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Clinical Sonography & Telecytology
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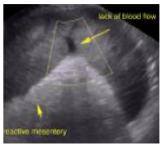
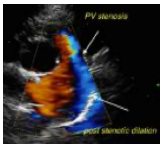
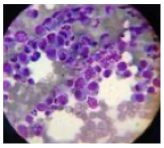
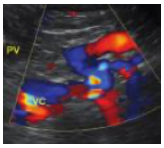

SonoPath.com
1-800-838-4268 info@sonopath.com

PATIENT

Bella Carter

SPECIES

Canine

BREED

Beagle X

SEX

Female Spayed

AGE

11 years

WEIGHT

44 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Jessica Bailes

HOSPITAL NAME

All Creatures Gr&Sm VC Corvallis, OR

REFERRING VET

Justin Vaughn

INVOICE

13760

DATE

7.20.23

PRESENTING CLINICAL SIGNS

History: acute onset decreased appetite, intermittent vomiting and lethargy despite Cerenia and bland diet.

Abnormal PE/Chem/CBC/UA Results: Tense on abdominal palpation, otherwise NSF on PE. BW/UA: SC: ALP 1056. All other wnl. CBC: UR UA: USG 1.017. IS. UPC 2.7. Elevated ALP and proteinuria--historic to 2021. Pt LDDS was normal. Seemed painful R abdomen today Thoracic rads/lateral lumbar spinal rads NSF today.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is small with a normal thickened and irregular appearance of the apical wall, with the rest of the wall having normal thickness and smooth appearance. 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 kidney 670 cm / right kidney 6.20 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.

Adrenal Glands

Normal shape, echogenic appearance, size (left: 2.65 cm in length x 0.56/0.56 cm in width) (right: 2.69 cm in length x 0.45/0.58 cm in width), position, and appearance of the visible peri-renal vasculature.

Spleen

Normal size (1.90 cm) 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.

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 moderate amount of floating and adherent hyperechogenic sediment. The adherent sediment is in an early-stellate pattern. 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, 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. Segmental thickening of the small intestines (up to 0.56 cm) with no loss of layering, maintaining a 1:3 muscularis to mucosa ration, normal peristaltic activity and no distention of the lumen.

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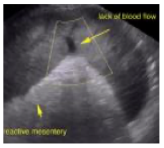
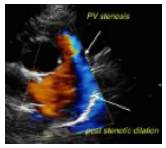
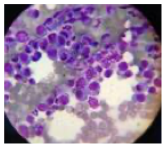
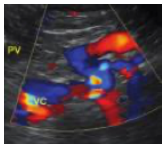

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Pancreas
Normal size, with a mottled, echogenic appearance and irregular capsule. Normal echogenic appearance of the mesentery and fat surrounding the pancreas.

Free Abdomen
Normal mesenteric lymph nodes.

No ascites evident.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Pancreatitis (?)
- Enteropathy
- Focal thickening of the urinary bladder wall

Secondary Findings

- Gall bladder sediment

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Although the appearance of the pancreas may be age-related fibrosis, pancreatitis needs to be considered.

Etiologies for the enteropathy would be nonspecific enteritis (dietary indiscretion, toxins, viral), parasitic enteritis, inflammatory bowel disease, and dietary hypersensitivity, with neoplasia an unlikely differential diagnosis.

Etiologies for the urinary bladder wall would be chronic cystitis is emerging neoplasia.

Although the gall bladder sediment may be an incidental finding and associated with the enteropathy, an emerging mucocele needs to be considered.

Further assessment would be urine and fecal analysis, urine culture, possibly BRAF analysis and cPL/PSL assay. Endoscopy of the upper GI tract could also be considered, especially if there is not a satisfactory improvement with symptomatic therapy.

Further specific therapy would be dependent on an etiological diagnosis. Ongoing symptomatic management would be to continue with the maropitant and feeding of small, frequent meals of an intestinal-type diet. Fluid therapy and correction of any electrolyte anomalies also needs to be considered.

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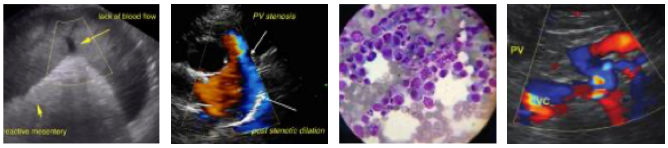

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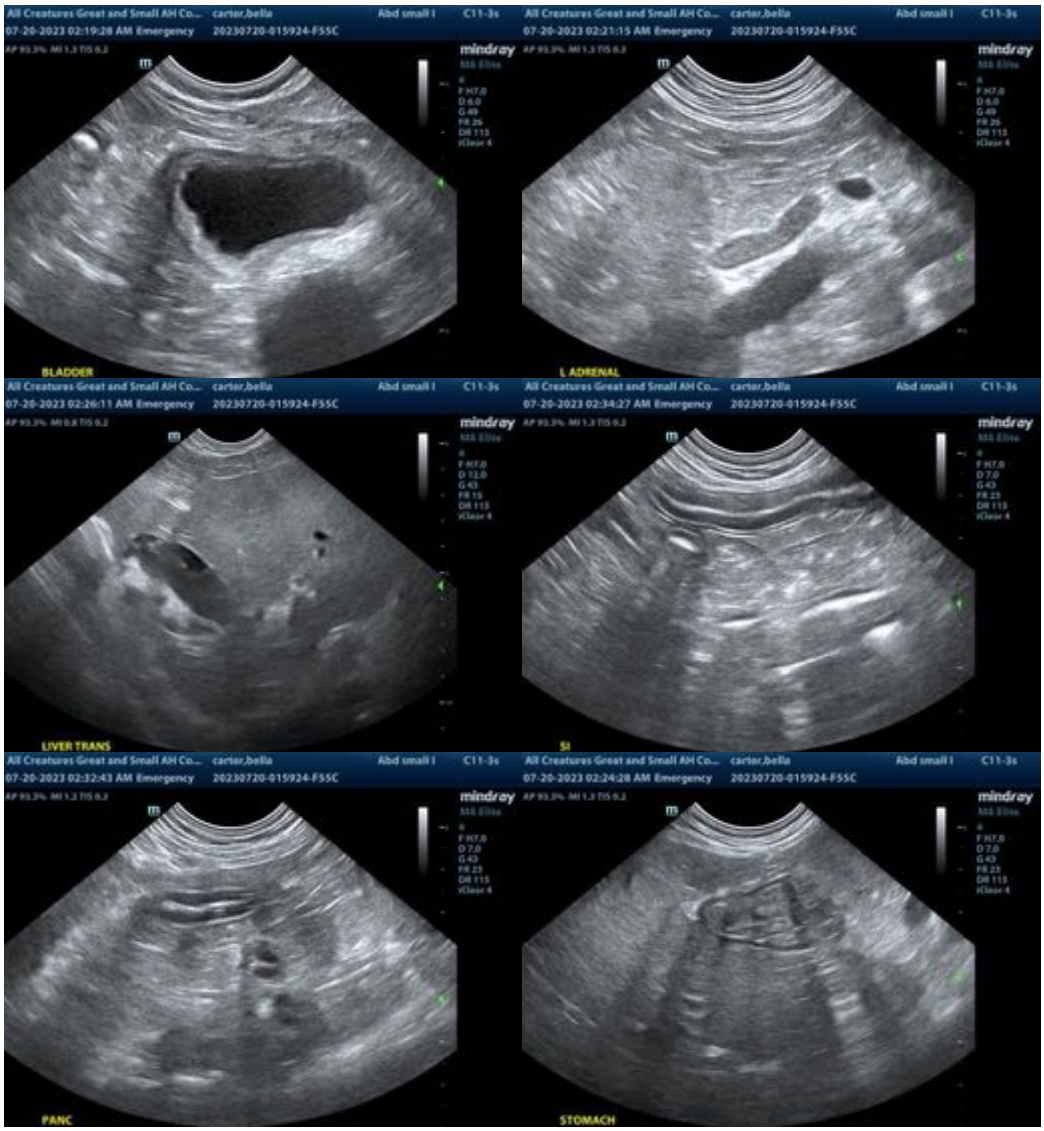

The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Remo Lobetti, BVSc, MMedVet (Med), PhD, Dipl. ECVIM (Internal Medicine)
info@sonopath.com