

PATIENT

Emma Tileston

SPECIES

Canine

BREED

Aussie

SEX

Spayed Female

AGE

15 Years

WEIGHT

19 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Loetitia Saint-Jacques,
LVT

HOSPITAL NAME

Donner Truckee VH

REFERRING VET

Nathaniel Brown, DVM

INVOICE

36792

DATE

2/10/26

PRESENTING CLINICAL SIGNS

- **Historical Conditions:** Congestive heart failure, Kidney disease (glomerulonephritis), Suspected Cushing's disease, Bloodwork from December 2024 was reportedly normal, Inappetence for over 2 days, Normally fed a kidney diet, Ate a small amount of chicken overnight but refused food this morning, Ate a Greenie and a turkey jerky treat at the clinic, Drinking and urinating normally, Diarrhea occurred last night, No vomiting reported, History of coughing up phlegm, but not within the last week.
- **Current Medications:** Lasix 12.5mg: 1.5 tablets in the morning, 1 tablet at night, Pimobendan 5mg: 1/2 tab PO q24hr, Telmisartan 20mg: 1/2 tab PO q24hr, Spironolactone 25mg: 1/2 tab PO q24hr, Monthly heartworm and flea/tick preventive
- **Additional Information:** Energy has been progressively declining over a long period, with no acute change noted in the last few days.
- **Assessment:** Inappetence 48 hours, suspected acute pancreatitis supported by elevated pancreatic enzymes and inflammatory, leukogram, Congestive heart failure (CHF) previously diagnosed and under medical management (no evidence of active congestive failure at this time), Proteinuria / chronic kidney disease (suspected) - patient currently receiving telmisartan, consistent with prior diagnosis of proteinuria likely associated with CKD
- **Azotemia - r/o pre-renal (decreased intake/dehydration) vs renal component, Treatment** Cerenia, Panquell
- **Abnormal PE/Chem/CBC/UA Results:** 2/7/2026- CHEM-WBC 17.38, NEU 14.38, BUN 68, Crea 1.4, QPL 912 (0-200), Amylase: 2,042 U/L. Albumin 2.9 (normal) ALT 69(N), ALKP 93 (N), GGT 3, Na/K 40 PE- Abdomen: soft, non-painful; no palpable masses or organomegaly.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

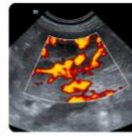
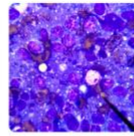
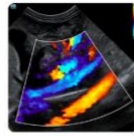
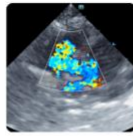
Urinary System

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.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. The left kidney measures 4.13 cm. The right kidney measures 4.87 cm.

Adrenal Glands

Left adrenal gland is normal in size (0.51 cm at cranial pole and 0.71 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.



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Right adrenal gland is normal in size (0.55 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal. The cranial pole is unable to be well visualized in these images.

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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). Except for, an approximately 0.45 cm x 0.75 cm non-capsule-disrupting, hypo- to anechoic density noted near the cranial to mid aspect of the spleen. Splenic vasculature appears normal.

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Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is mildly heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. 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 very mildly subjectively hyperechoic and potentially a little thick and irregular in appearance. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

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Gastrointestinal

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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.

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The visible small intestines are normal in wall thickness and layering. Hyperechoic mucosal fogging or speckling is noted. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

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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.

Pancreas

Pancreas is prominent (enlarged) in size and mildly irregular in shape with a slightly undulating contour. Parenchyma is coarse in echotexture and heterogenous to hypoechoic in echogenicity.

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Free Abdomen

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

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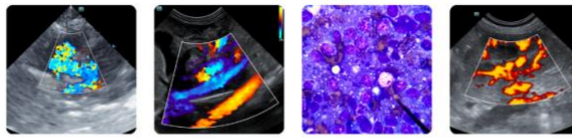
The mesenteric and medial iliac lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

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ULTRASONOGRAPHIC FINDINGS

Primary Findings



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- Chronic low grade smoldering pancreatitis can't be ruled out. There is no definitive ultrasonographically visible evidence of acute inflammation noted in these images at this time.
- Mildly heterogenous liver- These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.
- Mild to moderate 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.
- Mild/subtle mucosal speckling- Mucosal speckling is often present with inflammatory bowel disease (IBD). It is not specific for type or severity of disease. Mild speckling change can occur as a normal patient variant in the post-prandial state.
- Moderately reactive mesenteric, and mildly reactive medial iliac, lymphadenopathy- infiltrative neoplastic disease cannot be ruled out but is considered less likely.

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Secondary Findings

- Hypo- to anechoic splenic nodule- likely represents a benign lesion such as a cyst, hematoma, nodular hyperplasia, extramedullary hematopoiesis, etc., however while considered less likely, infiltrative neoplasia can mimic benign lesions and cannot be ruled out.
- Age-related kidney changes

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes described above are all largely mild/subtle and nonspecific without a definitive ultrasonographically visible intraabdominal explanation for patient's reportedly decreased appetite. Having said that, chronic low grade smoldering pancreatitis, or even emerging acute on chronic process, +/- concurrent gastroenteritis or other gastrointestinal disease cannot be ruled out. Therefore, especially given the concurrent diarrhea, a routine fecal/Giardia exam is recommended 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 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.

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Pending results of above, further evaluation for possible pain (dental, orthopedic, other), upper respiratory disease or oropharyngeal disease, cardiac disease and/or neurologic disease vs other as possible causes for decreased appetite is also recommended.

Other than supportive/symptomatic medical management of clinical signs, further diagnostic and treatment recommendations are largely dependent on results of the above.

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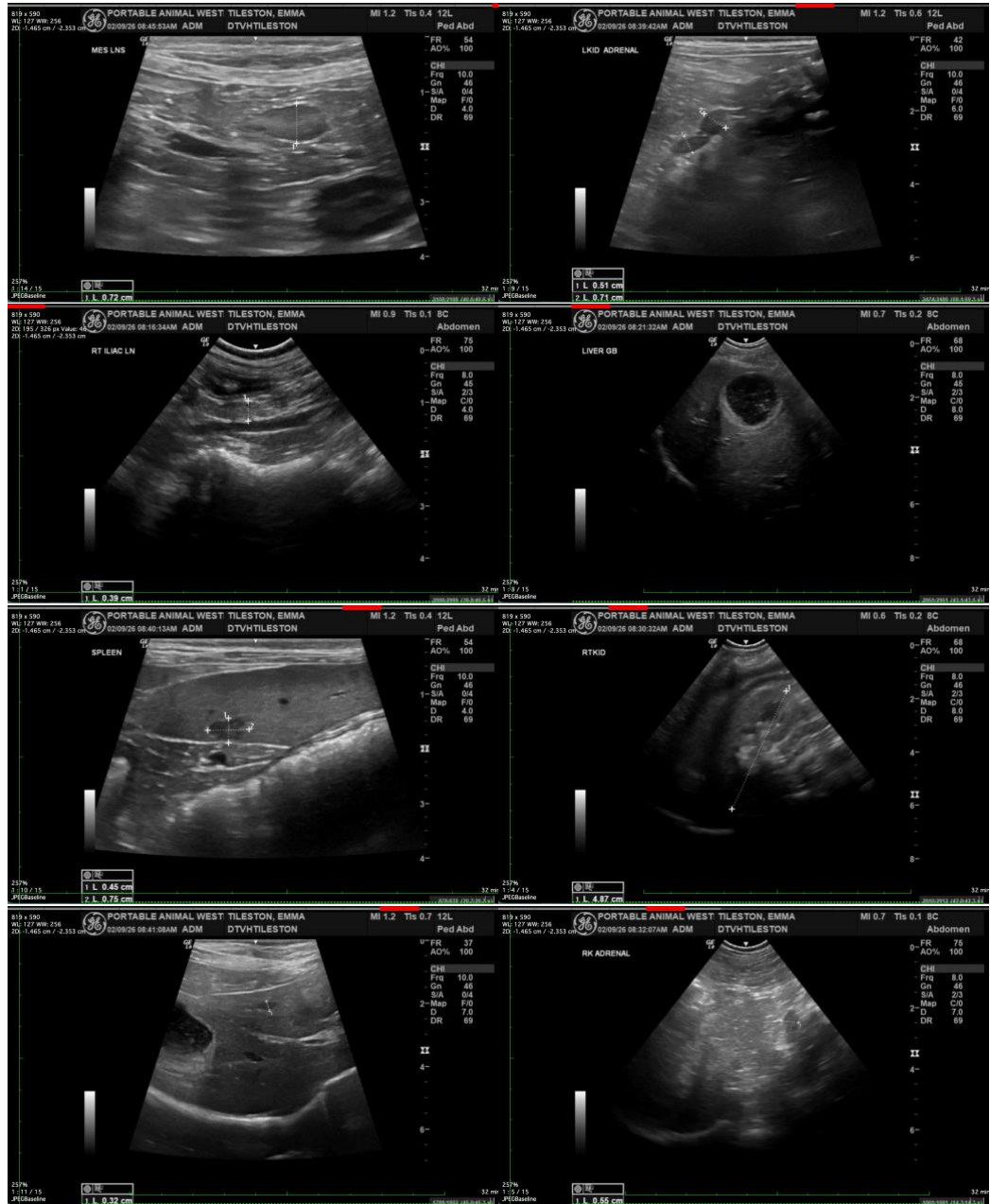
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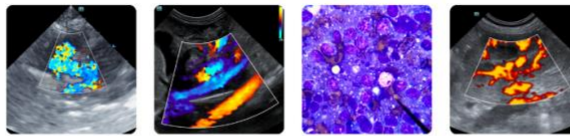
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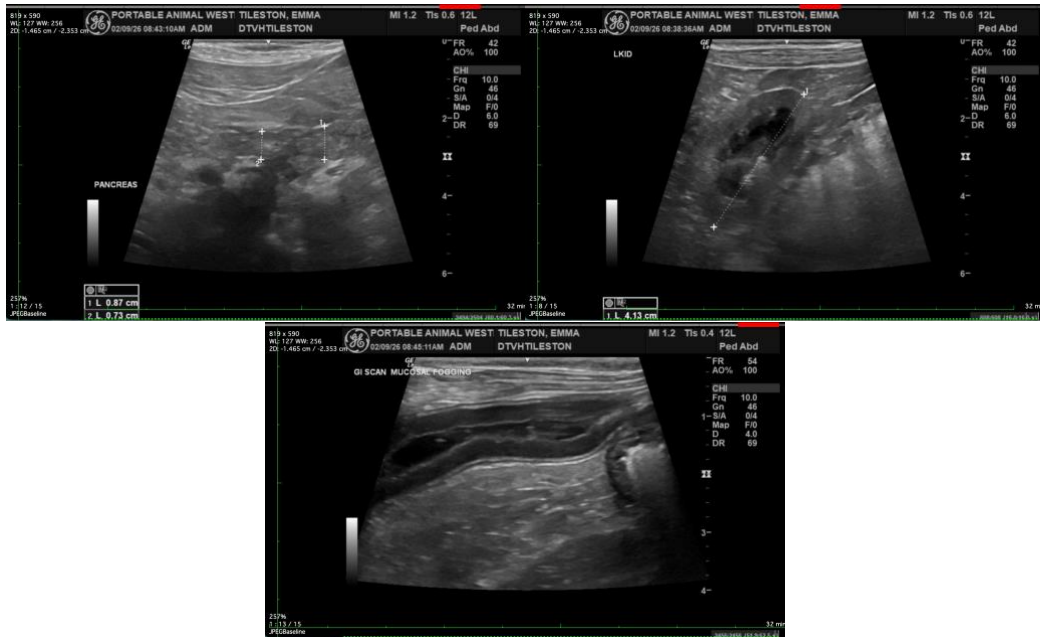
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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