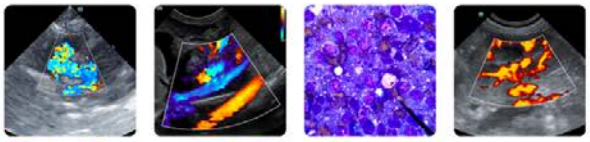


PATIENT

Scarlett Brunner

SPECIES

Canine

BREED

Mixed

SEX

Spayed Female

AGE

16 Years

WEIGHT

26 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Blue Pearl Wyomissing

REFERRING VET

Heatherlynn McFarlane, DVM (Internal Med)

INVOICE

72352

DATE

1/21/26

PRESENTING CLINICAL SIGNS

AUS to further evaluate chronic, large bowel diarrhea (increased frequency, urgency, hematochezia, tenesmus). Has a chronic history of soft stools but the past 6 months, stools progressed to diarrhea with intermittent hematochezia. Dx with Cryptosporidium (low burden) in 6/2025 and treated with tylosin, recheck Keyscreen 1 month later showed clearance of GI parasites. Work-up in 12/2025 included BW (elevated ALP 694, ALT 257 which chronic, stable; mildly elevated BUN 33), unremarkable UA, and an AUS. AUS revealed age-related SI with small ill-defined hyperechoic foci within mucosal/muscular layer (colon was not remarked on), renal changes, splenic mass (3.5cmx4cm ill-defined, elevated, heterogeneous, hypoechoic mass), numberous small hepatic nodules, biliary sludge, and a multicystic, thin-wall lesion within the abdomen. Minimal improvement with probiotics, metronidazole, steroids, and dietary changes (Purina EN, RC GI low fat, RC GI). No weight loss, acting normal outside of diarrhea.

Predisone (taper), Visbiome, Psyllium husk, Trazadone, Gabapentin

12/7/25 - CBC: WBC 9.3K, Neut 6.5K, Lymph 1.86K, Eos 0.46K, HCT 37%, PLT 445K (H). Mini Chem: TP 7.0, Al 3.7, Glob 3.3, Creat 1.0, BUN 33 (H), ALT 257 (H), ALP 694 (H), Na 148, K 5.1, Cl 112, Glu 89

12/10/25 - UA (Free Catch): USG 1.038, pH 5.5, WBC 0-1/HPF, RBC none, Bacteria none, Protein 1+ (H), glu/ketone negative, casts/crystals none

Abnormal PE/Chem/CBC/UA Results: 12/19/25 AUS Bladder: WNL Kidneys: B/L ill-defined CM transition. Renal cortex appears mildly hyperechoic no evidence of cysts/infarcts. Renal pelvis & ureters not dilated. Physiological hyperechoic renal pelvis & renal recesses. No renal calculi. Adrenals: WNL Spleen: A 3.5x4 cm ill-defined, elevated, heterogeneous, hypoechoic mass. Liver: mildly enlarged w/rounded borders. Small hyperechoic hepatic nodules between 6-10 mm. GB mod gravity-dependent hyperechoic material & the wall is hyperechoic & mildly irregular. GI: SI are well-defined & no space-occupying lesions or segmental dilatation. Small, ill-defined hyperechoic foci are present w/in the mucosal and muscular layers. Normal layering. LN WNL. A multicystic, thin-walled lesion (3-4 cm) is seen in the areas ventral to the spleen.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

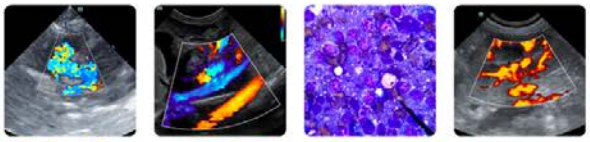
The urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney is normal is size (5.1 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 (6.6 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

Adrenal glands are plump/swollen in size. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature



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appears normal. Left measures 1.0 cm at the cranial pole and 1.1 cm at the caudal pole. Right measures 0.80 cm at the cranial pole and 0.70 cm at the caudal pole.

Spleen

The spleen contains an approximately 3.4 cm x 5.2 cm homogeneous, iso- to hypoechoic mass, non-capsule disrupting but resulting in a mild capsular bulge in the mid to caudal spleen.

Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is mildly heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with a small to moderate amount of echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is 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 is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta/chyme. There is no evidence of obstruction, foreign material or infiltrative disease.

What is definitively identifiable as the colon is normal in thickness and layering and luminal contents. However, at the end of this study in images labeled “scanning of the bowel”, there is a focal bowel loop that is mildly thick if it is colon, which I think it may be, measuring 0.45 cm thick, with normal intact layering. This loop of bowel is mildly distended with echogenic non-shadowing contents and fluid. This could, however, represent normal mildly fluid distended small bowel or even stomach, but if it is colon, it is mildly thick with no loss of layering.

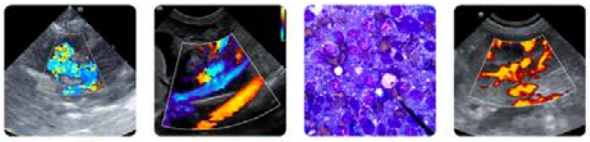
Pancreas

The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

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

In the cranial abdomen caudal to the liver and some views medial to the spleen, there is an approximately 2.9 cm x 3.1 cm cystic structure.



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Other

The visible heart base (RA) and pericardium are unremarkable without obvious pathology noted in these images at this time. If cardiac function evaluation is desired, a full echocardiogram is recommended.

ULTRASONOGRAPHIC FINDINGS

- Possibly mildly thick colon with no characteristics of malignancy – Differentials include benign inflammatory, parasitic, infectious, dietary related, other inflammatory disease, with infiltrative neoplasia not able to be definitively ruled out without tissue sampling.
- Mild 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.
- The splenic mass could represent a benign change such as extramedullary hematopoiesis, although infiltrative neoplasia, including round cell neoplasia versus other can't be ruled out without tissue sampling.
- Mildly heterogenous liver – These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.
- Mild gallbladder debris - Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.
- The cystic structure in the cranial abdomen is of unknown origin and trends in appearance toward benign, such as a cyst, hematoma, potentially cystic lymph node, although infiltrative neoplasia can't be ruled out without tissue sampling.
- Mild bilateral adrenomegaly – In a patient diagnosed with hyperadrenocorticism, this finding is most consistent with adrenal hyperplasia secondary to pituitary dependent hyperadrenocorticism. This finding can also be seen with stress and/or normal patient variant. Interpret in combination with clinical signs of hyperadrenocorticism and/or other adrenal disease.

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.

If not recently evaluated, a routine fecal/giardia exam is recommended.

As is reportedly already pending, 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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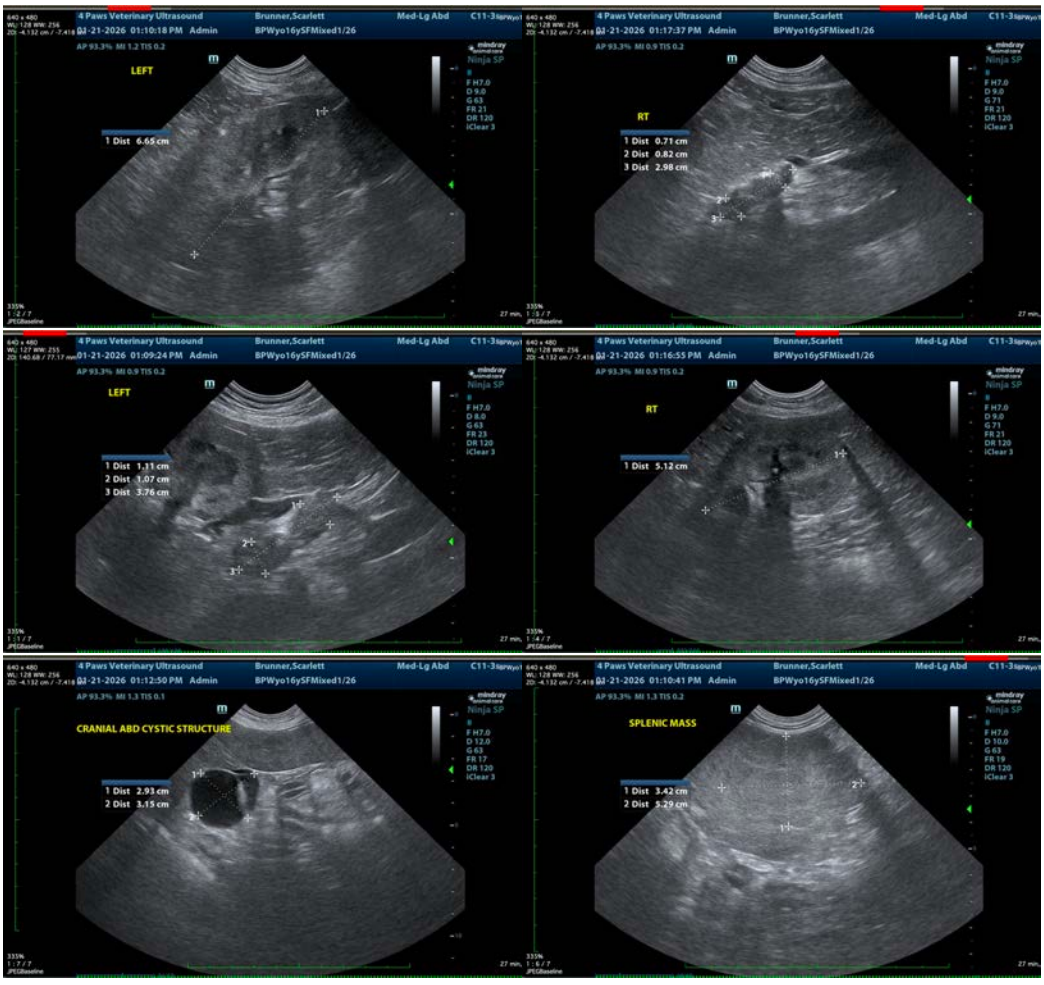
A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

Prior to more invasive sampling (including potentially colonoscopy if elected), fine needle aspirates of the splenic mass +/- liver and +/- the cranial abdominal cystic structure are recommended if patient's coagulation status is appropriate, with priority given to the splenic mass.

In the meantime, if tolerated, a transition in diet is recommended, based on trial-and-error response.

Some options to consider include a gastrointestinal biome diet vs a hydrolyzed protein diet (sometimes several trials with different brands are necessary) vs a fiber response/colitis diet vs a bland, easy to digest or low-fat diet vs other.

Additionally, fecal microbe transplant therapy is recommended.



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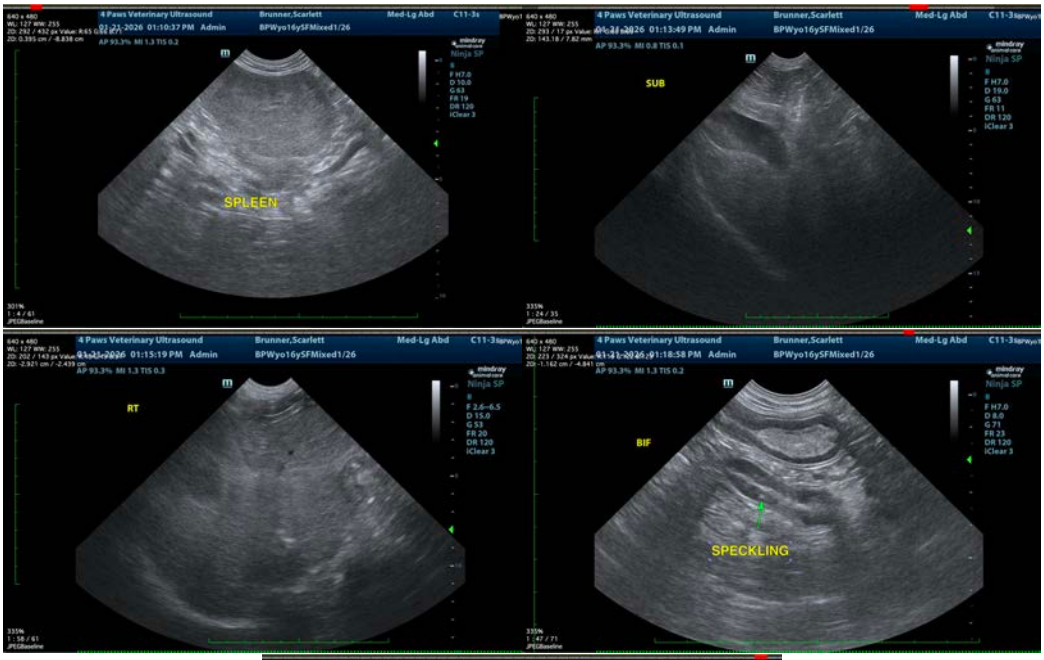

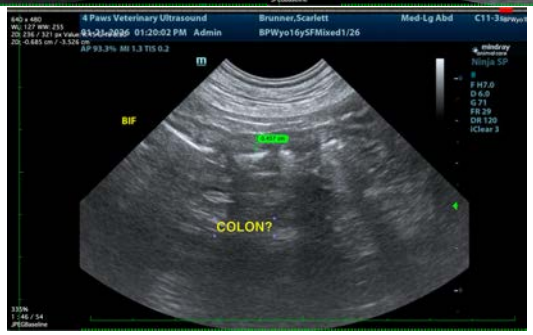

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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