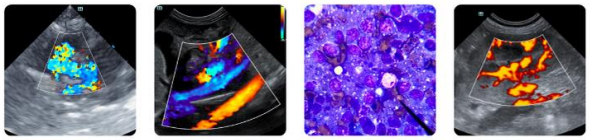


PATIENT

Boone Curtis

SPECIES

Canine

BREED

Braque Du Bourbonnais

SEX

MN

AGE

2 yrs

WEIGHT

43.2 lbs.

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY

Crissy Krell, DVM

HOSPITAL NAME

Isaacson VH

REFERRING VET

Barb Lester, DVM

INVOICE

10563

DATE

1/20/26

PRESENTING CLINICAL SIGNS

Owner says he had parasites that they treated for but then his stomach started to swell and they thought his intestines were enlarged so he was put on Prednisone and is poops never got solid and is stomach got big again. All his blood work shows low protein. Presented with signs starting November 20, 2025. Initially diagnosed with hypoalbuminemia. Treated for giardia and coccidia, has been CPD + on two of three fecal panels. Proteins have been stable but low (not progressing). On boutique diet. Stools have improved, but the abdomen still very distended. Decreasing appetite (suspect due to the fluid).

Abnormal PE/Chem/CBC/UA Results: PE: BAR, friendly, distended abdomen with ballottment. CBC: unremarkable Chem: - Total Protein: 2.8, Albumin: 1.6, Globulin: 2.2, Fecal: Coccidia and Giardia +, C. perfringens Alpha Toxin (CPA) on recent test (12/2025) Abdominocentesis: fluid clear, SpG 1.008, TP 0.2 Problems: ascites, diarrhea-chronic, r/o PLE-r/o parasitism, IBD, Neoplasic, hypoprotienemia-supsect PLE with diarrhea, but r/o PLN or liver dz XR Consult results: 1. Nonspecific peritoneal effusion. Consider transudate from hypoalbuminemia, inflammatory effusion, neoplastic effusion, hemorrhage, etc. 2. Normal thorax.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and cystourethral junction exhibited normal thickness and tone. Anechoic urine was present in the lumen with no evidence of urine or lumen sediment, mineral, or calculi. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

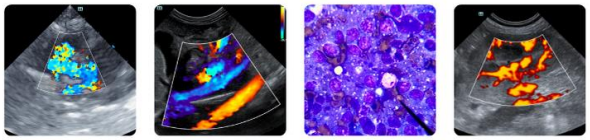
The residual prostate was symmetrically normal in size with uniform parenchyma and slight coarse echotexture.

No evidence of pathology in the area of the aortic trifurcation.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 6.5 cm in length. The right kidney measured 5.9 cm in length.

Adrenal Glands

The adrenals were subjectively borderline subnormal to flattened in appearance with symmetrical contour and homogeneous parenchyma. The left adrenal gland measured 0.41 cm width at the caudal pole. The e right adrenal gland measured 0.44 cm width at the caudal pole.



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Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver/ Gallbladder

The liver was subjectively normal in size, structure, and contour. Normal hepatic vascular volume was present. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty without evidence of retained ingesta, fluid, or foreign material.

Generalized thickened intact small intestinal wall exhibiting diffuse increased to hyperechoic mucosa echogenicity / mucosal fogging was present. Intestinal wall layering was maintained with mild altered 1:3 muscularis / mucosa ratio. Generalized empty small intestinal lumen was noted with minor segmental nonobstructive intestinal ileus. The small Intestinal wall width measured 0.60 cm. There was no evidence of an obstructive pattern or foreign material. The appearance of the small intestine is most consistent with protein-losing enteropathy or lymphangiectasia. There was no evidence of infiltrative or neoplastic intestinal disease which is considered unlikely but cannot be ruled out without full-thickness or endoscopic biopsies.

Normal visible colon wall layers were present with soft to non-formed fecal matter.

Pancreas

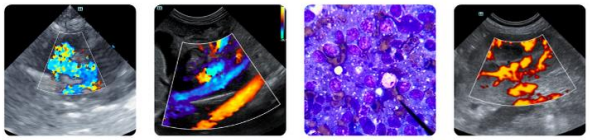
The parenchyma of the left limb, body, and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease were evident.

Free Abdomen

Moderate volume effusion was present. Generalized mild homogeneous hyperechoic mentum was noted. No significant omental lymphadenopathy was visualized.

ULTRASONOGRAPHIC FINDINGS

- PLE intestinal pattern
- Soft to non-formed fecal matter in colon
- Moderate peritoneal effusion
- Sonographically unremarkable normal volume liver
- Subjective borderline subnormal adrenal glands - nonspecific, suspect patient variant



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

IBD or other inflammatory enteropathy, lymphangiectasia, or infiltrative intestinal disease are all potentials. There is no evidence of hepatic disease or congestion in conjunction with no evidence of significant proteinuria as a contributing factor. Empirical PLE therapy which may include some or all of the following is warranted. Intestinal biopsies are required for a definitive diagnosis and may be considered if albumin level can be stabilized (>2.0). A GI panel to include PLI/TLI/Cobalamin/Folate and screening cortisol level are suggested.

Part or all of this protocol may be considered based on your clinical impression of the patient:

OBJECTIVE: keep albumin levels > 2 g/dl, avoid thromboembolism and cavitary effusions, monitor concurrent PLN (Wheaton Terrier PLE/PLN) and liver disease:
Plasma 10 mL / kilogram IV over 4 hours
Or **Human albumin** 2 ml/kg/h over 10 hours. Total daily volume 20.l/kg/day
And Colloids/Hetastarch
10 to 20 mL per kilogram per day and dogs
10 to 15 mL per kilogram per day cats
(Can bolus first 1/3 of dose over 15 minutes)
& maintain on LRS maintenance otherwise.
High colony count probiotic such as **Proviable**
Famotidine 1 mg/kg Iv Im po dc Sid /bid
Sucralfate 0.5-1 g po tid dogs, 0.5 g bid cats in slurry **Or Misoprostol** 1-5 ug/kg po tid
Diet: Highly digestible high quality protein, low fiber, low fat diet (< 15% of dry matter). Hydrolyzed protein or novel protein. Purina HA or Royal Canine HP or similar.
Prednisone or prednisolone 2 mg/kg bid x 3-5 days then 2 mg/kg sid. **Chlorambucil** in refractive severe IBD/alimentary lymphoma cases (monitor cbc for rare bone marrow suppression) 4 mg/m^2 Q 24-48 hours.
Cobalamine (B12) 250-1500 ug/dog weekly x 6 weeks.
Calcium supplementation if necessary.
Aspirin 0.5-1 mg/kg/day **or Clopidrel** (Plavix) 1-5 mg/kg/day.

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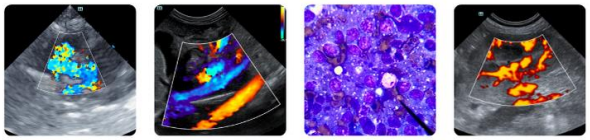

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath.com info@sonopath.com 1.800.838.4268

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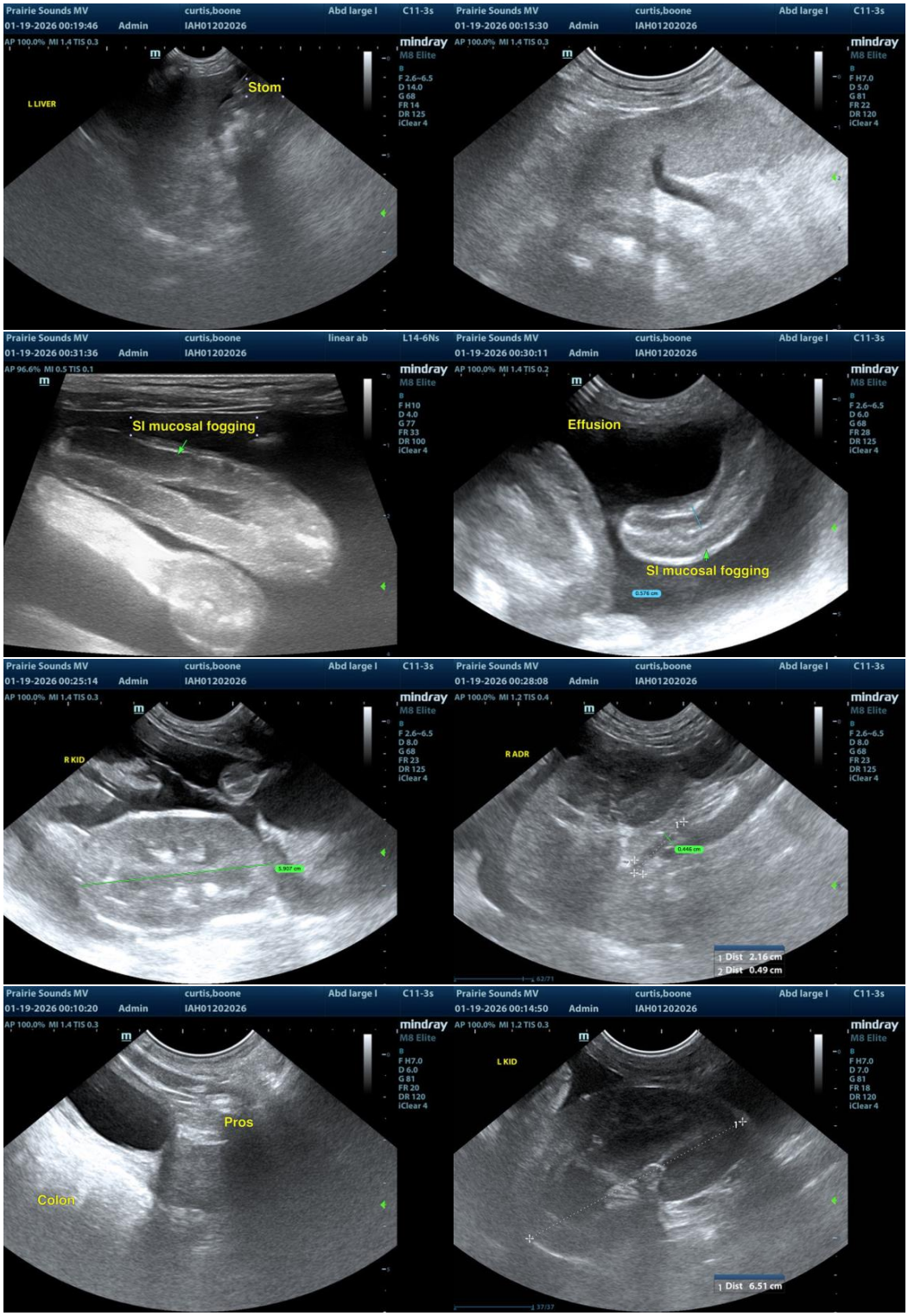

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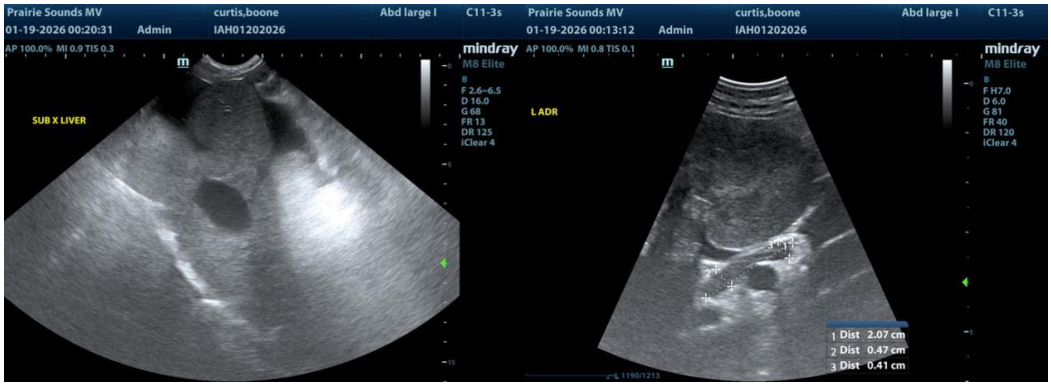

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine/Feline Practice)
info@sonopath.com