



PATIENT

Peyton Allspach

SPECIES

Canine

BREED

Labrador Retriever

SEX

Neutered Male

AGE

13 Years 9 Months

WEIGHT

47.2

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Joanne Goodman

HOSPITAL NAME

Evendale-Blue Ash Pet
Hospital

REFERRING VET

Dr. Stephanie Wehmer

INVOICE

72110

DATE

11/25/25

PRESENTING CLINICAL SIGNS

Antibiotic resistant infection in food Started with vomiting the end of October. Prescribed Ondansetron. Lethargic/not eating/Pancreatitis 11/7/25 - Hosp with iv fluids; Cerenia, famotidine; Sucralfate. Concurrent Pedal Dermatitis Vom/inappetence better by 11/12/25 Went on antibiotics - inappetence/vomiting started again 11/13 Oral antibiotics on and off - causing vomiting/diarrhea 11/19 Antibiotics stopped - giving Cerenia/bland diet/ondansetron 11/21 continued lethargy; inappetence - reco ultrasound 11/24 very low energy; 1x vomiting; hand feeding

Abnormal PE/Chem/CBC/UA Results: 11/7/25 CBC: WBC 16.9 (H) [reference <16.76], eosinophils elevated (double normal) - Chemistry panel: ALT in 300s (3x elevated), ALP 1300 (tripled from 2022 value of 400) - Pancreatic lipase (PLI): 879 [reference <200] - Urinalysis: pH basic, bacteria present, no RBCs or WBCs detected - Culture: multiple resistant bacterial strains in left hind foot draining tract, resistant to Convenia

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with a moderate amount of echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The area of the prostate is examined without evident prostatic pathology.

The right kidney is normal is size (6.3 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 (6.5 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 0.73 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. A small hyperechoic nodule is noted in the cranial pole. Nodule does not disrupt normal shape and/or architecture. Visible surrounding vasculature appears normal.

The left adrenal gland is small (flattened contour), measuring 0.31 cm at the cranial pole and 0.40 cm at the caudal pole. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

Spleen

The 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.



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Liver

Liver is subjectively enlarged (swollen contour) with a diffusely mildly coarse architecture and subtly increased portal markings. Mildly mixed echogenic changes are noted diffusely. No focal lesions are observed. 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 empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestine demonstrates areas of moderately 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.

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.

Medial iliac 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.

ULTRASONOGRAPHIC FINDINGS

- Flat left adrenal gland – This can be a normal patient variant and/or a sign of exogenous cortisol administration. If exogenous steroids are not being administered, hypoadrenocorticism (either relative or absolute) should be considered.
- Hyperechoic adrenal nodule (cranial pole right adrenal gland) – Differentials include primary adrenal cortical adenoma or adenocarcinoma, pheochromocytoma, myelolipoma, adrenal hyperplasia secondary to pituitary disease or metastatic disease. Ultrasound alone cannot differentiate between functional and non-functional nodules and/or between benign and malignant disease. Small nodules without other evidence of abdominal disease (to suggest metastatic disease) and/or clinical signs (to suggest adrenal disease) are most often incidental and should be monitored.



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- An obvious cause for the subtle liver changes 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.
- 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.
- 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, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling.
- Reactive reactive medial iliac lymph nodes - infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Moderate amount of echogenic urinary bladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If patient's gastrointestinal signs are primarily antibiotic induced, then the recommendations are largely geared towards addressing the wound that is resulting in the need for antibiotic therapy. Exploration of the draining tract, potentially deep culture and sensitivity with an expanded antibiotic panel, potentially histopath, and/or even consultation with a surgeon could be considered.

Having said that, there are some subtle changes in the abdomen that could be contributing to gastrointestinal signs, including the left adrenal gland and the bowel layering. Therefore, additionally, a baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

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.

In the meantime and while continuing workup:

- Supportive/symptomatic medical management of clinical signs is recommended, including anti-emetics, 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.



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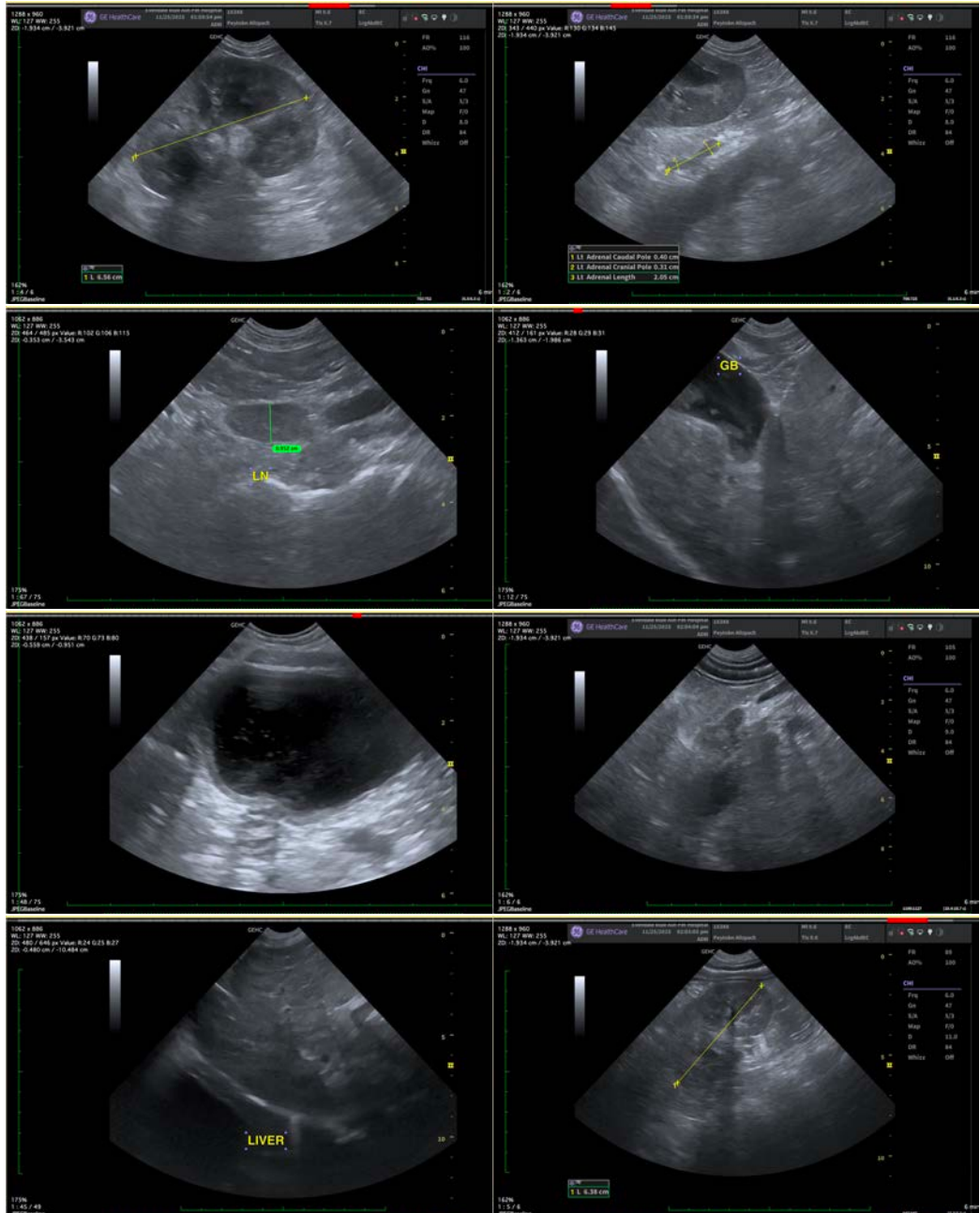
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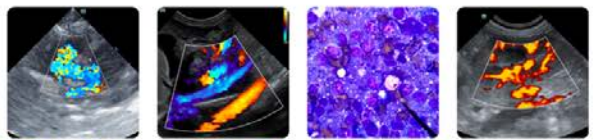
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- A probiotic, such a visbiome or proviable, may be helpful.
- Finally, if tolerated, a transition in diet could be considered, based on trial-and-error response with some options to consider including a gastrointestinal biome diet vs a hydrolyzed protein diet (sometimes several trials with different brands are necessary) vs an easy to digest, bland or low-fat diet vs other.





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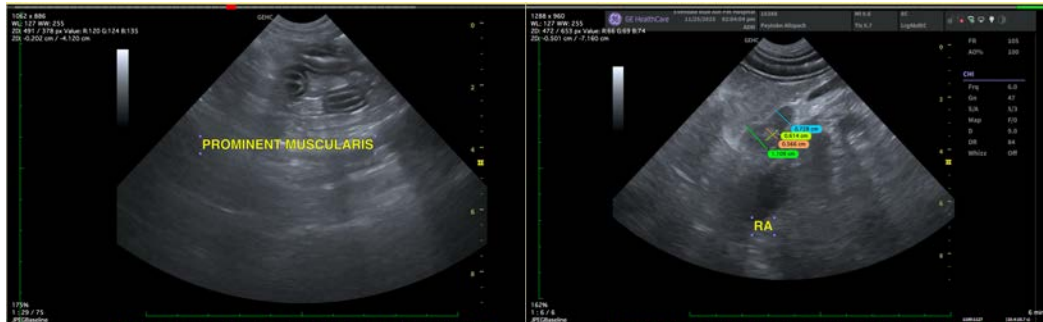
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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