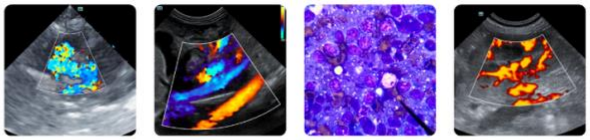


PATIENT

Bruce Wayne Slepma

SPECIES

Canine

BREED

French Bulldog

SEX

Neutered Male

AGE

3 Years

WEIGHT

13.4 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Erin Wicks

HOSPITAL NAME

Shores Veterinary Emergency Center

REFERRING VET

Dr. Law

INVOICE

12487

DATE

11/26/25

PRESENTING CLINICAL SIGNS

P has a history of chronic regurgitation after eating/drinking but has been excessive for this past week. happens after eating or drinking. P also has not wanted to eat for the past week but finally ate when hand fed last night and ate on his own this morning. P has had 2 urinary accidents in the house over the past 2 days. P is normally a chill dog but is not himself. In addition to the above, the owner said Bruce regurgitated this morning, bringing up food from last night. He then ate after this and has kept this done. He has been on the HA diet since his BOAS surgery due to his regurgitation problems. Previous Health Concerns BOAS done at about 1 year of age, aspiration pneumonia prior to BOAS surgery

Abnormal PE/Chem/CBC/UA Results: CBC: Normal WBC, RBC, and platelet counts. Elevated HCT 61.1%. EPOC: Increased Na+ 154 mmol/L and HCT 68%. Decreased K+ 2.1 mmol/L and Chloride 99 mmol/L. Chemistry: All normal. cPL: 144.7 ng/ml (normal) Rads: Thorax, 3 views: Normal trachea, heart, lungs, and esophagus. Hemivertebrae at T10. Abdomen, 3 views: Normal liver and spleen. Ingesta in the stomach and much stool in the colon. No obvious GI FB or intestinal obstructive pattern. With all the food in the stomach and stool in the colon, it is difficult to see all the other organs. The kidneys are not easily visible. Small urinary bladder. Urinalysis pH 8.0. SG 1.054. Imagyst/ sediment: WBC, Ca oxalate crystals, epithelial cells.

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.

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

Left kidney is normal in size (5.53 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.

Right kidney is normal in size (5.07 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

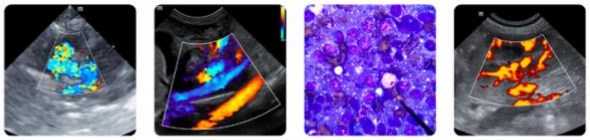
The adrenal glands are unable to visualized in these images.

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. The spleen measured 1.2 cm thick at the hilus.

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



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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.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with a small to moderate amount of echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is 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/normal structural abdomen without a definitive ultrasonographically visible intra-abdominal explanation for the patient's reported regurgitation.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Further gastrointestinal work up recommendations include:

- 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 baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.
- Additionally, additional imaging such as contrast radiography/barium swallow study could also be considered for further evaluation of the swallowing and esophageal function. In the

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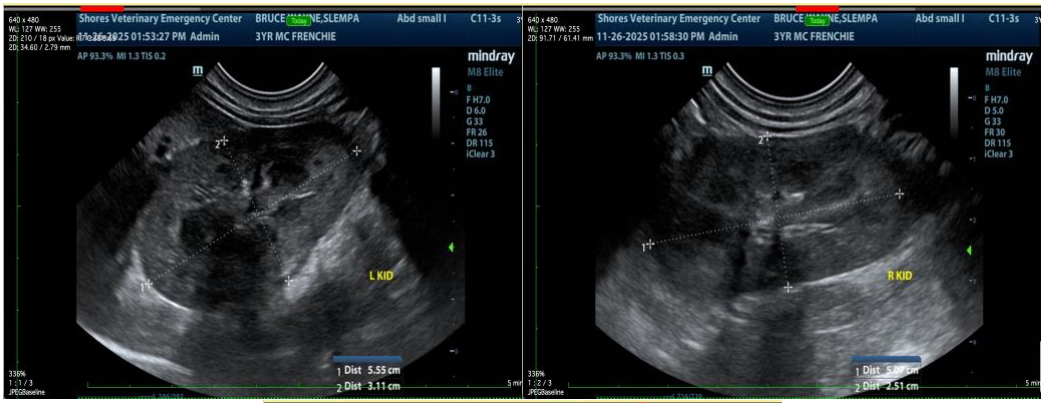
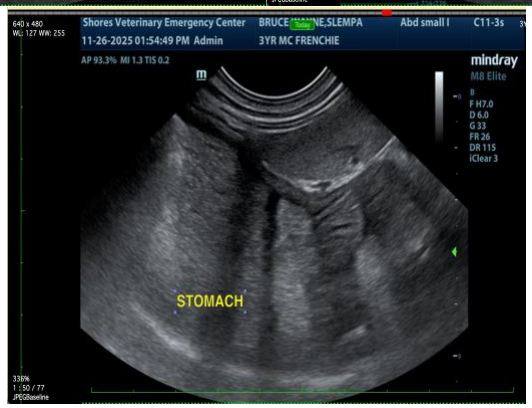
meantime, empirical deworming with a 5 day course of Panacur is recommended as is supportive/symptomatic medical management of possible esophagitis/GERD.

- Additionally, if tolerated, a transition in diet is recommended, based on trial-and-error response.

- Some options to consider include a gastrointestinal biome diet vs a hydrolyzed protein diet (sometimes several trials with different brands are necessary) vs a fiber response/colitis diet vs a bland, easy to digest or low-fat diet vs other.





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