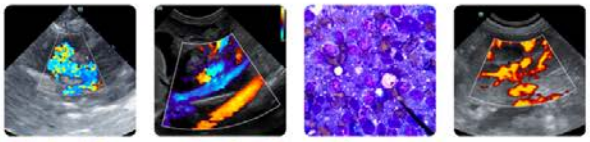


PATIENT

Chloe Hinkle

SPECIES

Canine

BREED

Pyrenees x

SEX

Spayed Female

AGE

5 Years 6 Months

WEIGHT

94.6

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Jessica Green

HOSPITAL NAME

Stanglein Veterinary Clinic

REFERRING VET

Dr. Daniel Hoffman

INVOICE

72900

DATE

2/11/26

PRESENTING CLINICAL SIGNS

The patient has a history of chronic/recurrent GI issues of nearly a year's duration. The issues were first reported as sporadic bilious vomiting that occured primarily in the morning. The patient was evaluated in December 2025 for acute vomiting, for which Maropitant (Cerenia) was prescribed. More recently, the Owner is reporting chronic/recurrent diarrhea/loose stools without any significant vomiting. The patient was evaluated for diarrhea on January 8, 2026. No significant changes were noted on physical examination. BW was submitted to the laboratory (see below for results) and the patient was prescribed the Proviable Diarrhea Support Kit. A STRICT Bland Diet was also recommended (the Owner is cooking boiled chicken or hamburger and rice for the patient). The Owner reports that bland diet and probiotics did not help. A physical examination performed today was relatively unremarkable, aside from some flatulence during abdominal palpation and approx. 4 pounds of weight loss since the previous visit on January 8, 2026.

Abnormal PE/Chem/CBC/UA Results: CBC/Chemistry/T4 and fecal screening performed 01/08/2026 -- mild leukopenia/neutropenia (WBC = 5.1 K/uL, NEUT = 2.657 K/uL), but the CBC and Chemistry was otherwise unremarkable and the T4 was WNL. The fecal screening was negative for ova and parasites.

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 (7.72 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 (7.68 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.

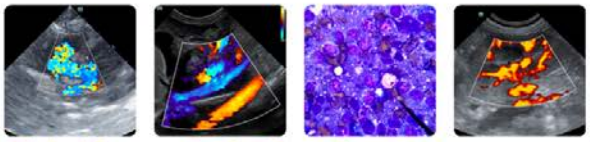
Adrenal Glands

The right adrenal gland is normal in size (0.53 cm at cranial pole and 0.81 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 cranial pole and 0.99 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. A hyperechoic nodule is noted in the caudal pole. Nodule does not disrupt normal shape and/or architecture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size with normal smooth margins. Parenchyma is normal in echogenicity with a diffusely coarse/heterogenous echotexture. No discrete sizable focal nodules or masses are observed. Splenic vasculature appears normal.



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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 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 very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material, or infiltrative disease; however, visualization is partially inhibited by gas.

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 mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material, or infiltrative disease; however, visualization is partially inhibited by gas.

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

- Coarse splenomegaly – can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.

- Hyperechoic adrenal nodule (caudal pole left adrenal gland) – Differentials include primary adrenal cortical adenoma or adenocarcinoma, pheochromocytoma, myelolipoma, adrenal hyperplasia secondary to pituitary disease or metastatic disease. Ultrasound alone cannot differentiate between functional and non-functional nodules and/or between benign and malignant disease. Small nodules without other evidence of abdominal disease (to suggest metastatic disease) and/or clinical signs (to suggest adrenal disease) are most often incidental and should be monitored.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is not a definitive ultrasonographically visible intraabdominal explanation for patient's reported gastrointestinal signs. However, given the splenic changes, while of unknown, if any relation, sampling could be considered, beginning with fine needle aspirates of the spleen if patient's coagulation status is appropriate.

Beyond that, further gastrointestinal workup recommendations include:

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.

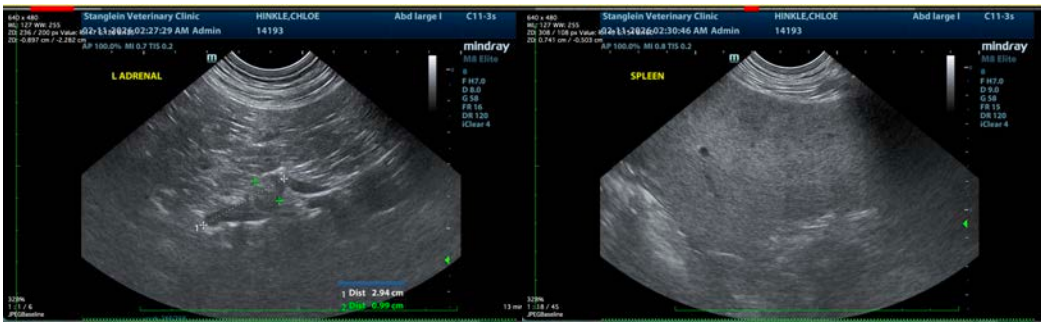
A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

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

Pending results of above, if a diagnosis is not obtained, further workup of the mild neutropenia may be warranted, including comprehensive infectious disease evaluation, further neoplasia screening including thoracic radiographs and/or ultimately bone marrow sampling.

In the meantime:

- Supportive/symptomatic medical management of clinical signs is recommended, including anti-emetics, gastroprotectants (+/- sucralfate, especially with any history of hematemesis), an appetite stimulant and fluid therapy if indicated, etc.
- Additionally, empirical deworming with a 5-day course of Panacur is recommended.
- A full course of empirical Helicobacter triple therapy could be considered.
- A probiotic, such a visbiome or proviable, may be helpful.
- Finally, if tolerated, a transition in diet could be considered, based on trial-and-error response with some options to consider including a gastrointestinal biome diet vs a hydrolyzed protein diet (sometimes several trials with different brands are necessary) vs an easy to digest, bland or low-fat diet vs other.



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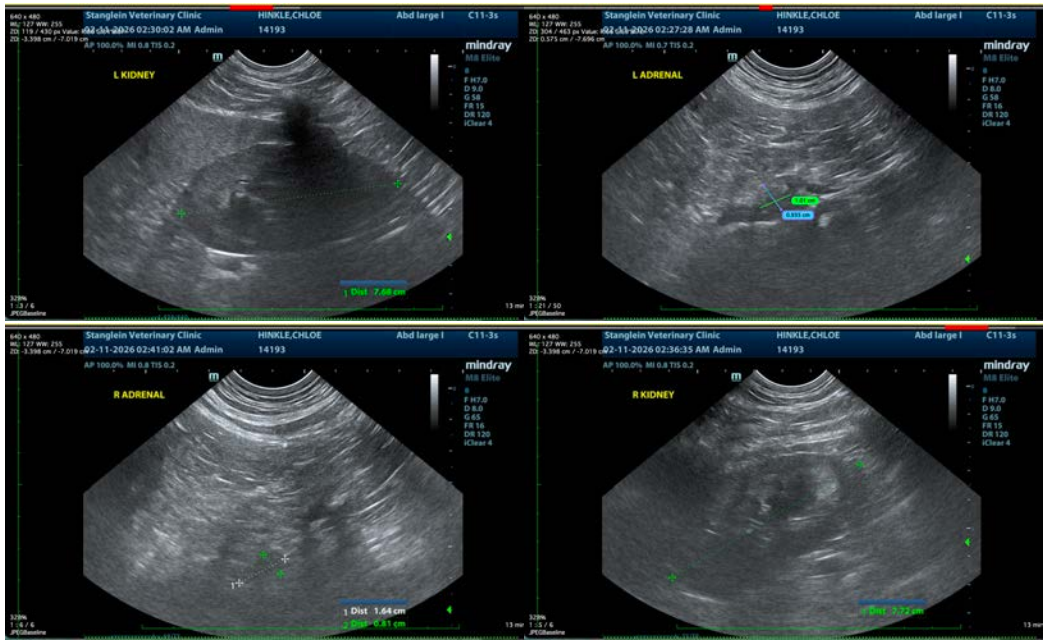

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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