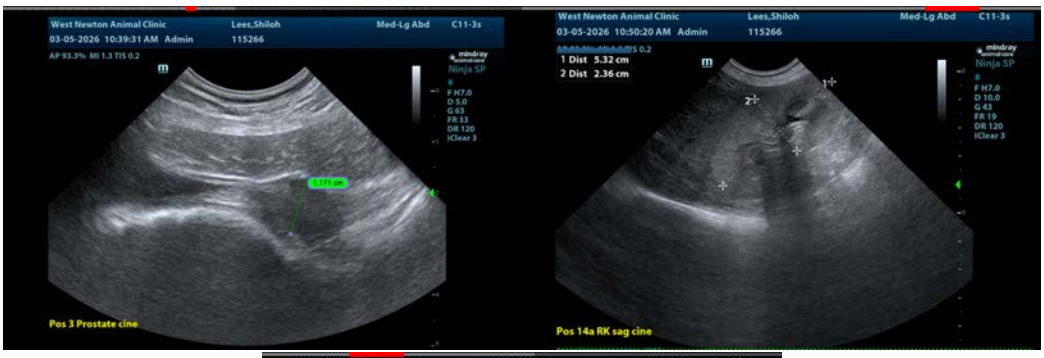

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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