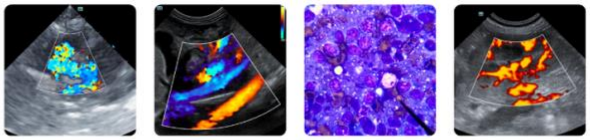




**PATIENT**

Bella Howe

**SPECIES**

Canine

**BREED**

Mixed

**SEX**

Spayed Female

**AGE**

9 Years 11 Months

**WEIGHT**

57 Pounds

**INTERPRETED BY**

Beth Johnson, DVM, DACVIM (SAIM)

**IMAGING PERFORMED BY**

Megan Cassels-Conway, DVM

**HOSPITAL NAME**

Central Broward AH

**REFERRING VET**

Janeen Lezcano, DVM

**INVOICE**

35515

**DATE**

1/19/26

## PRESENTING CLINICAL SIGNS

History: Chronic hx of intermittent hyporexia, eating grass and enteritis for several years. Recently slightly worsened symptoms. On most recent blood work (10/25) p had a newly acquired lymphocytosis. Screened with Accuplex (all neg) and resting cortisol level was normal. Although a food trial helped with the GI symptoms the lymphocytosis worsened. No respiratory symptoms reported by owner but chest rads to day revealed a ST opaque mass cranial to heart measuring 8x13 cm, marked widening of cranial mediastinum was noted.

Abnormal PE/Chem/CBC/UA Results: 1/2026: CBC: lymphs: 7308H 11/2025: accuplex: ALL NEG, cortisol: 2.5 10/2025: lymphs: 6448H 10/2025: CBC: lymphs: 6642H, Chem: creat: 1.4, T4: 1.9, UA: SG: 1.043, trace prot, slight pyuria (voided sample) 8/2025: fecal keyscreen PCR: all neg 1/2025: CBC: lymphs: 4320, Chem/T4/UA: NSF 6/2024: CBC: lymphs: 2688

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

Urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Left kidney is normal in size (6.24 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed. A subtle hyperechoic band parallel to the corticomedullary border is present.

Right kidney is normal in size (5.88 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed. A subtle hyperechoic band parallel to the corticomedullary border is present.

### *Adrenal Glands*

Left adrenal gland is normal in size (0.7 cm at cranial pole and 0.5 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

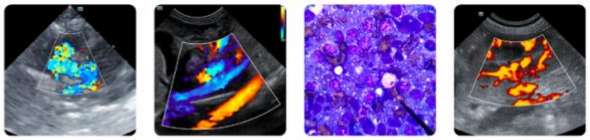
Right adrenal gland is normal in size (0.7 cm at cranial pole and 0.7 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

### *Spleen*

Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

### *Liver*

Liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.





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Gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

### *Gastrointestinal*

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. The lumen is mildly diffusely distended with soft stool.

### *Pancreas*

The area of the pancreas contains irregular hyperechoic pancreatic remodeling.

### *Free Abdomen*

There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

## ULTRASONOGRAPHIC FINDINGS

- Hyperechoic pancreas- This finding is suggestive of pancreatic fibrosis, possibly secondary to chronic pancreatitis. A TLI is recommended to rule out exocrine pancreatic insufficiency (EPI), especially if clinical signs (weight loss, diarrhea, etc.) are present.
- Suspect emerging soft stool or diarrhea
- Subtle bilateral medullary rim sign- This finding is of unknown clinical significance and can be a normal variant, often idiopathic. Medullary rim sign can be present with renal disease including lymphoma, hypercalcemic nephropathy, Leptospirosis, tubular disease, other and should be interpreted in combination with other more specific indications of kidney disease such as isosthenuria, proteinuria, azotemia, etc. This is a common incidental finding in patients with diabetes mellitus.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the patient's reported gastrointestinal signs, combined with the pancreatic changes, a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

Pending results of above, a routine fecal/Giardia exam could be considered, as could a fecal enteropathogen PCR panel to Texas A&M GI Laboratory, for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

Having said that, based on patient's history, the potentially more concerning problem is the suspected cranial mediastinal mass, lymphocytosis, etc. Therefore, further evaluation of the lymphocytes could

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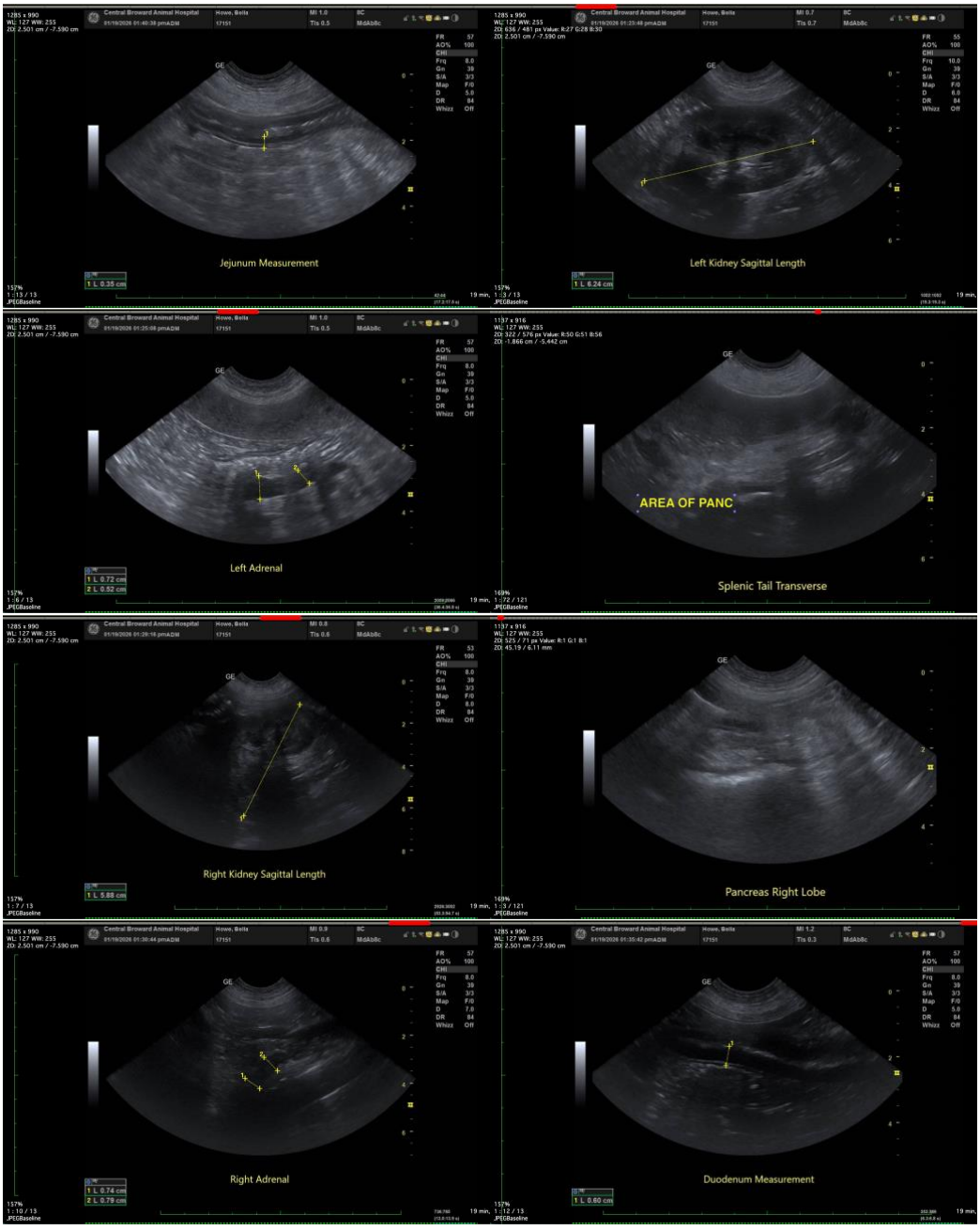
be considered beginning with a pathology review and sampling of the suspected mediastinal mass via fine needle aspirate could be considered if patient's coagulation status is appropriate.

Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.




**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.**

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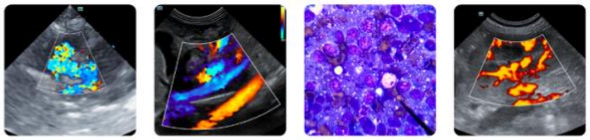

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Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

**Beth Johnson, DVM DACVIM**

info@sonopath.com