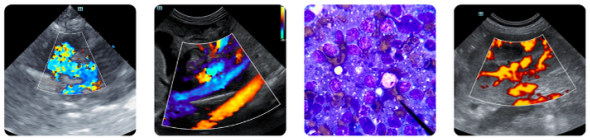


PATIENT

Grace Robinson

SPECIES

Canine

BREED

Great Dane

SEX

Spayed Female

AGE

7 years 7 months

WEIGHT

133.2

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Jessica Green

HOSPITAL NAME

Stanglein Veterinary Clinic

REFERRING VET

Dr. Laura Green

INVOICE

11172

DATE

1/21/2026

PRESENTING CLINICAL SIGNS

- Dental procedure done 1/8/26. p returned 1/16/26 for inappetence, diagnosed with pancreatitis. Presented again for vomiting/inappetence on 1/20/26. On IVF and supportive meds, no improvement.
- Meds: Pepcid, Cerenia, Metro, Buprenex.

Abnormal PE/Chem/CBC/UA Results: Elevated pancreatic lipase (526), otherwise normal. Rads: Gas in colon and cecum, no signs of fb or obstruction.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The 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.

The right kidney is normal is size (9.62 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.

The left kidney is normal is size (9.84 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. An approximate 1.0 cm in diameter cortical cyst in the caudal pole is noted. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

The area of the right adrenal gland is examined without evident adrenal gland pathology but it's difficult to fully visualize/isolate for measurement.

The left adrenal gland is normal in size (0.54 cm at cranial pole and 0.55 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size with normal smooth margins. Parenchyma is normal in echogenicity with a diffusely coarse/heterogenous echotexture. In the mid spleen there is an approximately 1.2 cm x 0.6 cm anechoic/cystic density, non-capsular disrupting. Splenic vasculature appears normal.

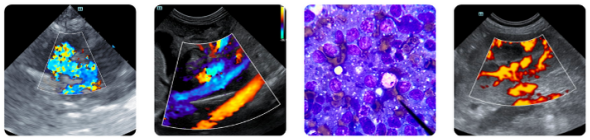
Liver

Liver is subjectively enlarged (swollen contour) with a diffusely mildly coarse architecture and subtly increased portal markings. Mildly mixed echogenic changes are noted diffusely. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The 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 moderately to markedly distended with echogenic non-shadowing ingesta/chyme, fluid, and gas. There is no



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definitive foreign material or obvious cause of obstruction, but the pylorus is unable to be well visualized in these images.

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. Contents are consistent with normal formed feces and gas.

Pancreas

There is no definitive pancreatic parenchymal pathology noted in these images at this time. However, the pancreas is difficult to fully visualize in part due to the cranial organomegaly and significant gastric distension, as well as artifact from gas and ingesta, etc.

Free Abdomen

There is a trace amount of anechoic free fluid, primarily adjacent to the spleen and some subtly enhanced hyperechoic mesentery and fat in the cranial abdomen.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- An obvious cause for the moderate liver changes is not identified in these images. Microscopic disease such as Leptospirosis, bacterial cholangiohepatitis, chronic active hepatitis, copper-associated hepatotoxicity, other hepatotoxicity, other reactive hepatopathy, infiltrative neoplasia (considered unlikely), etc. cannot be definitively ruled out.
- Coarse splenomegaly – can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.
- The free fluid and enhanced fat could be secondary to splenic and hepatic pathology. Although, concurrent bowel disease and/or even emerging or low-grade smoldering pancreatitis can't be definitively ruled out. Other pathologic causes are also possible.
- The gastric changes should be interpreted in combination with when patient last ate but are suspicious for gastric ileus/delayed gastric emptying with an obstruction not definitively visible but unable to be definitively ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

Fine needle aspirates of the spleen and liver are recommended if patient's coagulation status is appropriate.

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.

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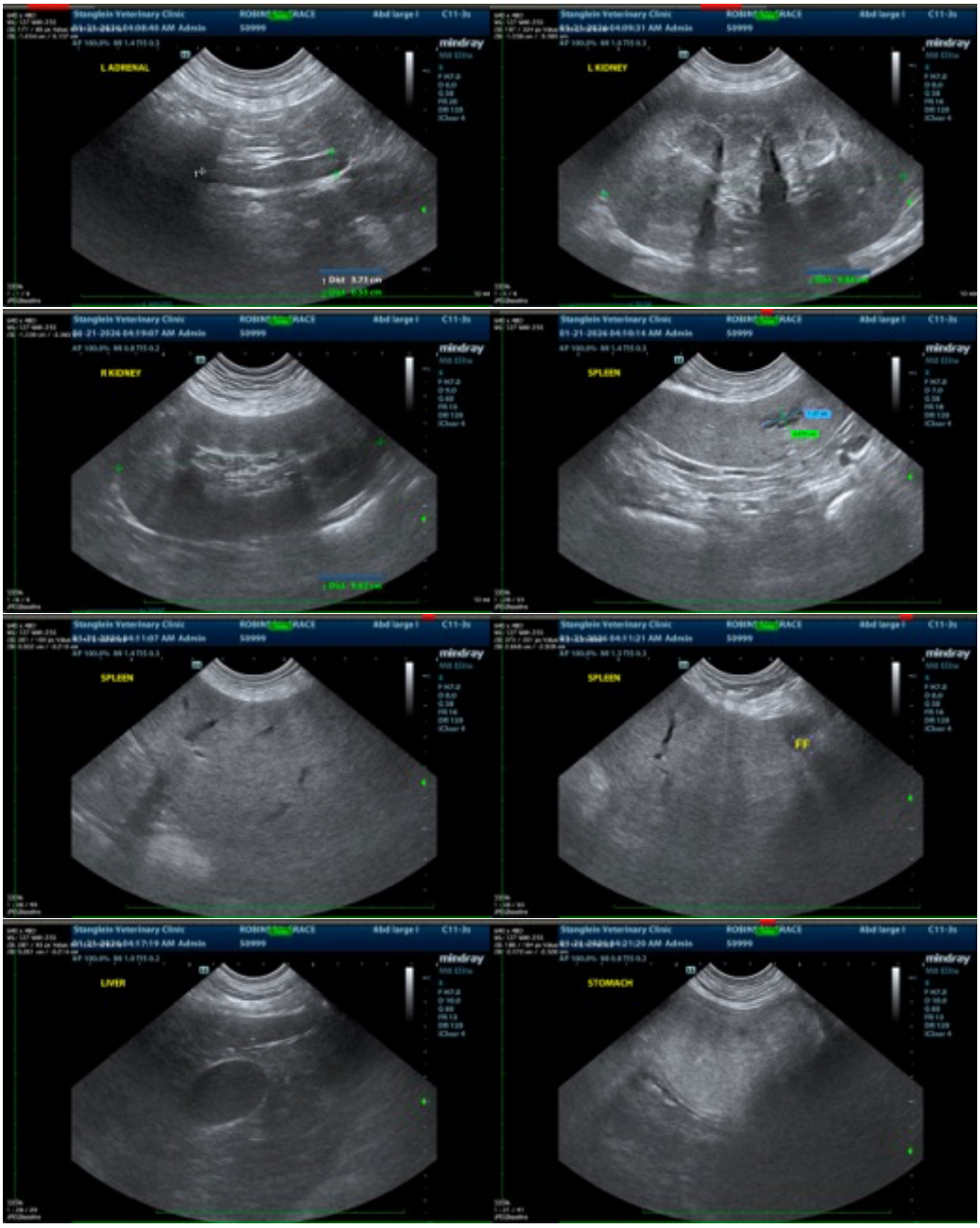
A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

Other than supportive/symptomatic medical management of clinical signs, further diagnostic and 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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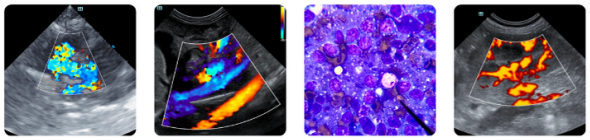

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Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

Beth Johnson, DVM, DACVIM
info@sonopath.com