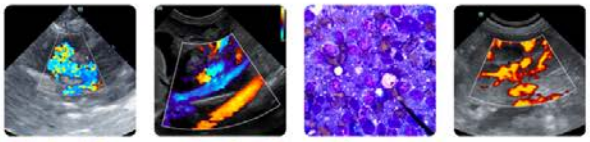


PATIENT

Sophie Dahllgren

SPECIES

Canine

BREED

Dalmatian

SEX

Spayed Female

AGE

8 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

72347

DATE

1/21/26

PRESENTING CLINICAL SIGNS

AUS to further evaluate chronic diarrhea and intermittently decreased appetite and lethargy. History of chronic soft stool/diarrhea since 2 years old but the past 2 years the episodes are occuring more frequently (every 60-90 days). In addition to the increased frequency, her appetite and energy are decreased during these episodes. Full work-up was performed in 2024 BW only abnormality was a mildly elevated ALP, ACTH stim ruled out hypocortisolemia, and AUS was unremarkable. Serial blood work since then has only showed a mildly progressive ALP elevation (11/30/25 ALP 389). Diarrhea was not responsive to multiple diet changes (RC HP, Hill's Z/D) but was responsive to metronidazole and probiotic administration. No weight loss.

Meds: Visbiome, Metronidazole, Apoquel, Hill's GI Biome

Abnormal PE/Chem/CBC/UA Results: Oct 2025 Fecal OP: NPS / Giardia Ag: Negative Nov 2025 (episode of illness) CBC: WBC 9.1, Neut 6.5, Lymph 1.93, Eos 0.28, HCT 56.3, PLT 366 Chem: Alb 3.0, Glob 4.0, Cr 1.0, BUN 19, ALT 55, ALP 389 H, Tbil 0.3, Chol 258 cPLI: Normal Previous AUS 9/2024 Liver: WNL GB: Mildly sludgy bile w/normal wall thickness 0.78 mm Spleen: WNL Kidneys: norm overall shape and size (R = 5.15cm , L = 6.07cm) w/ good CM & normal echogenicity of the 2 layers. No pelvis dilation but there is mineralization in the L renal pelvis UB: Wall thickness (0.18 cm), WNL Adrenals: R (0.56 cm) / L (0.57 cm). WNL Stom: wall thickness (0.25 cm) layering, pylorus patent WNL SI: wall thickness (0.38 cm) & layering Colon: wall thickness (0.13 cm) & layering Pancreas: WNL LN: no lymphadenopathy

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 (6.2 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 (5.44 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. Non-obstructive mineral densities are noted within the pelvis. There is no evidence of pyelectasia or infarcts observed.

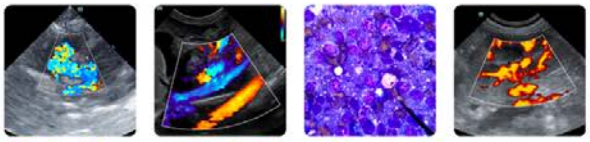
Adrenal Glands

The right adrenal gland is normal in size (0.35 cm at cranial pole and 0.46 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.65 cm at cranial pole and 0.62 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

The spleen is subjectively normal in size (1.7 cm thick at the hilus) with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity



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relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

The 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.

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 mildly distended with echogenic intraluminal contents that demonstrate strong acoustic shadow.

The visible small intestines are normal in wall thickness and layering. 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.

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

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

Within the abdomen, visible in images while scanning the bowel, but of unknown definitive location, there is a pocket of free fluid as well as enhanced hyperechoic mesenteric fat surrounding a coarse homogeneous hypoechoic density that is difficult to determine the origin, given the unknown location. This could represent a prominent pancreas with surrounding free fluid and enhanced fat, potentially a lymph node, or suspected focal peritonitis adjacent to bowel versus other.

PRIMARY FINDINGS

- As described above, there appears to be a focal area of peritonitis around a hypoechoic density of unknown location, and therefore unidentifiable origin. Differentials include pancreatitis, steatitis adjacent to a lymph node, or focal bowel wall versus other.
- The gastric contents could represent normal ingesta/gas, although given the shadowing, non-obstructive foreign material can't be ruled out. An additional 12-24 hours of fasting followed by recheck imaging could be considered.

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SECONDARY FINDINGS

- Non-obstructive mineral within the left renal pelvis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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

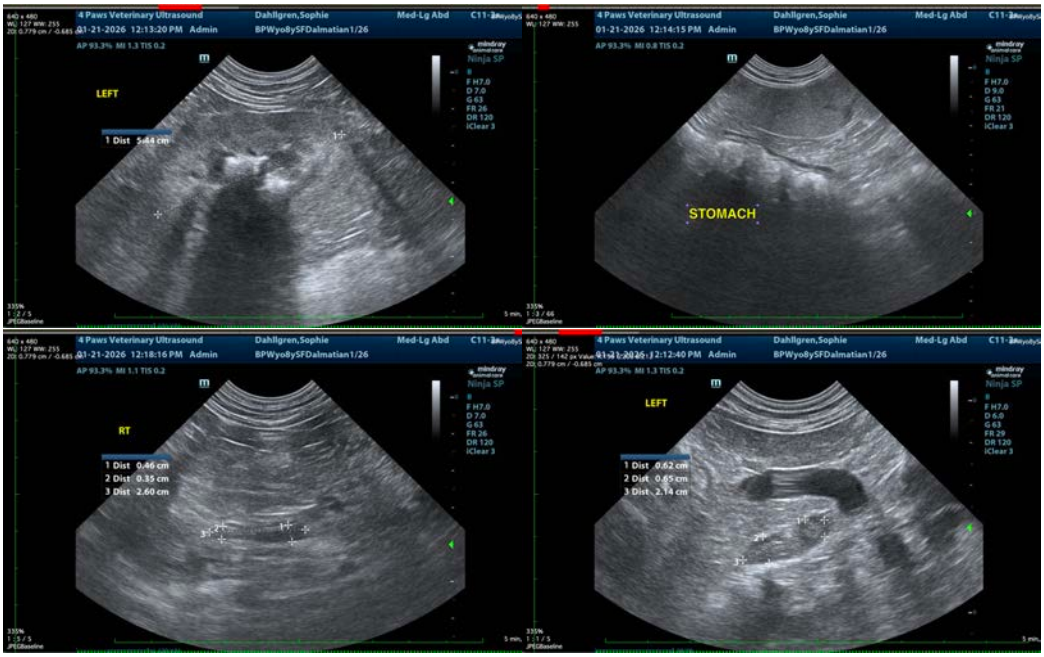
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

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.

Additionally, monitoring of the focal area of steatitis and free fluid or potentially sampling could be considered if patient's coagulation status is appropriate.

In the meantime, supportive/symptomatic medical management of clinical signs is recommended, including a probiotic (such as visbiome or proviable), empirical deworming with a 5-day course of Panacur and, if tolerated, a transition in diet, based on trial-and-error response, beginning possibly with a gastrointestinal biome diet vs a hydrolyzed protein diet vs other. Some patients respond to one brand/version of a hydrolyzed protein diet better than another brand, so several brand attempts may be required.

Additionally, given patient's history, fecal microbe transplant therapy is recommended.



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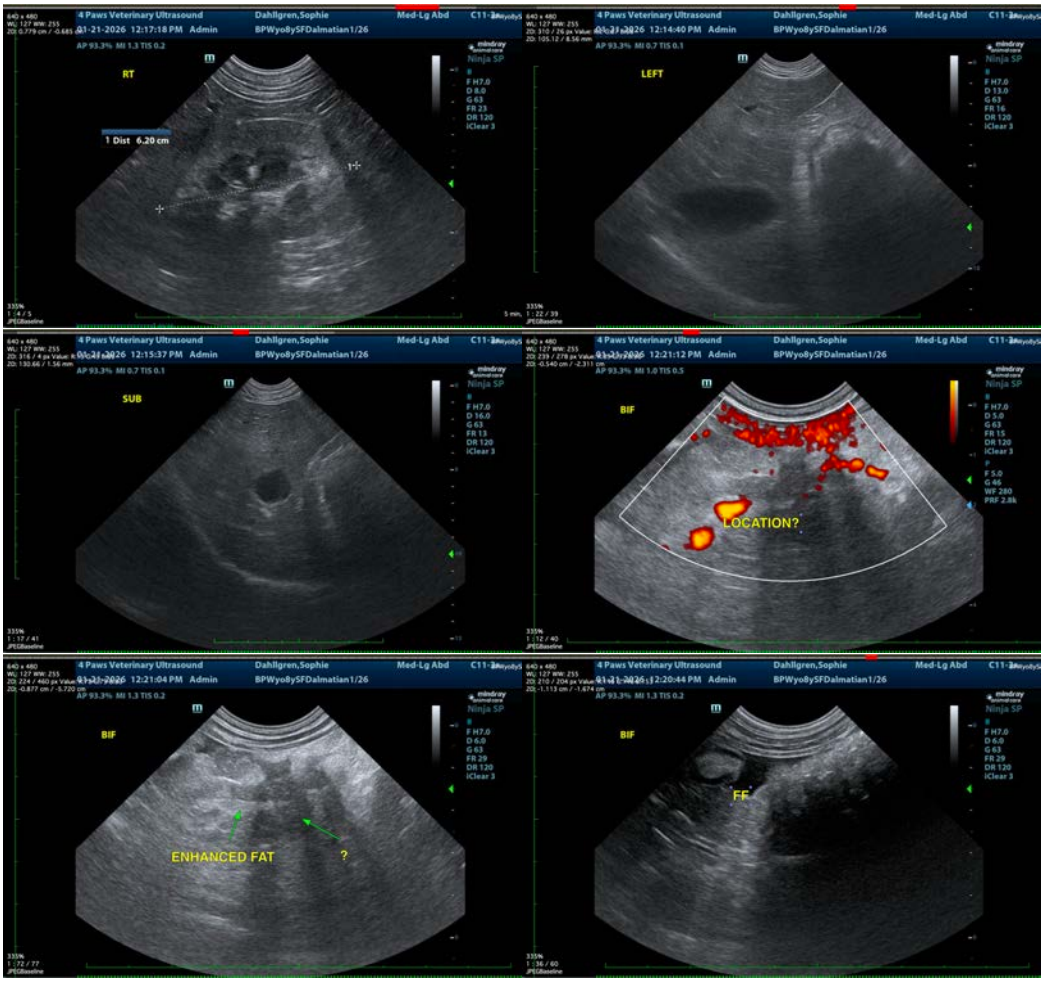

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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