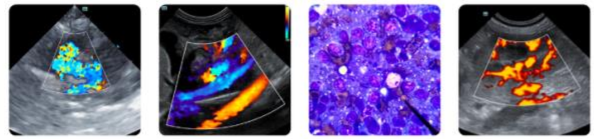


PATIENT

Ginger Brown

SPECIES

Canine

BREED

Labrador Retriever

SEX

Spayed Female

AGE

10 Years

WEIGHT

83.6 pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Mary Pearce

HOSPITAL NAME

Chambersburg Animal Hospital

REFERRING VET

Dr. Tanya Miller

INVOICE

12974

DATE

01/05/2026

PRESENTING CLINICAL SIGNS

Chronic enteropathy for several years but had been stable for 1-2 years. In last 3 months, anorexia and diarrhea started. Responsive to metronidazole. Recently started on Cobalamin supplement and RC low fat diet. Has been on Famotidine for several years. On and off use of probiotic in last 2 months. As of today, still having soft stools. Friday-Saturday was more liquid consistency.

Abnormal PE/Chem/CBC/UA Results: Spec CPL 414ug/L, TLI >50ug/L, Cobalamin 376ng/L, Folate >24ug/l. Negative fecal parasites. MCV 59.7fl, MCH 20.7pg, Eos 1.57k/uL, MPV 14.0fl, chem TP 6.3g/dl, Alb 3.2g/dl, Glob 3.1g/dl.

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.

The left kidney cranial pole is difficult to fully visualize/assess in the sagittal view, but in the portions that can be visualized, there appears to be some irregular shape to the cranial pole of the left kidney as well as slight decrease of normal internal architecture and decreased corticomedullary distinction as well as an overall small size to the kidney measuring 5.12 cm. The caudal pole is well visualized and has a normal appearance.

Right kidney is normal in size (6.9 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 mildly plump in size primarily at the caudal poles. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. The left adrenal gland measures 0.46 cm at the cranial pole and 0.94 cm at the caudal pole. The right adrenal gland measures 0.49 cm at the cranial pole and 0.84 cm at the caudal pole.

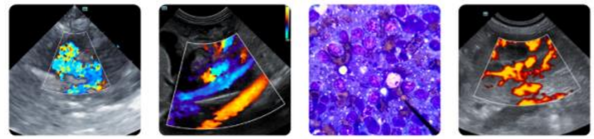
Spleen

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.

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.



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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material or infiltrative disease; however, complete visualization of far wall is partially inhibited by gas. Pyloric outflow tract appears patent.

The bowel is diffusely mildly thick with a representative loop of what I believe is duodenum measuring 0.59 cm thick with diffusely very prominently thick muscularis layer relative to the mucosa. There is no loss of layering appreciated and the lumen is empty with no evidence of obstruction or foreign material.

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

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

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Moderate inflammatory bowel disease (IBD) pattern – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No loss of layering or distinct characteristics of malignancy are present. Therefore, differentials cannot be further ranked without tissue sampling.
- Early or emerging chronic kidney disease affecting primarily the left kidney cannot be ruled out, however, it is difficult to fully assess the cranial pole of the left kidney where I suspect the most visible pathology is. Therefore, this finding should be interpreted in combination with any laboratory abnormalities, urinalysis results, clinical signs, etc.
- Very mildly 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

- 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.

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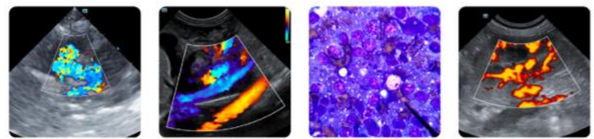

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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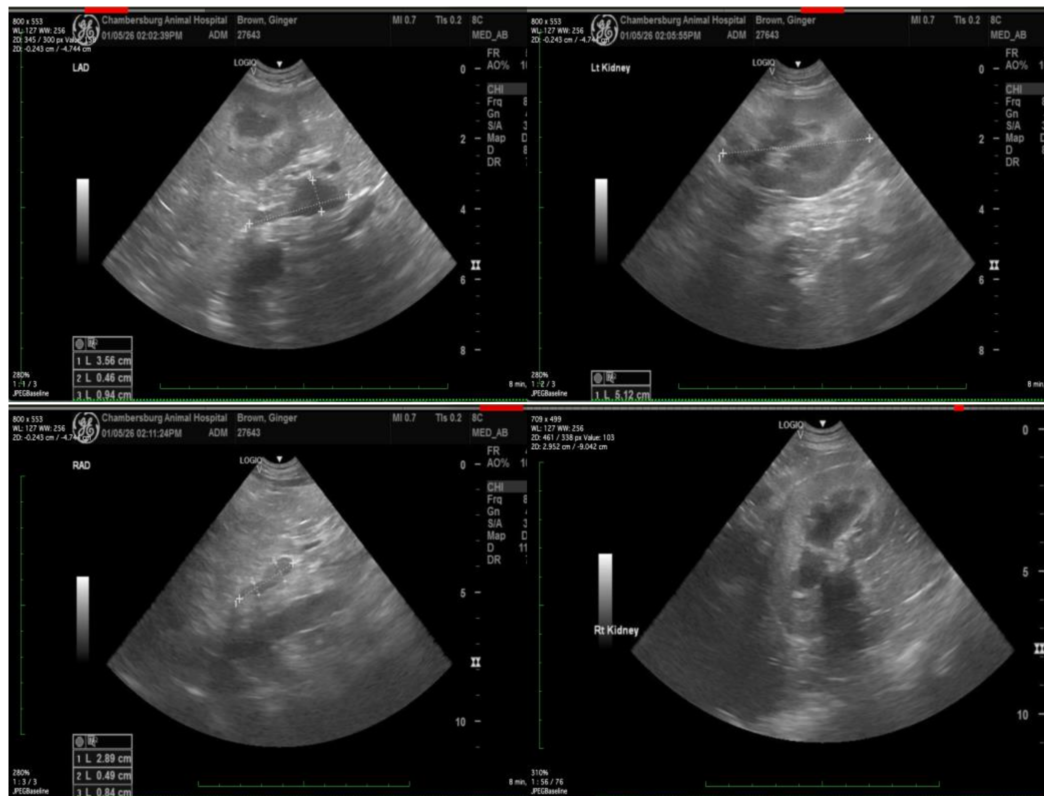
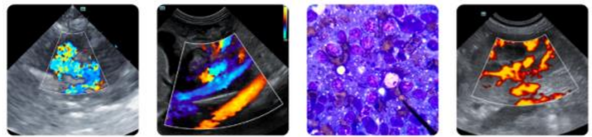
- Ultimately, however, given the patient's reported history of diarrhea, low/normal cobalamin, eosinophilia, etc., biopsies of the GI tract being sure to include the ileum may be necessary for a definitive diagnosis and to therefore further guide medical management.

- 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, fecal microbe transplant therapy could be considered.





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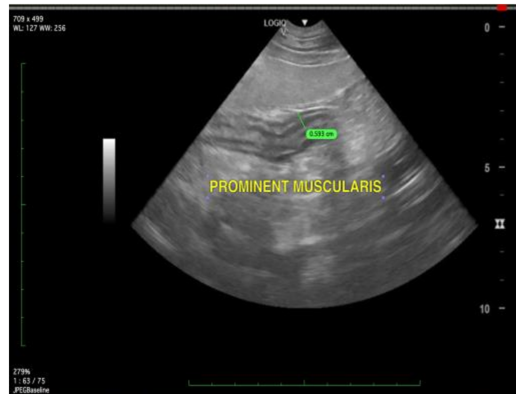

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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