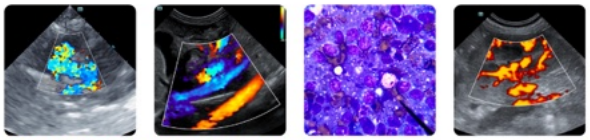


PATIENT

Chewy Behr

SPECIES

Canine

BREED

Pomeranian Cross

SEX

Neutered male

AGE

10 years

WEIGHT

10.27 kg

INTERPRETED BY

Remo Lobetti, BVSc, MMedVet (Med), PhD, Dipl. ECVIM

IMAGING PERFORMED BY

Ryan Bergner, LVT

HOSPITAL NAME

Waterville VC

REFERRING VET

Heather Culbertson, DVM

INVOICE

77997

DATE

5/27/26

PRESENTING CLINICAL SIGNS

History: Presented 4/29 for inappetance for 2 weeks, diarrhea for 1-2 days. P is typically very food motivated and will even eat other pet's food. He has not been even finishing his own food for 2 weeks now. The past 1-2 days, he has had mucoid watery diarrhea, waking overnight with urgency, and whimpering while defecating. Sent home with Proviable and Metro.
5/8 O called: Straining to defecate- pain when defecating but stool is loose and mucous, improved on metro - stool was formed but- now not in pain but still mucous stool and soft stool again. For last 2 weeks he is eating but not as well as usual. Sending home with Maropitant, Mirtazapine, Metro and Proviable today.
5/8: LDDS - resting cortisol high (11), but post samples are normal. 5/6: ALP 2230, Lipase 448, fecal neg, UA: SQ 1.012, Protein 2+

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is small with a normal thickness and smooth appearance of the wall. Normal anechoic urine with no sediment or uroliths evident.

Normal appearance of the trigone area, proximal urethra, and iliac blood vessels.

Normal appearance and size of the iliac lymph nodes. Ureters not visualized, which can be considered a normal finding.

Normal renal size (left measured 4.9 cm, right measured 5.7), architecture, echogenic appearance, cortico-medullary differentiation, which maintains a 1:3 cortex to medulla ratio, pelvis, and capsule. No infarcts, mineralization or renoliths evident. Normal color flow pattern is evident in both kidneys.

The prostate is small and hypoechogenic measuring 1.1 cm in width.

Adrenal Glands

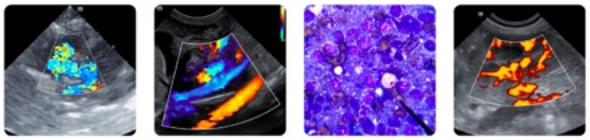
Normal shape, echogenic appearance, size, position, and appearance of the visible peri-adrenal vasculature. Left adrenal gland measured 1.7 cm in length x 0.55 cm and 0.57 cm in width. The right adrenal gland measured 0.47cm in width.

Spleen

Normal size and echogenic appearance. Smooth homogenous parenchyma and regular curvilinear capsule. Normal volume of the splenic vasculature without any overt congestion or thrombosis evident. No inflammatory, neoplastic, infarction, or infiltrative changes evident. The spleen measured 1.3 cm in width.

Liver

Normal size, echogenic appearance, portal markings, and regular curvilinear capsule. No nodules or masses evident. Normal appearance of the hepatic and portal vasculature.



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Gallbladder

The gallbladder is small containing normal anechoic bile. Normal thickness and echogenic appearance of the wall. Normal size and appearance of the cystic and common bile duct.

Gastrointestinal

Normal appearance of the stomach, duodenum, small intestine, ileo-cecal junction, and colon with no loss of layering, 1:3 muscularis to mucosa ratio, normal wall thickness and peristaltic activity, and no distension of the lumen. A moderate amount of ingesta is present in the stomach. The small intestine measured 0.35 cm. Fecal material was present in the colon.

Pancreas

The visible sections of the pancreas are of normal size and echogenic appearance with a regular capsule. Normal echogenic appearance of the mesentery and fat surrounding the pancreas.

Free Abdomen

Normal mesenteric lymph nodes.

No ascites evident.

ULTRASONOGRAPHIC FINDINGS

- Normal ultrasound examination of the abdomen.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

On this ultrasound there is no obvious etiology for the presenting clinical signs or the elevated ALP activity.

The presenting clinical signs are indicative of colonic disease with possible etiologies being idiopathic colitis, granulomatous disease, inflammatory bowel disease and possibly emerging neoplasia.

Although the liver appears ultrasonographically normal with the elevated ALP activity an underlying hepatopathy such as reactive hyperplasia, vacuolar and metabolic should still be considered. Hepatitis and infiltrative neoplasia would be highly unlikely differential diagnosis.

Further assessment of the colon that could be considered would be rectal cytobrush cytology and colonoscopy with biopsies.

Further assessment of possible hepatopathy would be FNA cytology of the liver. However, a tru cut or wedge biopsy may be required for a final etiological diagnosis. With the proteinuria a UPC would be indicated.

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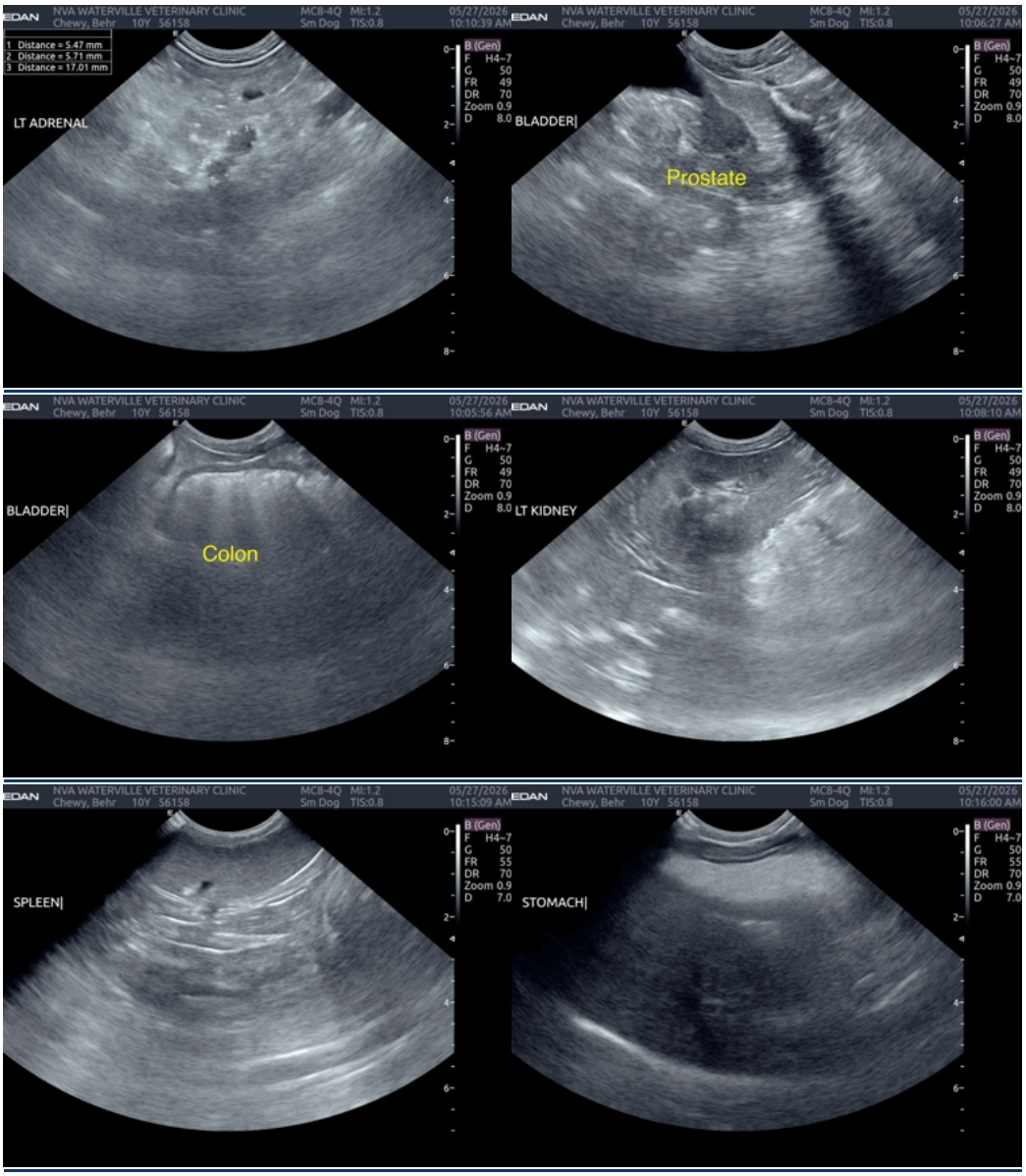
Further assessment would be dependent on an etiological diagnosis.



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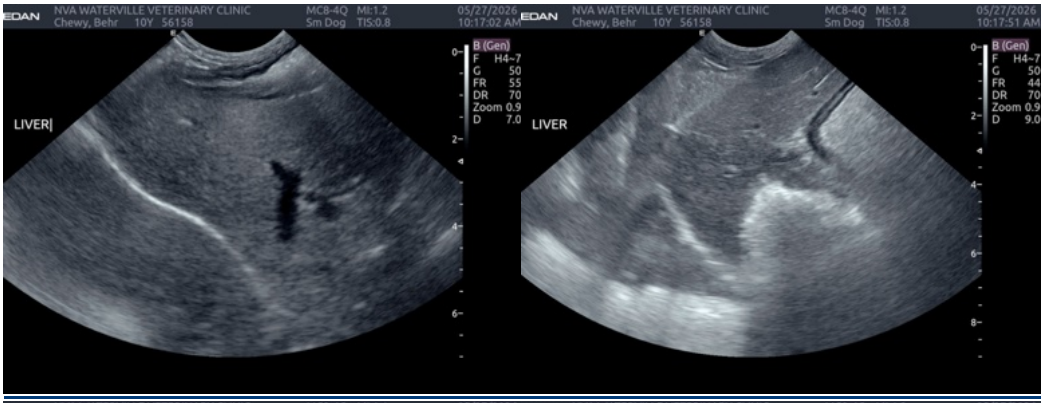

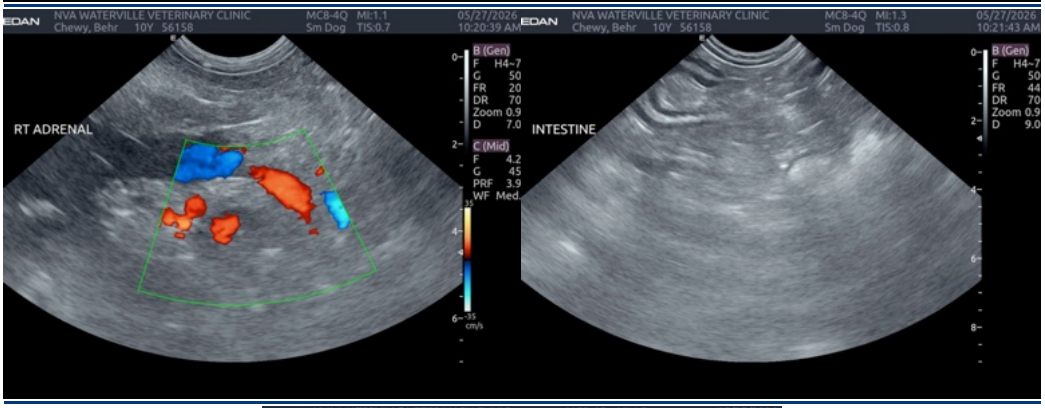

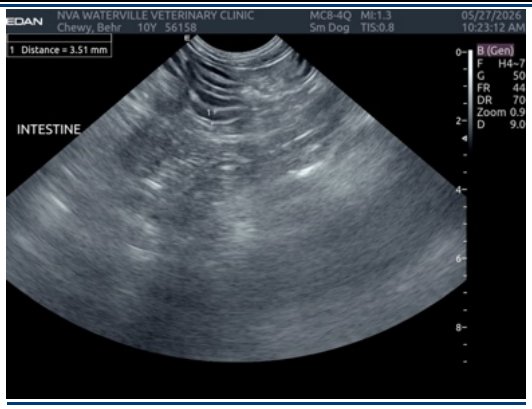

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Remo Lobetti, BVSc, MMedVet (Med), PhD, Dipl. ECVIM (Internal Medicine)

info@sonopath.com