

PATIENT

Massimo Hill

SPECIES

Canine

BREED

Chihuahua

SEX

Neutered Male

AGE

13 Years

WEIGHT

1.6 kg

INTERPRETED BY

Beth Johnson, DVM
 DACVIM

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Acton VC

REFERRING VET

Dr. Shah

INVOICE

35400

DATE

11/4/25

PRESENTING CLINICAL SIGNS

History: Findings: declined eating, up and down with appetite. O is very concerned of P's weight. P will not even eat some human food (chicken) and at times will then go eat his own food Very reluctant to eat kibble or wet if it is the only thing provided No c/s/v/d Stools are small Anorexic ad puts his nose up to all food More tired/lethargic than normal Current Medications Liver supplement, Prednisolone (2 doses given), Ursodiol (one dose given).

Abnormal PE/Chem/CBC/UA Results: Values ALT - too high to be read, ALP - 994U/L, GGT 39 U/L, Eosinophilia Radiographic Findings Not done Primary Question to Be Answered in This Exam Hepatitis concerns, whether it is a neoplasia.

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 unable to be well visualized in these images.

Left kidney is normal in size (3.24 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 (3.53 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.

Adrenal Glands

Left adrenal gland is normal in size (0.38 cm at cranial pole and 0.45 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

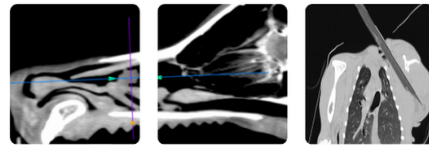
Right adrenal gland is normal in size (0.65 cm at cranial pole and 0.41 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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.



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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 of the stomach is moderately overdistended 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.

BREED

Chihuahua

The visible small intestine demonstrates areas of moderate to severely 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. One loop of bowel that I believe might be duodenum, has a very hyperperistaltic /corrugated appearance, but no evidence of shadowing or foreign material is noted.

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The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

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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.

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Free Abdomen

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

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There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

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Primary Findings

- Moderate inflammatory bowel disease 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.
- The hyperperistaltic/corrugated loop of small bowel is likely secondary to the underlying gastrointestinal disease or concurrent irritation secondary to bacterial, viral, protozoal, parasitic disease, toxin, other underlying metabolic disease, such as pancreatitis versus other. A nonvisible, nonshadowing chronic foreign body, such as a subtle linear foreign body can't be ruled out but is considered less likely.

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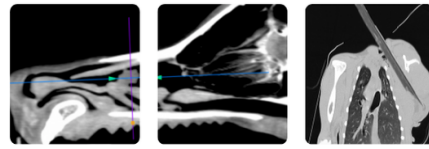
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- Similarly, the gastric distention is likely secondary to underlying gastrointestinal or metabolic disease, although partial obstruction due to nonvisible foreign material, while thought less likely, can't be definitively ruled out.
- An obvious cause 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, etc. cannot be definitively ruled out.

Secondary Findings

- 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Especially given the patient's reported eosinophilia, a routine fecal/Giardia exam is recommended if not recently evaluated.

A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

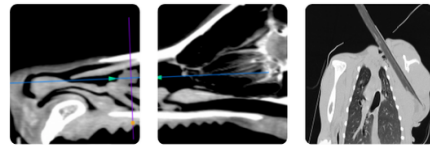
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

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.

Additionally, bile acids are recommended if patient's total bilirubin is not increased.

In the meantime, in addition to supportive/symptomatic medical management of clinical signs, i.e., antiemetics, gastroprotectants, an appetite stimulant, fluid therapy if clinically indicated, pain management if clinically indicated, etc., empirical deworming with a 5-day course of Panacur is recommended. If appetite doesn't improve drastically, placement of a feeding tube may be indicated.

Ultimately, if clinical signs persist and a diagnosis is not obtained, an exploratory laparotomy for further evaluation of especially the hyperperistaltic/corrugated bowel loop to more definitively rule out a possible chronic foreign material, as well as obtain full thickness biopsies of the GI tract and liver, may be necessary for a definitive diagnosis, and therefore, to further guide medical management.



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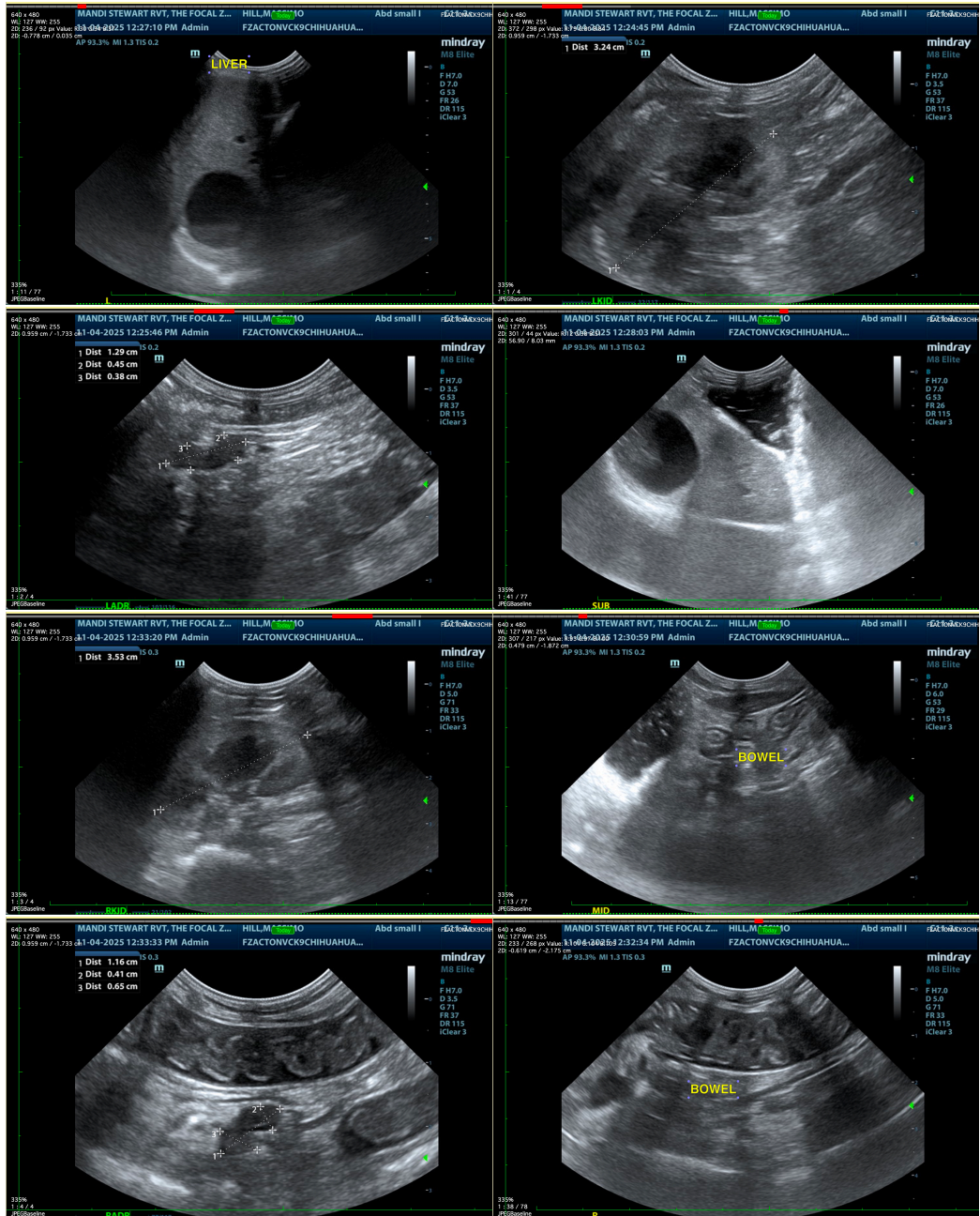
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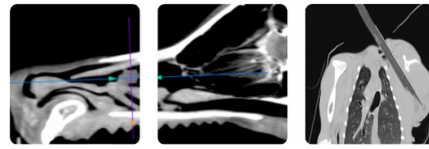
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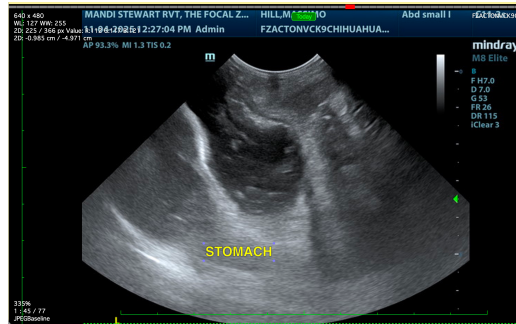
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

info@sonopath.com