



PATIENT

Maggie Burritt

SPECIES

Canine

BREED

Boxer x

SEX

Spayed Female

AGE

6 Years

WEIGHT

51

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Jessica Green

HOSPITAL NAME

Stanglein Veterinary
Clinic

REFERRING VET

Dr. Daniel Hoffman

INVOICE

72423

DATE

12/9/25

PRESENTING CLINICAL SIGNS

History of atopic dermatitis, but seems to be doing fairly well on Fluconazole pulse-dosing, Zenrelia, and a hydrolyzed diet; history of exocrine pancreatic insufficiency, but had been well-controlled on PancreaVed Powder - there has been continued, gradual weight loss for several months, despite a reportedly normal appetite and no diarrhea (the stools are reported to be formed and normal); worsening PU/PD and urinary accidents are also reported... current meds: 1. Fluconazole 150 mg PO twice weekly 2. Ilunocitinib (Zenrelia) 15 mg PO SID 3. PancreaVed Powder 1 tsp. 2-3 times daily (with food) 4. Zyrtec 20 mg SID 5. Vitamin B12 SID

Abnormal PE/Chem/CBC/UA Results: 1. CBC/Chem/T4/UA/fecal, 11/01/25 - CBC: WNL; Chem: a mild stress-hyperglycemia is noted (GLU = 120 mg/dL), but no other abnormalities are appreciated, and the T4 was WNL; mildly increased WBC were noted on UA, but no bacteria, blood, etc. was noted; fecal negative for O&P 2. 4DX 11/01/25 - negative 3. CBC/Chem, performed 11/25/25, CBC: mild leukopenia (WBC = 4.70 K/uL), but the differential counts were all WNL/no changes noted in platelets or RBC; Chem WNL 4. Urine Culture and MIC, 11/25/25 - NO GROWTH 1. Right Lat Abd Rad, 11/25/25 - the stomach is moderately distended with gas and what appears to be normal ingesta, and relatively formed feces in the descending colon, no obvious FB or obstructive patterns are noted; no any other obvious masses or organomegaly, and no cystoliths

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.

The right kidney is normal is size (6.36 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 (6.45 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 (0.56 cm at cranial pole and 0.52 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.47 cm at the cranial pole and 0.53 cm at the caudal pole) shape and overall architecture, echogenicity and echotexture. 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.

Liver



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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 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. Contents are consistent with normal formed feces and gas.

Pancreas

The area of the pancreas is examined without any definitively visible pancreatic parenchymal abnormalities noted in these images at this time.

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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given patient's history, continued very close monitoring for the development of diabetes mellitus is recommended, including potentially, given the recently reported "stress hyperglycemia", a Fructosamine level.

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

Further investigation may or may not be warranted for the reported mild leukopenia i.e., comprehensive infectious disease evaluation, further workup evaluation for neoplasia outside the abdomen i.e., 3-view thoracic radiographs, etc.

In the meantime, while continuing to work up the PU/PD and weight loss, increasing daily caloric intake could be considered.



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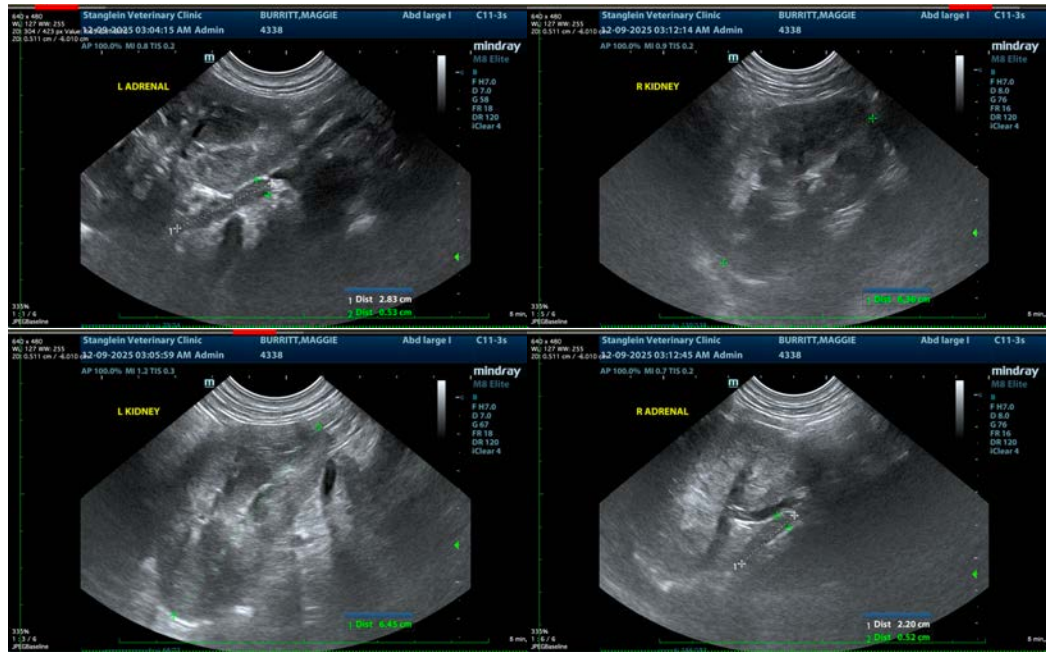
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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