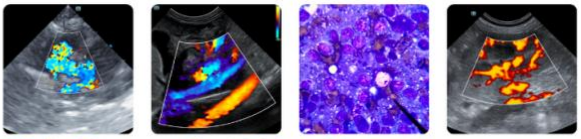


PATIENT

Luna Sanchez

SPECIES

Canine

BREED

Poodle Mix

SEX

Spayed Female

AGE

11 Years 5 Months

WEIGHT

9.33 kg

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

IMAGING PERFORMED BY

Dr. Jill Rankin

HOSPITAL NAME

Southwood Veterinary Hospital

REFERRING VET

Dr. Alissa

INVOICE

14554

DATE

03/23/26

PRESENTING CLINICAL SIGNS

- Luna, an 11-year and 5-month-old Poodle mix, presents for a follow-up examination due to the recurrence of trembling. The patient has a several-month history of chronic, metronidazole-responsive gastrointestinal signs and associated trembling, with differentials including inflammatory bowel disease, chronic enteropathy, visceral pain, or a neurologic disorder.
- The primary clinical issue has been a nebulous trembling and soft-formed stool, both of which were observed to be very responsive to metronidazole. Following an attempt to taper the metronidazole, the patient's stool remained normal, but the trembling returned. A subsequent six-week course of B12 injections was completed and seemed to help significantly. However, at the time of the current assessment, the trembling has recurred while the stool remains mostly normal.
- Diagnostic findings include bloodwork showing a high ALP of 348 (reference range < 131), which was noted to be a decrease from a previous measurement, while ALT, albumin, bilirubin, and GGT were within normal limits. A fecal parasite screen was negative. The patient also has a known grade 3-4 heart murmur, which was assessed on previous chest radiographs.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 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 change were noted.

The area of the aortic trifurcation was free of pathology.

Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 4.7 cm in length. The right kidney measured 3.8 cm in length.

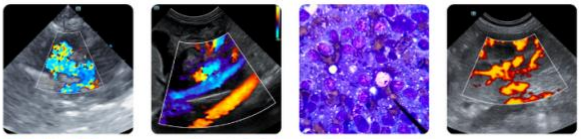
Adrenal Glands

Bilateral symmetrical adrenal gland borderline to mild enlargement given the patient’s body weight with uniformly hypoechoic parenchyma was present. The left adrenal gland measured 0.77 cm width at the cranial pole and 0.66 cm width at the caudal pole. The right adrenal gland measured 0.50 cm width at the caudal pole.

Spleen

The spleen presented normal in size and contour with primarily homogenous parenchyma. A solitary isoechoic mildly nonhomogenous noncapsule deforming nodule was present measuring 0.75 cm. Intermittent, discrete, hypoechoic, non-capsule deforming nodules and solitary, hyperechoic splenic nodule were visualized as well with the hyperechoic nodule measuring 0.20 cm diameter.

Liver & Gallbladder



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The liver presented subjective borderline to mildly enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was non distended in size with normal wall. Nondependent emerging organized nonmineralized to congealed gallbladder debris is present with areas of entrapped peripheral lumen hypoechoic mucus. The biliary sludge is congealed without organization. No signs of peripheral inflammation. The common bile duct was normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material.

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

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 was evident.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Benign hepatopathy.
- Immature to early emerging gallbladder mucocele.
- Bilateral borderline mild adrenomegaly.
- Mild chronic renal changes.
- Sonographically normal gastrointestinal tract/colon.
- Normal pancreas.
- Discrete nonhomogenous hypoechoic to focally hyperechoic splenic nodules- tend to trend benign i.e. hyperplasia, hematopoiesis, focal small myelolipomas or similar.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Aside from the early to emerging gallbladder mucocele, no evidence of abdominal visceral pathology as an obvious contributing factor to the patient's clinical signs or potential area of abdominal pain. Adrenal screening or workup is indicated if clinical signs consistent with Cushing's Syndrome are non-reported or arise. Recheck GI panel to include PLI, TLI, cobalamin and folate may be considered. Continued as needed gastrointestinal support which may include dietary trial, high colony count probiotic +/- empirical therapy for antibiotic responsive gastrointestinal signs if recurrent. Ursodiol trial if tolerated, is warranted with sonographic reassessment of the gallbladder if evidence of cranial abdomen/subxiphoid discomfort on palpation, progressive gastrointestinal signs, or cholestasis.

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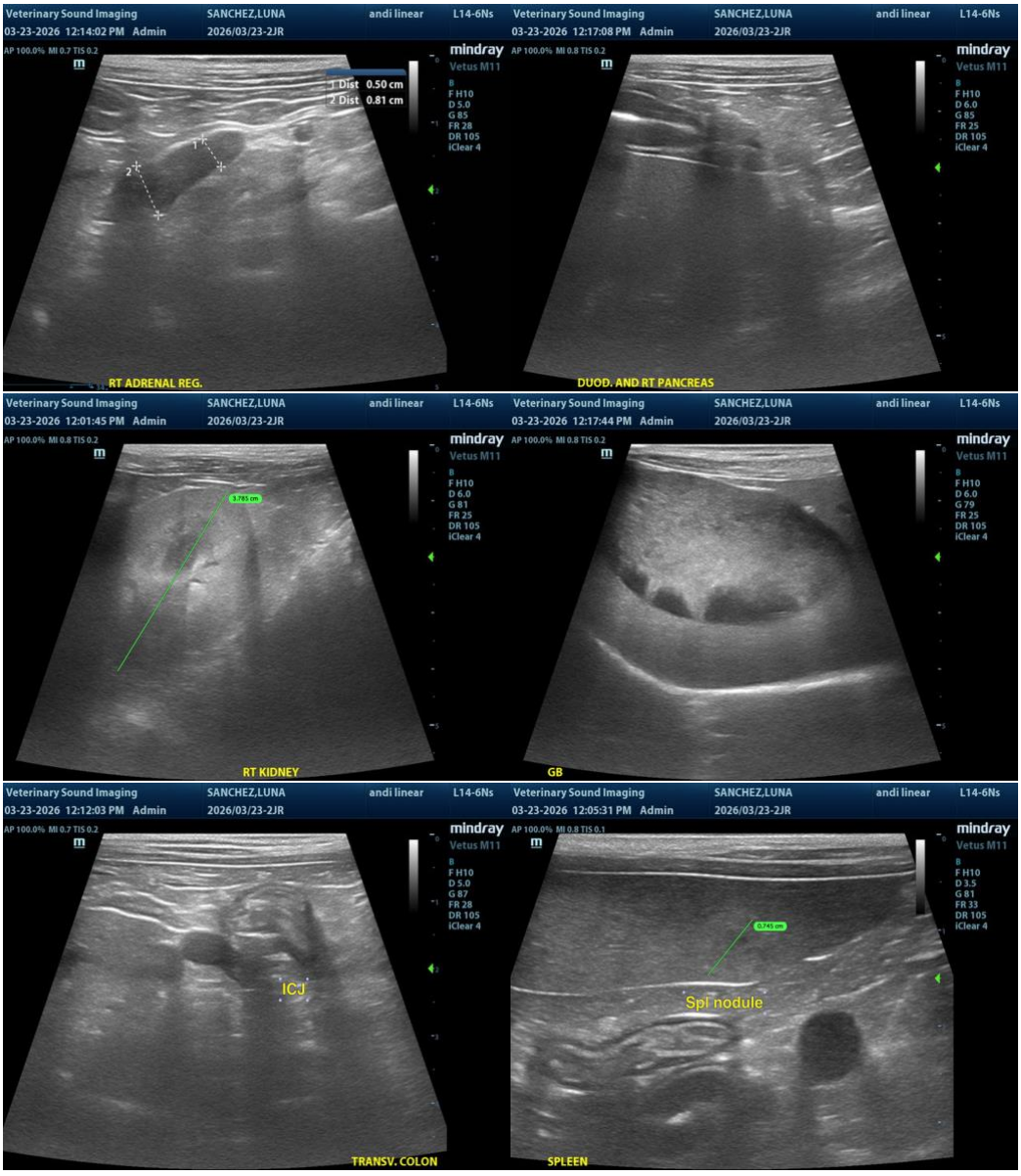
Concurrent sonographic monitoring of the splenic nodules for evidence of persistence or progression +/- nodule FNA cytology using 25-gauge needle is recommended.



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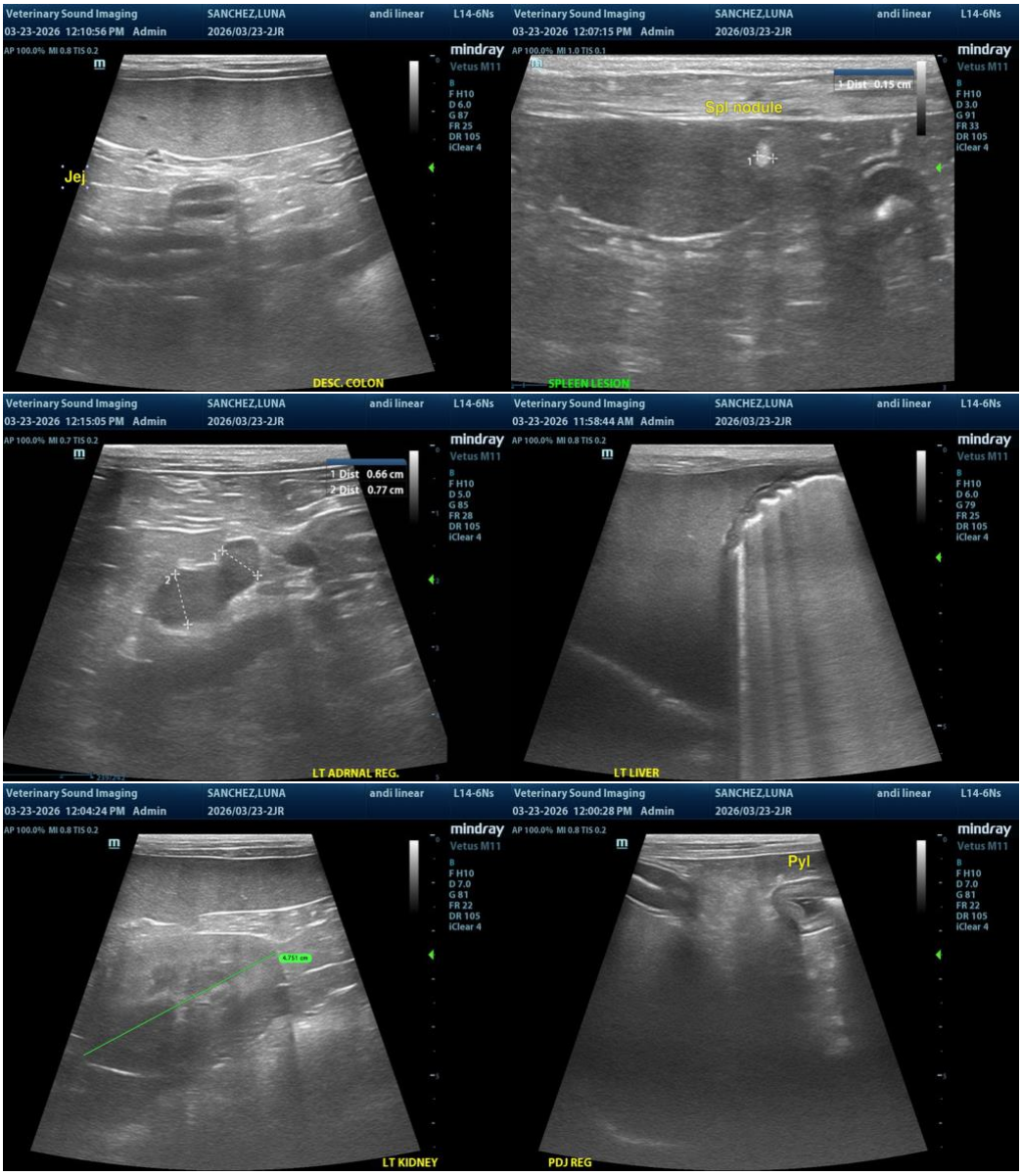

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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