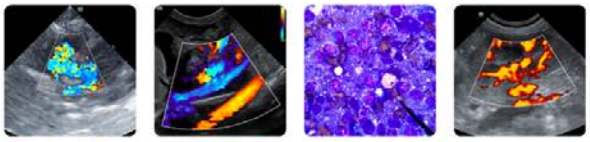


PATIENT

Bindi Norman

SPECIES

Canine

BREED

Australian Shepherd

SEX

Spayed Female

AGE

10 Years

WEIGHT

41.5 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Megan Cassels-Conway, DVM

HOSPITAL NAME

Central Broward Animal Hospital

REFERRING VET

Megan Cassels-Conway, DVM

INVOICE

74541

DATE

4/16/26

PRESENTING CLINICAL SIGNS

Presented for vomiting once last night and once this morning, bile with some food, last ate 16hours prior to vomit. Was seen in January for intermittent vomiting and diagnosed with delayed gastric emptying, resolved with adjustment of feeding for few days to smaller meals more frequently. Chronic weight loss past 6 months. Initially O decreased food as P was overweight but continued to lose weight (additional 1lb) after increased food 25% for 3 weeks. Currently underweight BCS 3-4/9.

Abnormal PE/Chem/CBC/UA Results: 4/16/26 Thoracic rads WNL Abdominal rads showed no sign of obstruction, gas distended transverse colon. Bloodwork (CBC/chem/UA, PT/PTT) pending 1/21/26 CBC: WNL Chem: Phos: 1.9L T4: 1.7 UA: SG: 1.032, 1+ prot, quiet sediment HW neg Fecal keyscreen PCR: Undetected Radiographic Conclusions/Recommendations: 1. The segment moderately gas-distended bowel is most likely a part of the ascending colon and cecum. This segment being a part of the small intestines would be less likely in the absence of any segmental dilation in the remainder of the small intestinal tract. 2. Constipation. 3. Radiographically normal thorax.

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 (5.94 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 pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (6.15 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 pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

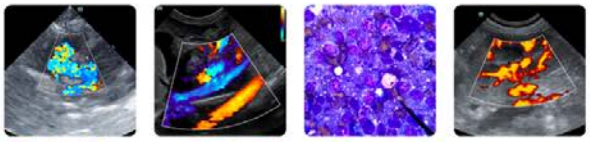
Adrenal Glands

The left adrenal gland is normal in size measuring 0.40 cm at the cranial pole and 0.47 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 0.42 cm at the cranial pole and 0.40 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 (2.06 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 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. There is a complex, slightly hyperechoic cystic/cavitated appearing lesion visualized on the right side of the liver near the gallbladder, measuring 4.03 cm x 1.67 cm. Additionally, there are numerous ill-defined hypoechoic nodules visualized on the left liver. Examples measures 1.16 cm and 0.96 cm.

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 gas. 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 appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. Duodenum wall measures 0.37 cm. Jejunum wall measures 0.32 cm. Visualized peristalsis appears appropriate. Some sections of small intestine appear somewhat “ropey” with a prominent muscularis layer.

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

There is no free fluid. There are occasional slightly prominent mesenteric lymph nodes. An example measures 0.60 cm. The omentum is of normal echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Mild age related changes visualized associated with both kidneys.
- Slightly hyperechoic complex cystic/cavitated lesion visualized associated with the liver – This could represent a benign lesion such as cystadenoma or cystadenocarcinoma. A cavitary neoplastic lesion cannot be ruled out.
- Mildly thickened/ropey small intestine – The mild small intestinal wall changes may be a normal variant in this patient or could be consistent with an inflammatory process (e.g., inflammatory bowel disease).
- Hypoechoic nodules in the left liver – Findings could be benign (regenerative nodules, etc.) or could represent an early neoplastic process.

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- Occasional prominent mesenteric lymph nodes – Findings are most consistent with reactive lymph nodes. Early neoplastic change cannot be ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small intestine appears somewhat "ropey" with a prominent muscularis layer. No focal lesions are visualized. There is a slightly hyperechoic mixed echogenicity complex cystic mass effect visualized in the liver. This could represent a benign or neoplastic lesion. If a safe window for sampling is available, consider a fine needle aspirate of a more solid region. If surgical intervention would be considered, you could consider a contrast CT scan to further evaluate. There are also poorly defined hypoechoic nodules in the left liver. These could be benign such as regenerative nodules, etc., but early neoplastic lesions cannot be definitively ruled out. If a safe window for sampling is available, consider a fine needle aspirate.

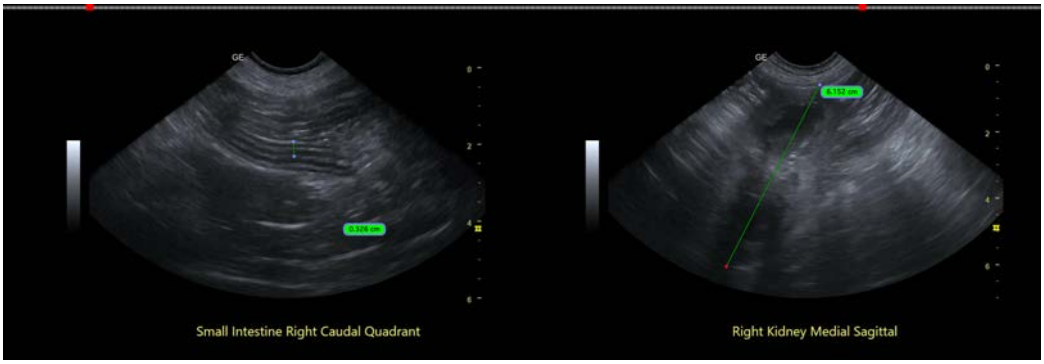
Correlate the renal changes described with current lab work and a urinalysis.

A definitive cause for the weight loss and vomiting is not clearly observed. You can still have a significant gastroenteropathy with relatively mild changes. You could 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.

If gastrointestinal disease is strongly suspected and is supported by the GI panel (B12 deficiency, etc.), then ultimately biopsies of the GI tract may be helpful to further evaluate. Consider continued monitoring of the liver lesion, looking for progressive growth/change (recheck in 2-3 months).

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



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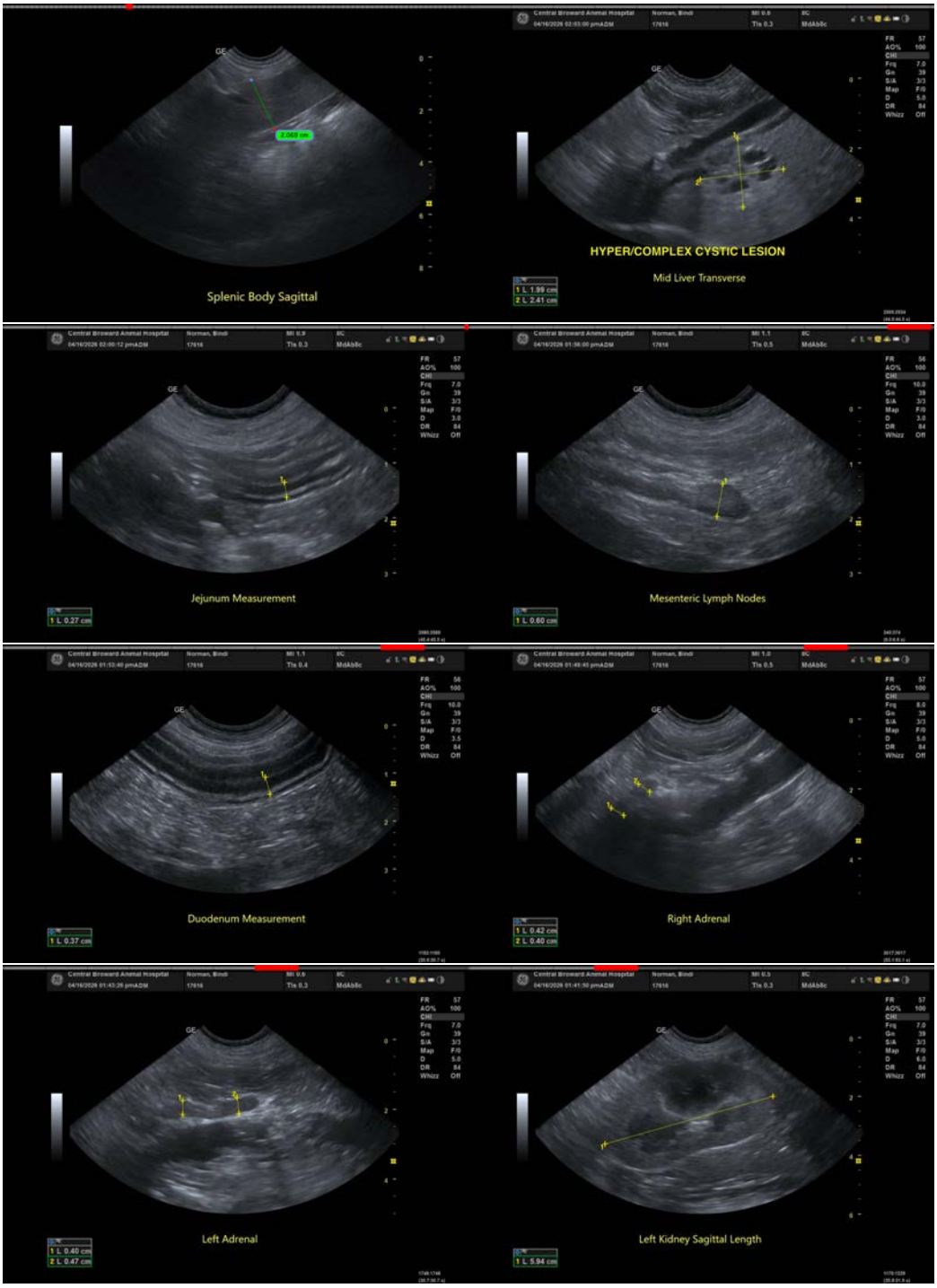

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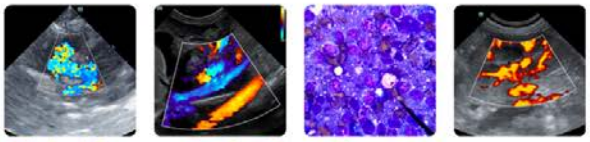

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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