



PATIENT

Pancho Ramirez

SPECIES

Canine

BREED

Australian Shepherd

SEX

Intact Male

AGE

11 Years

WEIGHT

36.8 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Gabriel Ferrer, DVM

HOSPITAL NAME

Pulse: Pet Ultrasound

REFERRING VET

Dr. Rios Cabrera

INVOICE

72094

DATE

1/8/26

PRESENTING CLINICAL SIGNS

Presented as a referral for an abdominal ultrasound to evaluate inappetence, lethargy, anemia, thrombocytopenia and vomiting. Pt also started to develop pollakiuria. Pt was previously was diagnosed with Ehrlichia in Sept 2025 and was treated and completed a tx with doxycycline, prednisone and was doing well, but recent CBC showed anemia and now thrombocytopenia.

Abnormal PE/Chem/CBC/UA Results: Bloodwork CBC was attached as supporting document HCT: 21%, Plat: 68k, Neutro: 12.9k FNA of the spleen and Prostate: Pending

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is only mildly distended. Visible contents are anechoic. Urinary bladder wall is unable to be fully assessed for pathology without further distension. No visible masses or definitive cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface. In the face of urinary signs and/or suspected urinary bladder pathology, reassessment after complete filling is recommended.

Prostate is symmetrically enlarged (6.68 cm wide in transverse view) with smooth margins that are well differentiated from surrounding tissue. Normal bilobed shape is maintained. Parenchyma is diffusely hyperechoic. Several small anechoic cysts are noted. No mineral is noted.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. No infarcts observed. Left kidney measures 5.6 cm. Right kidney measures 6.14 cm with trace pyelectasia noted. Additionally, pinpoint non-obstructive mineral densities are noted bilaterally.

Adrenal Glands

The right adrenal gland is normal in size (0.50 cm at cranial pole and 0.57 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.53 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 (1.7 cm thick at the hilus) with normal smooth margins. Parenchyma is normal in echogenicity with a diffusely coarse/heterogenous echotexture. No discrete sizable 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.



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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.

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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen 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. Pyloric outflow tract appears patent.

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The visible small intestine demonstrates areas of mildly thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

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The colon is diffusely thick, measuring maximally 0.50 cm thick with normal intact layering. The lumen is empty.

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Pancreas

The observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

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Free Abdomen

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

Mesenteric and cranial abdominal/suspect portal lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

IMAGING PERFORMED BY

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Both testicles are visible without evident testicular pathology.

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PRIMARY FINDINGS

- Benign Prostatic Hyperplasia with cysts – Prostatic findings are most consistent with Benign Prostatic Hyperplasia (BPH) and concurrent benign prostatic cysts. Active prostatitis cannot be ruled out. Infiltrative neoplasia cannot be ruled out but is considered less likely.
- 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.
- Mild/emerging 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.

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- The diffusely thick colon similarly could represent both benign and/or infiltrative neoplastic differentials. Having said that, there are no characteristics of malignancy present in these images at this time.

- Mildly to moderately reactive mesenteric and cranial abdominal/suspect portal lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

SECONDARY FINDINGS

- Age related kidney changes with pinpoint non-obstructive mineral densities and trace pyelectasia in the right kidney.
- 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.
- Pancreatic age-related remodeling/Chronic pancreatitis – Mild irregularities are consistent with benign age-related change. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Regarding patient's reported pollakiuria, if not recently evaluated, a 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 ratio is recommended.

As is reportedly pending, fine needle aspirates of the prostate could be considered if patient's coagulation status is appropriate.

While infiltrative neoplasia is considered less likely, additionally submission of urine to look for BRAF gene mutation could be considered.

Patient's splenomegaly could be a residual change i.e., extramedullary hematopoiesis or other related to the previous infectious disease. However, as is reportedly already pending, fine needle aspirates could be considered if patient's coagulation status is appropriate.

Otherwise, continued evaluation, workup for possible recurrence of infectious disease, treatment, etc. of the anemia and thrombocytopenia is indicated, as there is not a definitive intraabdominal ultrasonographically visible explanation as to why the recurrence occurred.

Given patient's reported gastrointestinal signs combined with the mild GI changes noted above, a routine fecal/giardia exam could be considered.

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.



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In the meantime, supportive/symptomatic medical management of clinical signs is recommended.

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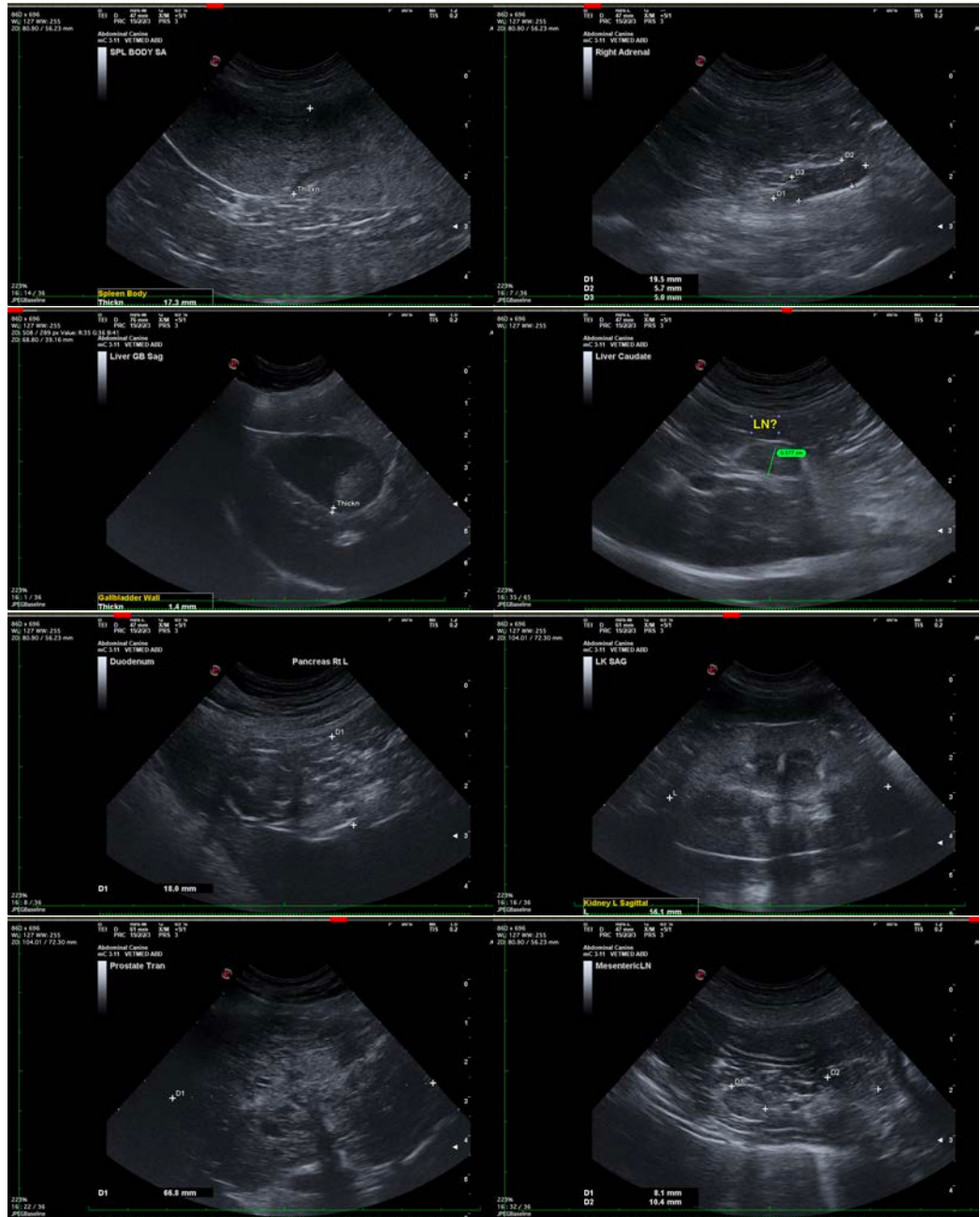
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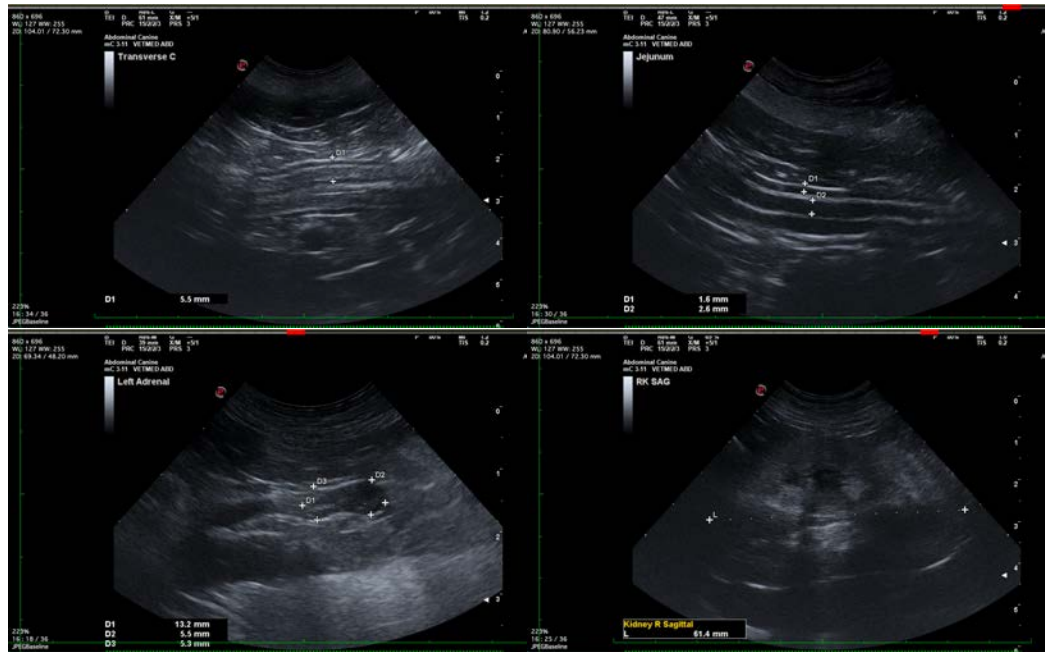
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
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