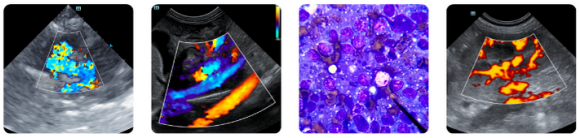

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PATIENT

Puck Luchessa

SPECIES

Canine

BREED

Corgi

SEX

Male Neutered

AGE

8y

WEIGHT

27.8 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Sara Hansen

HOSPITAL NAME

Alpine AH

REFERRING VET

Dr. Hunt

INVOICE

13426

DATE

4/22/26

PRESENTING CLINICAL SIGNS

History: Difficulty Defecating. Vomiting EOD. P lethargic, not feeling well at home

ABNORMAL Lab work Values: SDMA 15 0 - 14 ug/dL. Neg fecal testing. Lab: CRYPTOSPORIDIUM by RealPCR POSITIVE. GIARDIA SP by RealPCR NEGATIVE. SALMONELLA PCR NEGATIVE. CIRCOVIRUS REALPCR K9 NEGATIVE. CANINE ENTERIC CORONAVIRUS NEGATIVE. CANINE PARVOVIRUS 2 NEGATIVE. CANINE DISTEMPER VIRUS NEGATIVE. CAMPYLOBACTER JEJUNI PCR NEGATIVE. CAMPYLOBACTER COLI PCR NEGATIVE. C. PERF ALPHA TOXIN GENE POSITIVE. CPA GENE QUANTITY 1.6 x 10^6 copies/g. CPA GENE INTERPRETATION HIGH LEVELS OF CPA GENE COPIES PRESENT In animals where the number of Clostridium perfringens alpha (CPA) gene copies are high (above 3.0x10^5/g feces), the toxin may be contributing to diarrhea. C.PERF ENTEROTOXIN GENE POSITIVE CPE GENE QUANTITY 1.6 x 10^6 copies/g Please note the use of scientific notation to express the copy numbers. E.g.: 5700 = 5.70 x 10^3 15,600 = 1.56 X 10^4. CPE GENE INTERPRETATION HIGH LEVELS OF CPE GENE COPIES PRESENT In animals where the number of Clostridium perfringens enterotoxin (CPE) gene copies are high (above 3.0x10^5/g feces), the toxin may be contributing to diarrhea. C PERF CPnetEF TOXIN GENE NEGATIVE. C. DIFFICILE TOXIN A/B NEGATIVE.

Current Medications: Fortiflora, Tylosin

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.

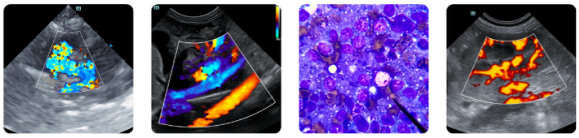
Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 4.7 cm in length. The right kidney measured 5.4 cm in length.

Adrenal Glands

Bilateral symmetrical mild adrenal gland enlargement with uniformly hypoechoic parenchyma was present. The left adrenal gland measured 0.76 cm width at the caudal pole. The right adrenal gland measured 0.64 cm width at the caudal pole.

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.



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Liver

The liver was subjectively normal in size, structure, and contour. 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 minor, non-organized, echogenic, nonmineralized biliary sludge. The cystic duct and common bile ducts were normal without evidence of dilation.

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. Segmental non-obstructive gas and non-shadowing chyme present.

The colon exhibited primarily intact wall layering with generalized distention and containing semi-formed to soft fecal matter. A Segment of the descending colon exhibited thickened wall with loss of colon mural detail. Thickened colon wall measured 1.2 cm. The thickened descending colon wall was subjectively at the approximate level of the urinary bladder

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.

PRIMARY FINDINGS

- Segmental descending colon mass with generalized colon distention containing semi-formed to soft fecal matter
- Sonographically unremarkable gastrointestinal tract with mild, non-obstructive intestinal gas/chyme

SECONDARY FINDINGS

- Nonspecific bilateral mild adrenomegaly
- Sonographically normal liver with minor, non-organized gallbladder debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The segmental descending colon mass appears at least partially obstructive to fecal outflow. Correlation with abdominal radiographs is recommended. Inflammatory neoplastic or granulomatous etiologies for the descending colon mass all potentials with primary suspicion for neoplasia given loss of colon wall layering. No overt visible significant medial iliac or pericolic mesenteric lymphadenopathy. 3-view chest radiographs and surgical/oncology consult is recommended with concurrent gastrointestinal support.

Animal Sounds NW
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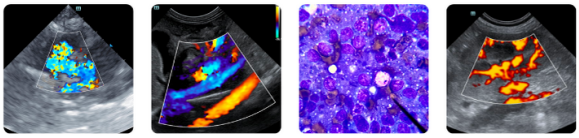

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Educational Teleconsultation Services™

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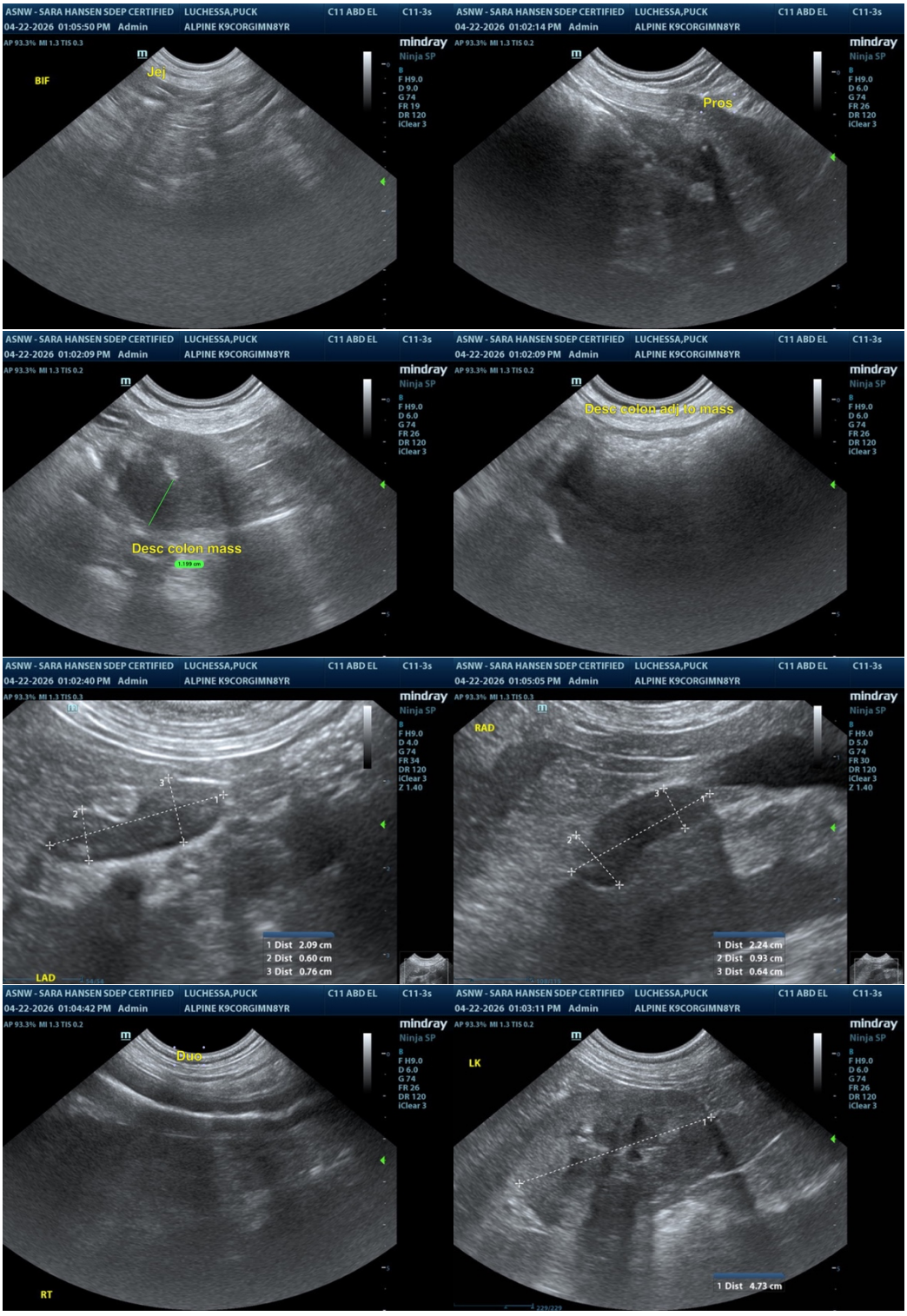

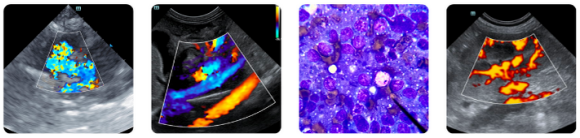

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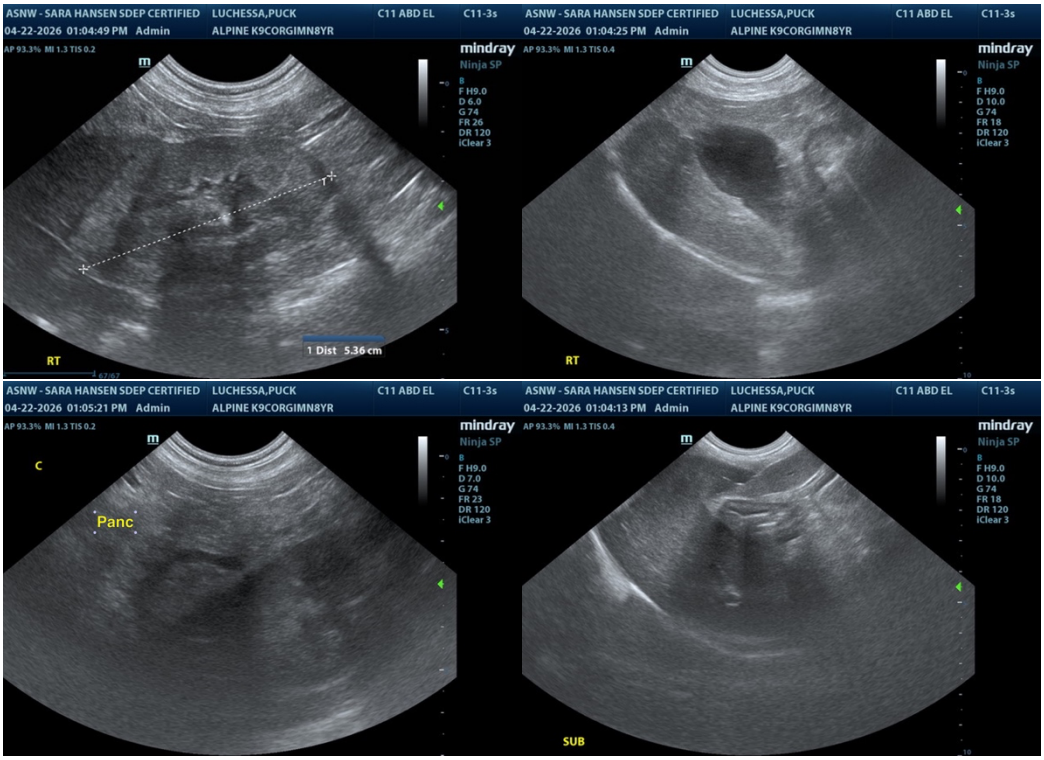

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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