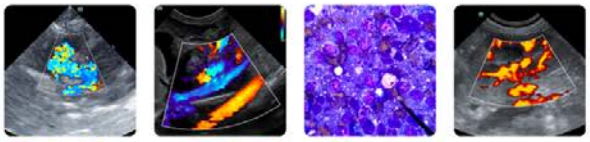


PATIENT

Buddy Noll

SPECIES

Canine

BREED

Yorkshire Terrier

SEX

Neutered Male

AGE

4 Years

WEIGHT

2.6 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Blue Pearl Wyomissing

REFERRING VET

Heatherlynn McFarlane, DVM (Internal Med)

INVOICE

72634

DATE

12/17/25

PRESENTING CLINICAL SIGNS

AUS to further evaluate lethargy and anorexia. Hx of Addison's diagnosed Sep 2024. Diagnosed with Addison's disease 2024 (ACTH Stim Pre: 1.3, Post 1.4) and treated with Prednisone 1.25mg PO q24hr and DOCP (though has not had since Aug 2025). Had been doing well until 12/11/25 when a decrease in energy was noticed. Energy remained decreased and then stopped eating 12/14/25. ER Mgmt: Plasmalyte 6mL/hr, DexSP 0.15mg/kg IV q24hr, DexSP 0.15mg/kg IV q12hr, DOCP 2.2mg/kg SQ given 12/15/25

Abnormal PE/Chem/CBC/UA Results: 9/2024 ACTH Stim: Pre: 1.3 (L), Post 1.4 (L) Oley Vet 12/15/25: - CBC: WBC 12.47K, Neut 6.62K, Lymph 4.03K, Mono 1.81K (H), Eos 0.01K (L), HCT 27.8% (L), PLT 253K - Chem: TP 8.6 (H), Alb 3.8, Glob 4.9 (H), Creat 1.6, BUN 85 (H), SDMA 23 (H), ALT 97, ALP 115, GGT 0, Tbil 0.5, Chol 161, Na 130 (L), K 4.9, Cl 94 (L), Ca 11.9, Phos 8.7 (H), Glu 103 - T4: 3.6 BP WYO ER: - EPOC (6PM): pH 7.185 (L), PCO2 35.4, HCO3 13.4 (L), Creat 1.48, BUN 85 (H), Na 125 (L), K 4.4, Cl 99 (L), iCa 1.53 (H), Glu 136 (H) - PCV/TS: 34% (L)/9.4g/dL (H) - cPL: 357 (H, 0-200) - UA: USG 1.024, pH 5.5, WBC none, RBC none, bacteria none, protein 2+ (H), glu/ketones negative, amorphous urate crystals 4-10/HPF (H), fine granular casts 0-1/LPF (H)

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 (2.97 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 or infarcts observed. Pinpoint non-obstructive nephroliths are noted.

The left kidney is normal is size (2.53 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 or infarcts observed. Pinpoint non-obstructive nephroliths are noted.

Adrenal Glands

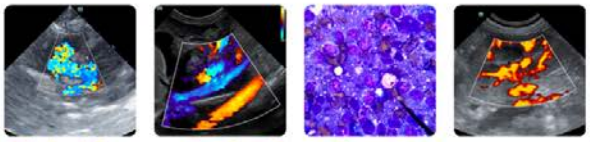
Adrenal glands are small (flattened contour). Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. Left measures 0.23 cm at the cranial pole and 0.23 cm at the caudal pole. Right measures 0.22 cm at the cranial pole and 0.26 cm at the caudal pole.

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.

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



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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 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 is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta/chyme. There is no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. The lumen is mildly diffusely distended with soft stool.

Pancreas

The observed pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and irregular in shape with a swollen undulating contour. This change is mild/subtle and most appreciated in the left limb. Enhanced hyperechoic ill-defined surrounding fat is noted.

Free Abdomen

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

There is no apparent pathologic lymphadenopathy noted in these images.

PRIMARY FINDINGS

- Suspect mild to moderate acute pancreatitis.
- The adrenal glands are flat, which is consistent with patient's history of steroid therapy for suspected hypoadrenocorticism.

SECONDARY FINDINGS

- Pinpoint non-obstructive nephroliths bilaterally.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

Given that the pancreatic changes are very mild/subtle, other workup for other concurrent contributing conditions may be warranted, especially given patient's reported hyperglobulinemia and lymphocytosis. Other infectious and/or even neoplastic disease without visible supporting changes within the abdomen can't be ruled out. A pathology review of the lymphocytes could be considered, as could serum electrophoresis for further evaluation of the hyperglobulinemia.

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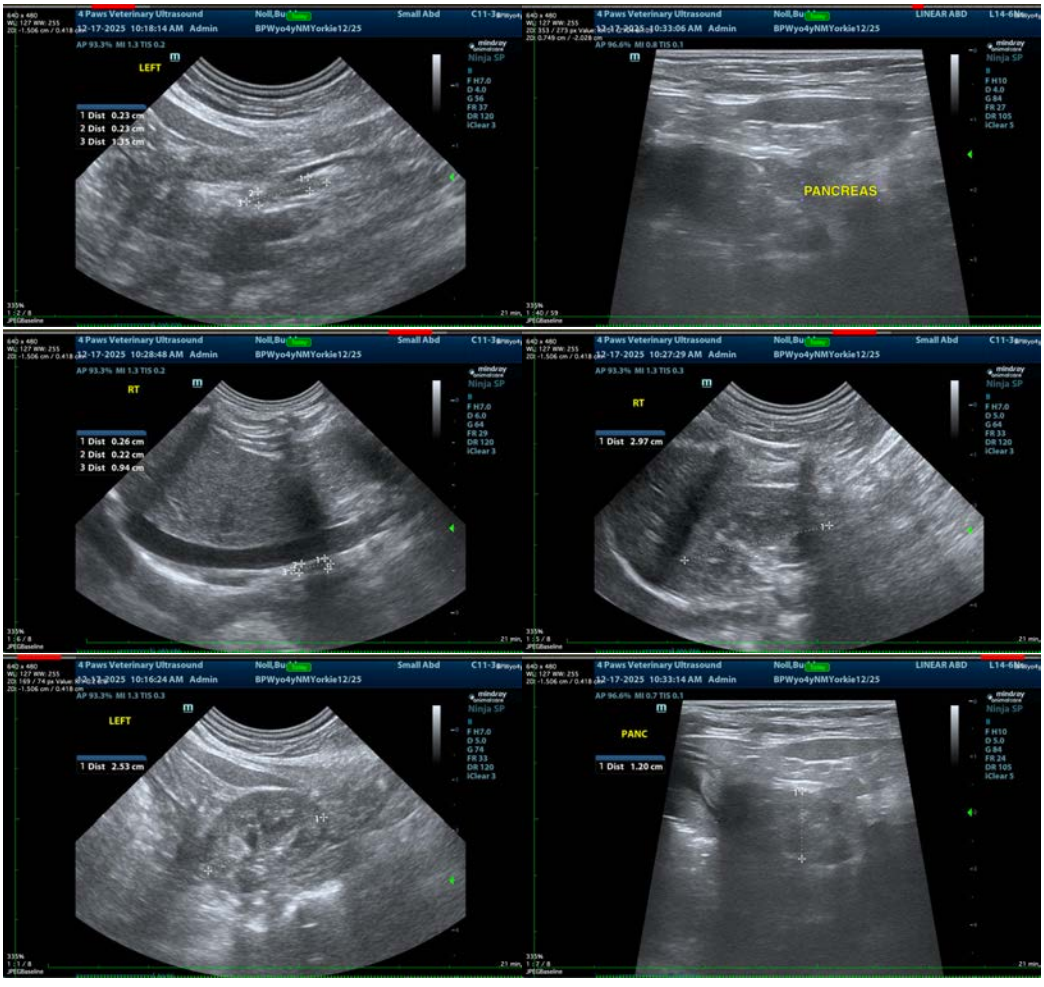
Reevaluation of patient's hypoadrenocorticism diagnosis may also be indicated, including a thorough history to be sure that patient was not receiving steroids and/or had not recently received steroids at the time of the reported ACHTH stimulation test results, just to double check.

In the meantime, medical management of pancreatitis with anti-emetics, gastroprotectants, appetite stimulants or nutritional support as needed, pain management, broad spectrum antibiotics, and fluid therapy is recommended. Monitoring of the pancreas with power doppler is recommended to identify possible necrosis as well as other potential sequelae such as abscesses, etc.



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