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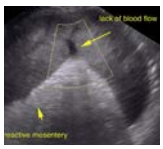
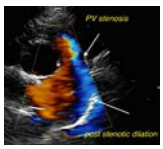
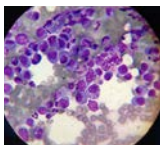
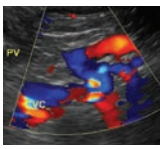





SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT
Belle Ridlon

SPECIES
Canine

BREED
Cocker Spaniel X

SEX
Spayed Female

AGE
10 Years

WEIGHT
28 Pounds

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

IMAGING PERFORMED BY
Dr. Ebersole

HOSPITAL NAME
Scanvet

REFERRING VET
Dr. Allen

INVOICE
29819

DATE
11/16/21

PRESENTING CLINICAL SIGNS

Presented 1 month ago for lethargy, inappetence, diarrhea and ocular changes. O declined further diagnostics except IOP/Fluorecein stain (Neg); elevated IOP (38 OD/55 OS). Started Cosopt, NeoPolyDex, Cerenia and Metronidazole. At recheck, eyes had improved but still loose stools and lethargic. IOP 11 both eyes. Consented to BP, on 3 separate days/multiple measurements, systolic BP 173 - 276. Started Benazepril 7.5mg SID. Still ADR, consented to BW (results below).
Abnormal PE/Chem/CBC/UA Results: PE: T-103.1, systolic heart murmur 1/6, Abd: moderate discomfort on palpation, tense in cranial abdomen. Questionable vision. Alb 2.2, Glob 4.4, SDMA 19, BUN/Creat WNL. Chol 80. ProBNP 1,002. UA SG 1.051, Prot 1+, Bili 2+ Anaplasma + (but was + in 2019 also)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. Subjective mild decreased corticomedullary echogenicity was noted with focal area of non-obstructive medullary mineral. No evidence of pelvic dilation was present. Multiple thinly walled cortical cysts were present. The left kidney measured 5.6 cm. The right kidney measured 5.9 cm.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The adrenal glands were uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 1.8 cm length x 0.52 cm at the caudal pole. The right adrenal gland measured 2.1 cm length x 0.57 cm at the caudal pole.

Spleen

The spleen exhibited subjective generalized mild enlargement, yet primarily maintained symmetrical capsule contour. Generalized parenchymal heterogeneity noted with focal, subtly expansive, hypoechoic nodule noted in the subjective caudolateral spleen measuring 1.0 cm diameter.

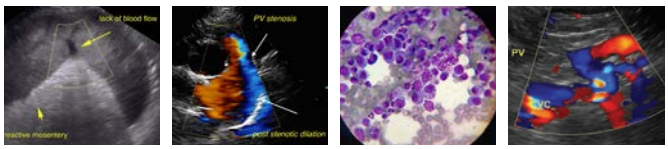
Liver

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non distended in size with mild, echogenic, nonmineralized biliary sludge. The cystic duct and common bile ducts were normal without evidence of dilation.

Gastrointestinal

The stomach presented intact yet subjective prominent wall layering with empty lumen. No evidence of retained ingesta, fluid or foreign material.

The intestinal walls demonstrated intact wall layering and maintained 1:3 muscularis / mucosa ratio. The mucosa exhibited mild decreased echogenicity with occasional mucosal speckling. A generalized mild duodenal and segmental jejunal ileus pattern noted without evidence of mechanical obstruction. No



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evidence of loss of intestinal wall layering. Duodenum wall measured 0.36 cm. Jejunum wall measured 0.23 cm.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The left limb, right limb, and base of the pancreas presented hypoechoic to heterogeneous echogenicity compared to adjacent omental fat. The pancreas was mildly prominent in size. Mild asymmetrical capsule margination was present with mild variable parenchymal swelling and mild peripancreatic inflammation. No overt evidence of neoplasia.

Free Abdomen

Several mildly prominent to enlarged hepatic and jejunal lymph nodes were present. Example of hepatic lymph node measured 2.0 cm x 1.0 cm. The lymph node was essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5).

A small pocket of scant peritoneal free fluid was noted adjacent to the spleen.

ULTRASONOGRAPHIC FINDINGS

- Bilateral mild chronic renal changes with subjective non-specific mild decreased corticomedullary echogenicity, focal minor medullary mineral, and left kidney cortical cysts
- Mild splenomegaly with generalized parenchymal heterogeneity and solitary, non-specific, subtly expansive nodule
- Hepatic parenchymal remodeling, minor gallbladder debris (non-mucocele)
- Gastroenteritis pattern – possible IBD, PLE, or infiltrative gastroenteropathy possible, although potential for gastrointestinal neoplasia is considered less likely.
- Mildly prominent hepatic and jejunal lymph nodes – hyperplasia, reactive lymphadenitis suspected. The lymph nodes were not overtly consistent with neoplastic criteria, although cannot be definitively excluded.
- Active to chronic active pancreatitis

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Potential considerations for the abnormal albumin/globulin in this patient may include mild hyperglobulinemia owing to underlying inflammatory process (i.e., pancreatitis or gastrointestinal inflammation), while the decreased albumin may be secondary to GI loss, blood loss (less likely), with compensated hypoalbuminemia given the mild hyperglobulinemia.

Protein electrophoresis could be considered for further clarification of the globulin level if persistent or increasing globulin levels noted. Assuming normal clotting status, splenic parenchymal and nodular FNA warranted for screening cytology. UPC level suggested. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended. Empirical therapy for pancreatitis and inflammatory gastroenteropathy would be appropriate.

For an additional charge, internal medicine consult can be utilized through Sonopath.com. You can select the internal medicine drop down at http://spa.sonopath.com/.

One of the world's top internists & SonoPath associate Dr. Remo Lobetti BVSc, MMedVet, PhD, DECVIM can evaluate your case through SonoPath. https://sonopath.com/resources/sonopath-services/internal-medicine-teleconsultation-services

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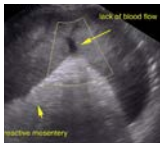
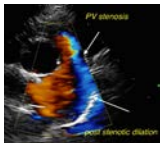
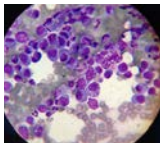
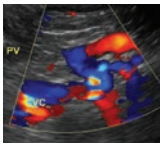

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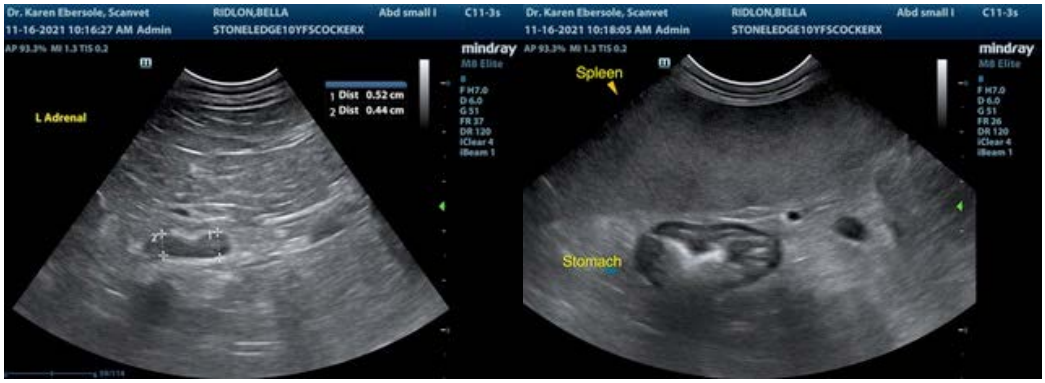

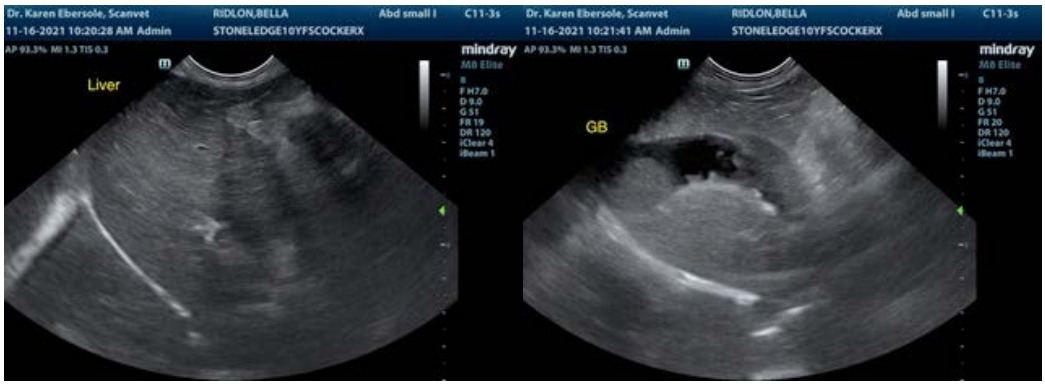

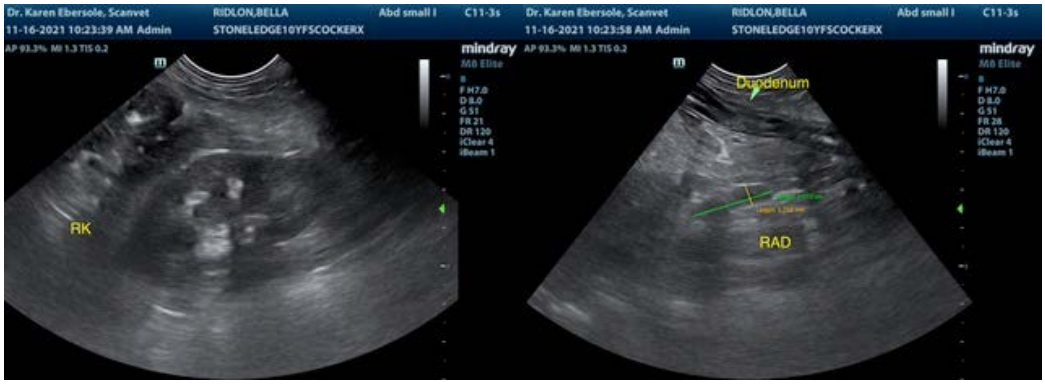

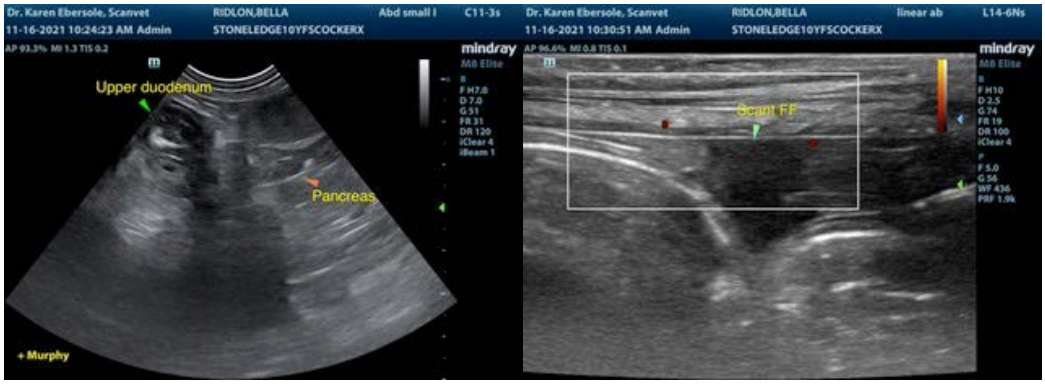

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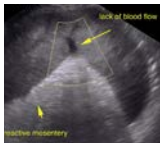
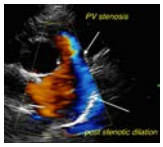
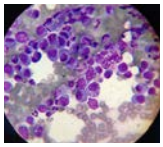
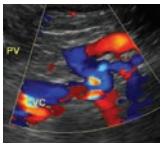

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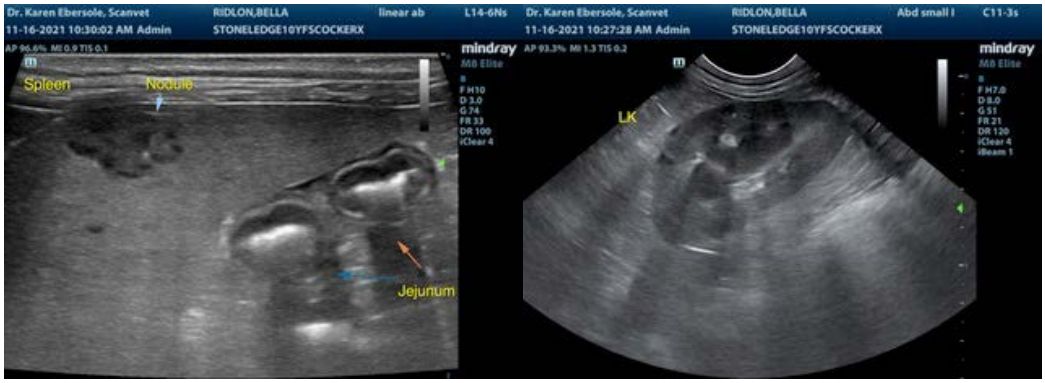

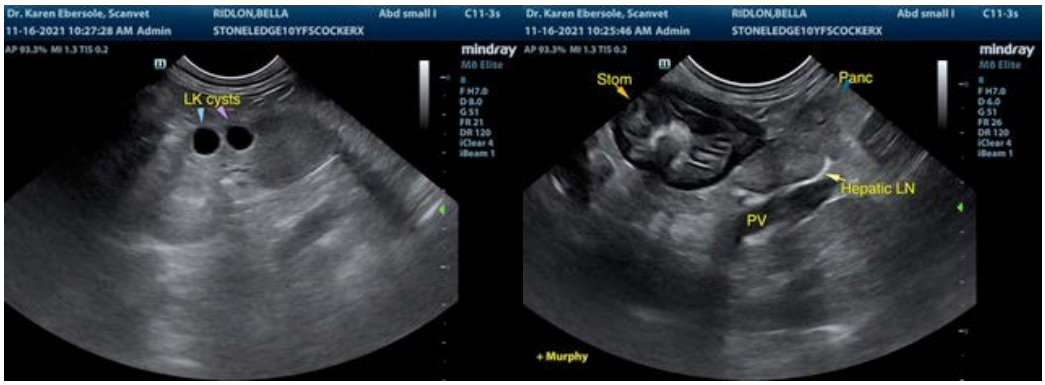

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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