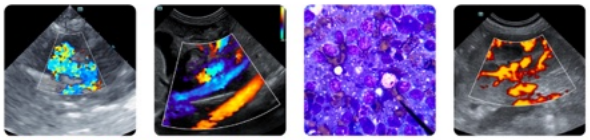


PATIENT

Solo Fiacco

SPECIES

Canine

BREED

Husky

SEX

Neutered male

AGE

4 years

WEIGHT

57.6 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Danielle Shemanski, DVM, MA

HOSPITAL NAME

Western New York Vetererinay Service

REFERRING VET

Dr. Richard Parsons

INVOICE

78321

DATE

6/3/26

PRESENTING CLINICAL SIGNS

History: RDVM REASON FOR REFERRAL: P presents due to ongoing diarrhea, anorexia, weight loss, and dehydration associated with chronic enteropathy.
Patient history includes: Chronic GI dis w/ intermittent hematochezia & recent fecal incontinence. Severe abdominal borborygmus typically precedes acute diarrhea episodes. Wt. loss of approximately 5–6 lbs has been reported, with the patient currently weighing 57 lbs. Long-standing hx of being a picky eater and refusing new diets after several days; currently eating 2–2.5 cans of Science Diet Biome wet food daily. Vomiting is uncommon, though occasional regurgitation of white foamy fluid occurs after excessive water intake. The P has a hx of dietary indiscretion, including ingestion of rabbit feces, a bird, and a rabbit. Owners report decreased energy levels and increased irritability toward other dogs during the current episode. A fever was documented at Green Acres on 5/5/26 but has since resolved. Recent blood work is reportedly stable, though there is a history of hypoalbuminemia.
CLINICAL SIGNS: Lethargy and weight loss, but mostly diarrhea with frank blood.
MEDICATIONS: Cerenia, Entyce, Ondansetron, Metoclopramide, GI Biome food
BIZ injection, Proviable Forte, LRS therapy, 0.6ml of butorphanol for today's exam
Abnormal PE/Chem/CBC/UA Results: 6/2/26 – Churchville Veterinary Hospital CBC: Mild microcytosis (MCV 61.1 fL) and low reticulocyte hemoglobin (22.1 pg). BC: WNL 5/21/26 – Churchville Veterinary Hospital Rads: Findings consistent with functional ileus/gastroenterocolitis. No evidence of GI obstruction, foreign material, or intestinal plication. May 2026 – Green Acres Emergency CBC: Mild leukocytosis with neutrophilia and hypoalbuminemia (2.2 g/dL). Pancreatic lipase, SDMA, and 4DX testing were normal/negative. UA: USG >1.050, w/ mild proteinuria and non-hyaline casts. Fecal Testing: Negative for Giardia and other common parasites. 5/3/26 – Green Acres VC Rads: Findings most consistent with inflammatory or infectious gastroenteritis. No evidence of GI obstruction. Further eval of the peritoneal cavity was recommended.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

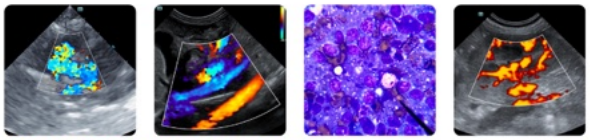
The urinary bladder is small with a thickened, but smooth appearance of the wall. The bladder wall measures up to 0.7 cm. Normal anechoic urine with no sediment or uroliths evident.

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 7.3 cm, right measured 7.2 cm), 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.



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Adrenal Glands

Normal shape, echogenic appearance, size, position, and appearance of the visible peri-adrenal vasculature. Left adrenal gland measured 2.12 cm in length x 0.45 cm and 0.38 cm in width. The right adrenal gland measured 2.77 cm in length x 0.39 cm and 0.33 cm 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 2.7 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.

Gallbladder

The gallbladder is full 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 and ileo-cecal junction with no loss of layering, 1:3 muscularis to mucosa ratio, normal wall thickness and peristaltic activity, and no distension of the lumen. Thickening of the wall of the colon measuring up to 0.6 cm with no loss of layering and maintaining a 1:3 muscularis to mucosa ratio. Fecal material is 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.

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Thorax

Normal appearance of the heart. No pericardial or pleural effusion evident.

ULTRASONOGRAPHIC FINDINGS

- Colonic thickening.
- Urinary bladder thickening.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Etiologies for the colonic thickening would be idiopathic colitis, parasitic disease, granulomatous colitis, ulcerative colitis with neoplasia a less likely differential diagnosis.

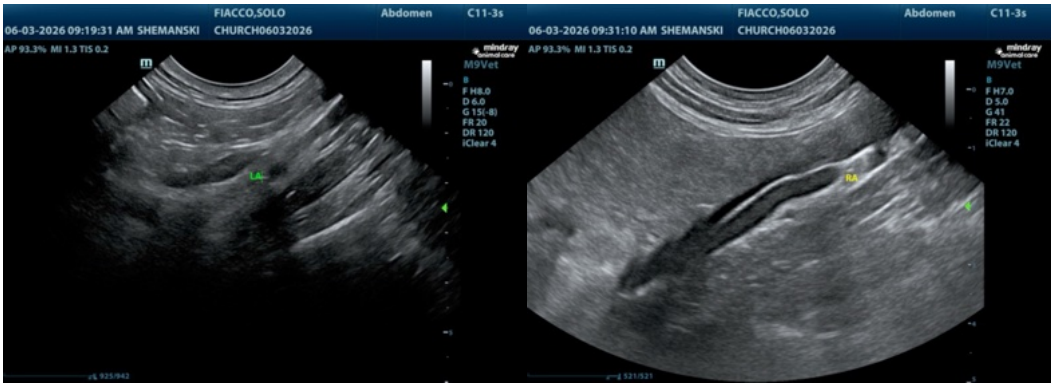
The most likely etiology for the urinary bladder thickening would be chronic bacterial cystitis with emerging neoplasia an unlikely differential diagnosis.

Although the small intestine appears ultrasonographically normal, with the history of weight loss and hypoalbuminemia, an underlying small intestinal enteropathy such as parasitic enteritis, dietary hypersensitivity and inflammatory bowel disease still needs to be considered.

Further assessment would be urine and fecal analysis, cobalamin and folate assay and endoscopy of both the upper and lower GI tract with biopsies.

Specific therapy would be dependent on an etiological diagnosis.

Symptomatic management that could be considered would be feeding a novel protein/hypoallergenic diet, course of Fenbendazole, cobalamin supplementation and if there is still not a satisfactory improvement then a course of Prednisolone would then be indicated.



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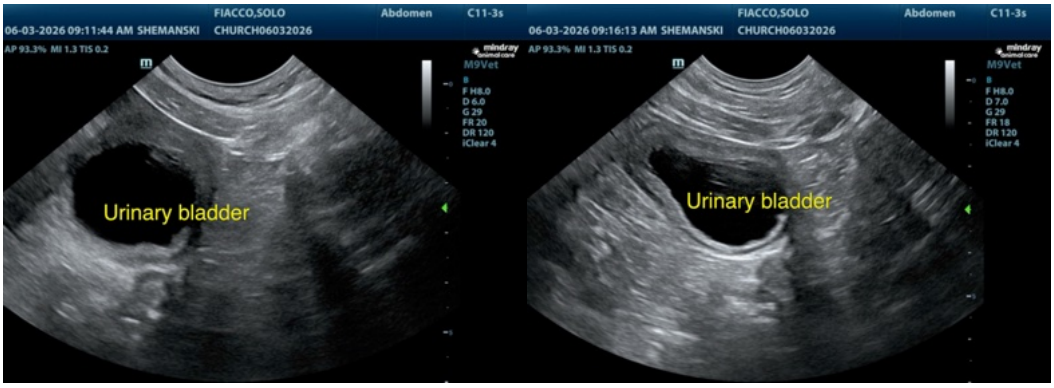

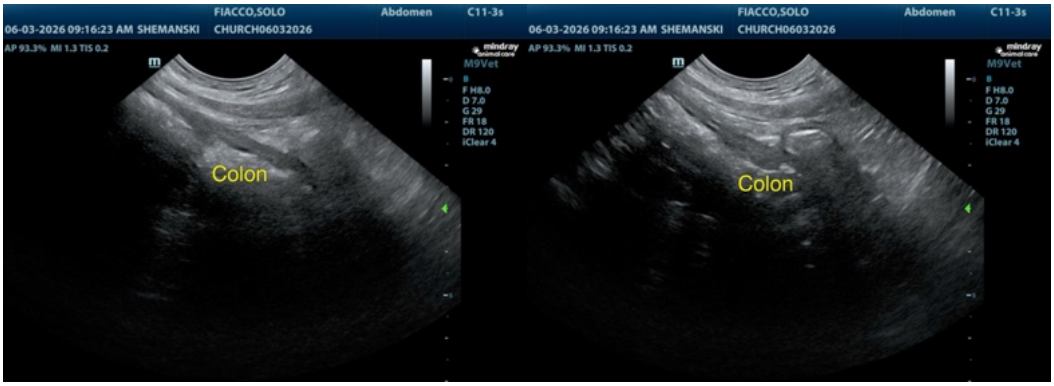

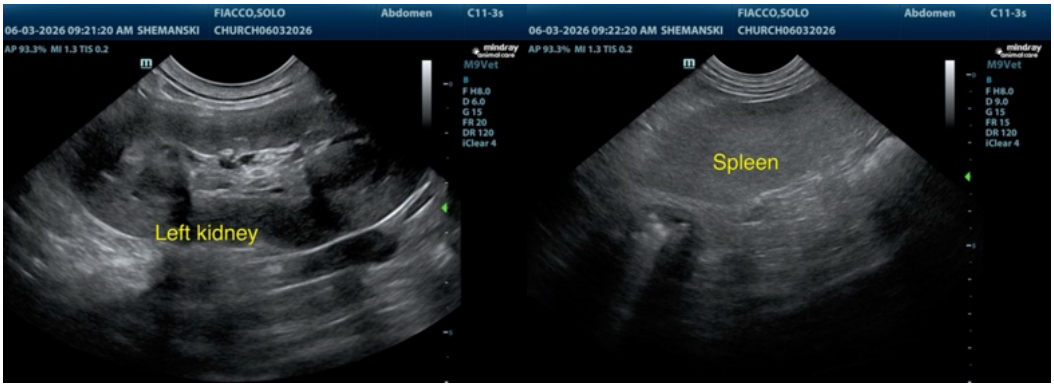

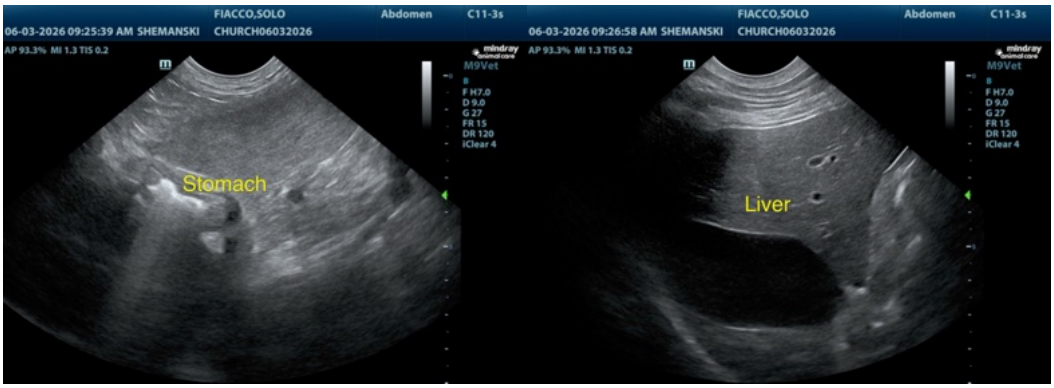

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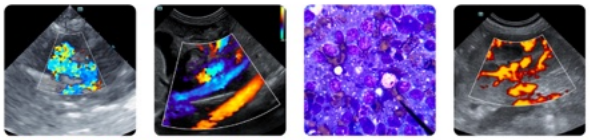

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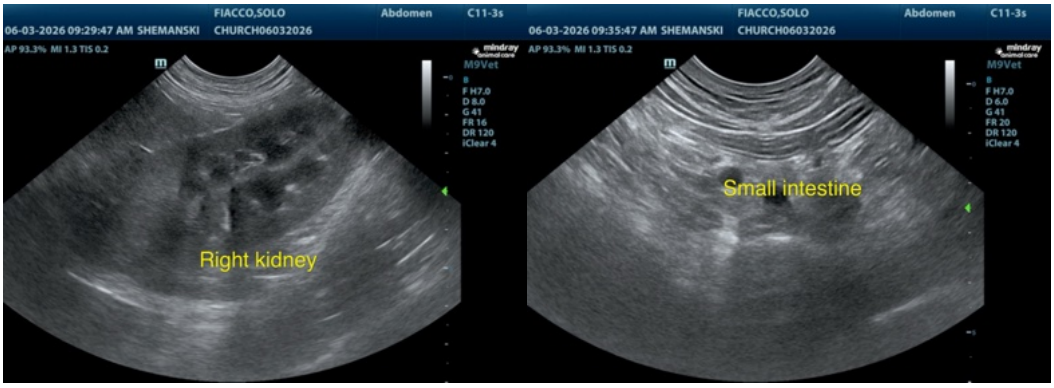

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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