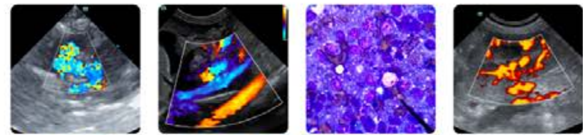


PATIENT
Bruce Grim

SPECIES
Canine

BREED
Rotti x Bernese

SEX
Neutered Male

AGE
7 Years

WEIGHT
51.1 kg

INTERPRETED BY
Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY
Amanda Stewart

HOSPITAL NAME
Wellington Animal Hospital

REFERRING VET
Dr. Grodecki

INVOICE
71988

DATE
11/20/25

PRESENTING CLINICAL SIGNS

Initially on October 30th presented for weight loss (about 2kg), lower energy and intermittent billious vomiting with decreased appetite for about 1 week -Bloodowk October 30th showed elevated PLI, and continued/persistently elevated ALP with a mild anemia -Was started on Low Fat GI food and continued to have intermittent vomiting, decreased appetite -Seen Nov. 18th for recheck - another 1kg Weight loss, abdominal discomfort/licking lips on palpation and persistently picky/low appetite with intermittent/daily vomiting of bile -Owner declined repeat bloodwork but elected to proceed with ultrasound -Cerenia and Gabapentin with low fat GI food started in meantime Note: had previous u/s with Focal Zone May 30th 2024 for persistent ALP elevations Current Medications Cerenia tablets and Gabapentin

Abnormal PE/Chem/CBC/UA Results: See attached See email - bloodwork from October. 30th ALP 292 U/L HCT 38% Hemoglobin 137 Reticulocytes 17.4k/uL Clumped platelets Spec cPL = 1,418 (0-200ug/L) Radiographic Findings n/a Primary Question to Be Answered in This Exam Any obvious cause for persistent vomiting/appetite concerns other than pancreatitis?

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.

Prostate is normal in size, echotexture and echogenicity for a neutered male.

The right kidney is normal is size (7.9 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.

The left kidney is normal is size (7.8 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.

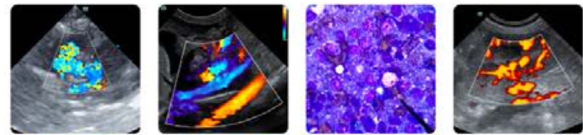
Adrenal Glands

The right adrenal gland is normal in size (1.1 cm at cranial pole and 0.82 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.59 cm at cranial pole and 0.71 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

The spleen is subjectively normal in size (2.6 cm thick at the hilus) 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.



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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 empty with 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. 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

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.

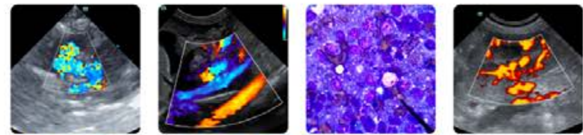
ULTRASONOGRAPHIC FINDINGS

- This is a largely unremarkable/structurally normal abdomen without a definitive ultrasonographically visible intraabdominal explanation for patient's reported gastrointestinal signs.
- An obvious cause for the reported increased liver enzymes 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not already evaluated, workup of the chronically increased ALT is recommended, beginning with bile acids if patient's total bilirubin is not increased, +/- testing for Leptospirosis, and ultimately potentially liver sampling if patient's coagulation status is appropriate.

Additionally, however, further gastrointestinal workup recommendations include:



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A routine fecal/giardia exam if not recently evaluated.

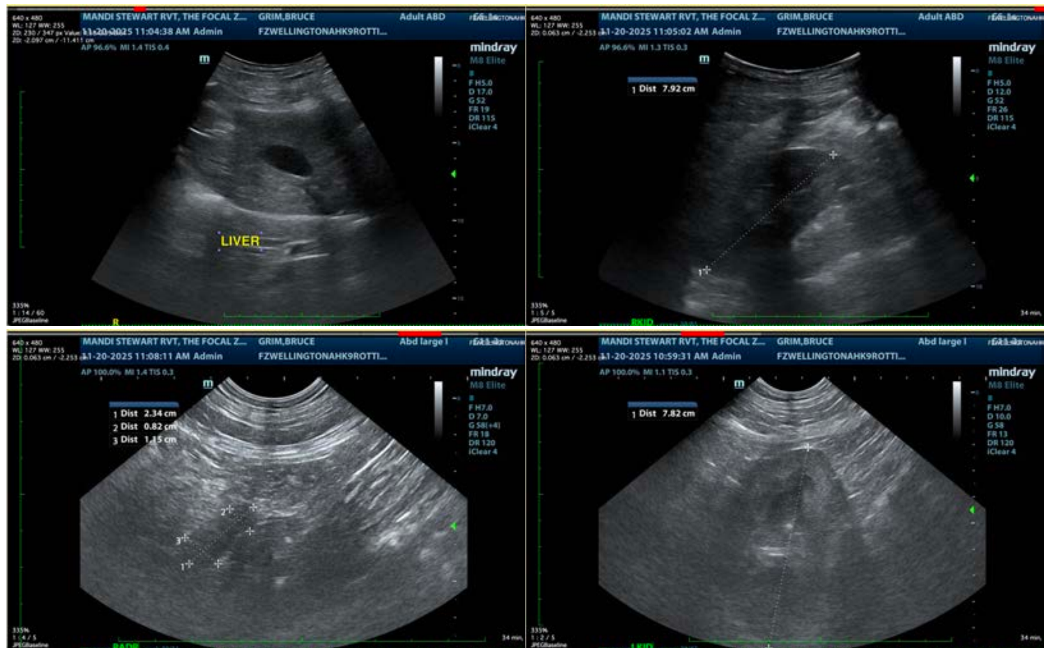
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

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.

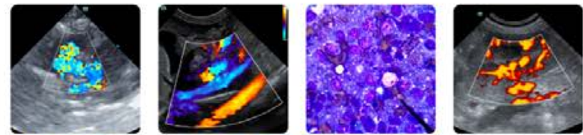
+/- (pending results of above) a baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

In the meantime:

- Supportive/symptomatic medical management of clinical signs is recommended, including anti-emetics, appetite stimulants or other nutritional support as needed, gastroprotectants (+/- sucralfate, especially with any history of hematemesis), an appetite stimulant and fluid therapy if indicated, etc.
- Additionally, empirical deworming with a 5-day course of Panacur is recommended.
- A full course of empirical Helicobacter triple therapy could be considered.
- A probiotic, such a visbiome or proviable, may be helpful.
- Finally, if tolerated, a transition in diet could be considered, based on trial-and-error response with some options to consider including a gastrointestinal biome diet vs a hydrolyzed protein diet (sometimes several trials with different brands are necessary) vs an easy to digest, bland or low-fat diet vs other.



The Focal Zone
FUELED BY SONOPATH VETERINARY ULTRASOUND



SonoPath
www.thefocalzone.com
info@thefocalzone.com
289.808.2608

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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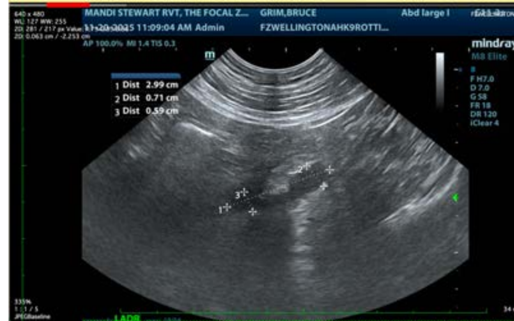

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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