



**PATIENT**

Chunk Papson

**SPECIES**

Canine

**BREED**

Labrador Retriever

**SEX**

Neutered Male

**AGE**

10 Years

**WEIGHT**

75.6 Pounds

**INTERPRETED BY**

Beth Johnson, DVM,  
DACVIM (SAIM)

**IMAGING PERFORMED BY**

Meghan Morse, LVT,  
CVT

**HOSPITAL NAME**

AH of Sussex County

**REFERRING VET**

Dr. Catania

**INVOICE**

35504

**DATE**

1/19/26

**PRESENTING CLINICAL SIGNS**

- Generalized lethargy
- Inappetence
- Scant free fluid in abdomen found on AFAST along with very bright mesentery
- Hx of PLE

Abnormal PE/Chem/CBC/UA Results: lymphopenia 0.85, hyperglycemia 132, hypoglobulinemia 2.3

**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.

Prostate is normal in size, echotexture and echogenicity for a neutered male.

Left kidney is normal in size (6.08 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.

Right kidney is normal in size (5.89 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.

**Adrenal Glands**

Left adrenal gland is normal in size (0.74 cm at cranial pole and 0.8 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (1.7 cm at cranial pole and 0.86 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). Except for an approximately 0.8 cm in diameter non-capsule-disrupting hypo- to anechoic nodule near the cranial aspect of the spleen. 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. Hyperechoic mucosal fogging or speckling is noted. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is mildly distended with primarily fluid as well as some echogenic non-shadowing luminal contents and gas consistent with normal chyme. There is no evidence of obstruction, foreign material, or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

**Pancreas**

The observed pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and irregular in shape with a swollen undulating contour. Enhanced hyperechoic ill-defined surrounding fat is noted.

**Free Abdomen**

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

There is no apparent pathologic lymphadenopathy noted in these images.

Diffusely, but primarily, throughout the cranial abdomen, enhanced hyperechoic mesenteric fat is noted.

**ULTRASONOGRAPHIC FINDINGS**

**Primary Findings**

- Mucosal speckling- Mucosal speckling is often present with inflammatory bowel disease (IBD). It is not specific for type or severity of disease. Mild speckling change can occur as a normal patient variant in the post-prandial state.
- Suspect mild to moderate acute pancreatitis given the prominent pancreatic changes, as well as the enhanced fat throughout the cranial abdomen. Having said that, enhanced fat/chronic low grade smoldering inflammation secondary to patient's reported historical gastrointestinal disease, can't be definitively ruled out.

**Secondary Findings**

- Hypo- to anechoic splenic nodule- likely represents a benign lesion such as a cyst, hematoma, nodular hyperplasia, extramedullary hematopoiesis, etc., however while considered less likely, infiltrative neoplasia can mimic benign lesions and cannot be ruled out.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**



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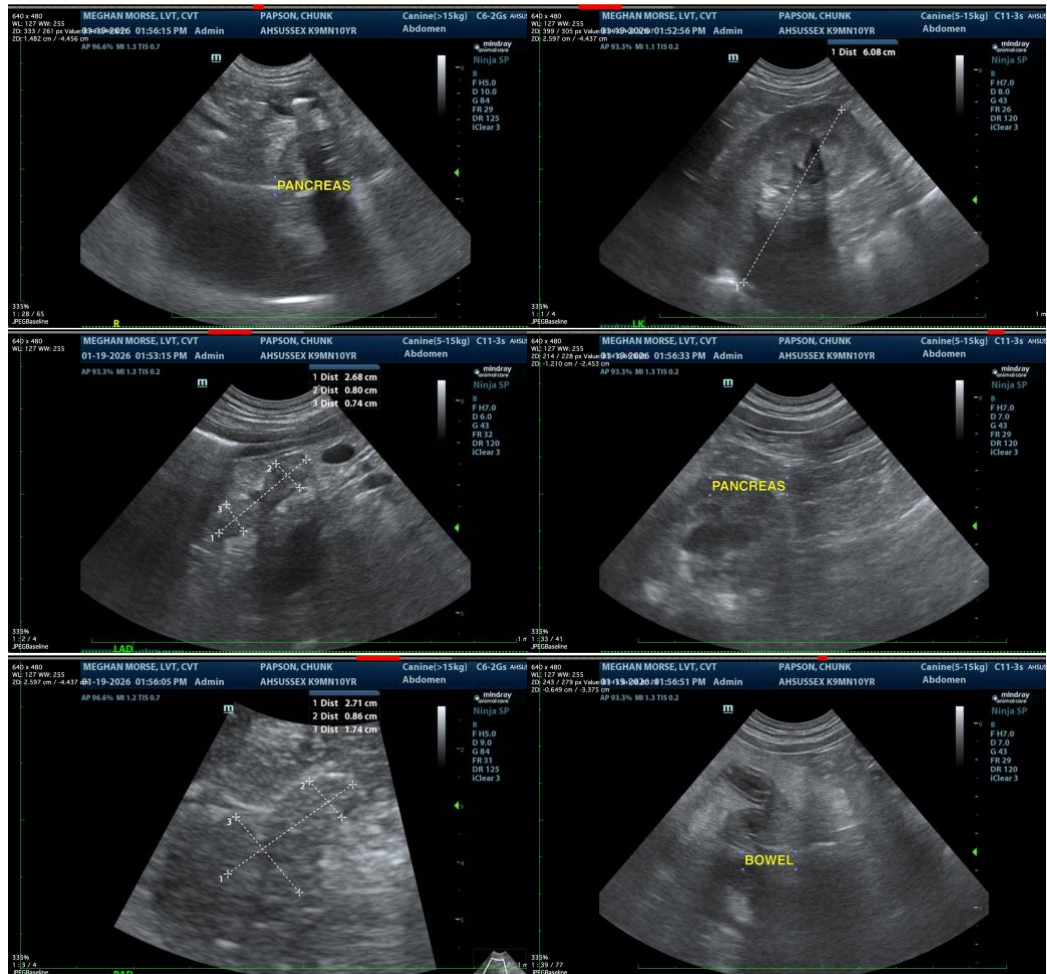
Further recommendations depend in part on previous work up, treatments, etc., for the reported suspect historical PLE. Having said that, if not recently evaluated, and especially if hypoalbuminemia has been or is present, a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

Additionally, a routine fecal/Giardia exam could be considered if not already evaluated.

A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

Urinalysis, and if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

In the meantime, medical management of pancreatitis with anti-emetics, gastroprotectants, appetite stimulants or nutritional support as needed, pain management, broad spectrum antibiotics, and fluid therapy is recommended. Monitoring of the pancreas with power doppler is recommended to identify possible necrosis as well as other potential sequelae such as abscesses, etc.





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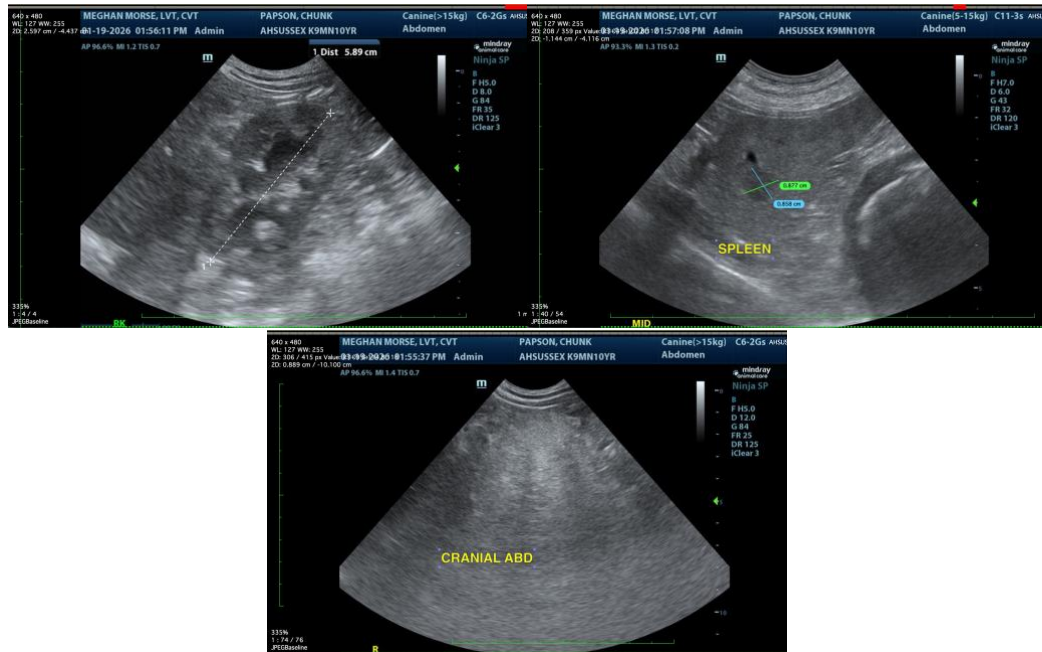
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**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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.

**Beth Johnson, DVM DACVIM**

info@sonopath.com