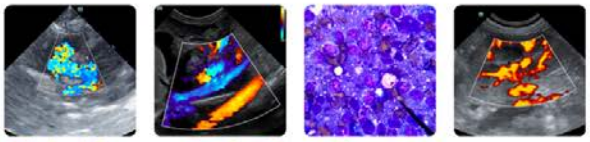


PATIENT

Hugo Thomas

SPECIES

Canine

BREED

English Bulldog

SEX

Castrated Male

AGE

10.3 Years

WEIGHT

41.6 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Kristen Carpenter

HOSPITAL NAME

Pennridge Animal Hospital

REFERRING VET

Dr. Kristin Cody

INVOICE

73028

DATE

2/17/26

PRESENTING CLINICAL SIGNS

Hx: Sedated with butorphanol. Patient presented 1/6/26 for intermittent vomiting and hx of suspect food sensitivities with certain diets. Patient was treated supportively with bland diet, cerenia, pepcid, SQF and B12. Patient re-presented 2/13/26 as patient would do well on bland diet and cerenia but once cerenia was discontinued and normal diet re-introduced patient would vomit undigested food 2-3 hours after eating. Bloodwork and rads were performed and AUS scheduled.. Current diet: Home cooked/bland. Current meds: Cerenia 30 mg EOD

Abnormal PE/Chem/CBC/UA Results: Diagnostics - Bloodwork 2/13/2026: CBC WNL. Chem: Glob 4.6 (2.5-4.5), Albumin 2.8 (normal). CPL 58 (0-200), Resting Cortisol: 2.79 - Abd rads: 6-8 hour fast. Food in stomach with suspect thickened gastric wall. Otherwise NSF. No obvious megaesophagus on visible portion of thoracic rads.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is only mildly distended (empty). Visible contents are anechoic. Urinary bladder wall is unable to be fully assessed for pathology without further distension. No visible masses or definitive cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface. In the face of urinary signs and/or suspected urinary bladder pathology, reassessment after complete filling is recommended.

Prostate is normal in size, echotexture and echogenicity for a neutered male.

The right kidney is normal is size (5.14 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 mineral or infarcts observed. Trace pyelectasia is noted.

The left kidney is normal is size (4.76 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 mineral or infarcts observed. Trace pyelectasia is noted.

Adrenal Glands

The right adrenal gland is normal in size (0.51 cm at cranial pole and 0.58 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

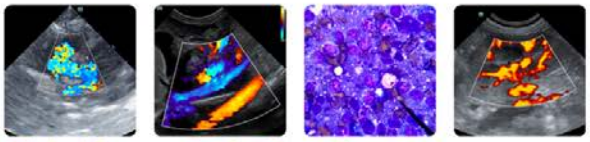
The left adrenal gland is normal in size (0.58 cm at cranial pole and 0.65 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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

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 empty with 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 of the small intestine is empty with 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

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.

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

- Chronic low-grade smoldering pancreatitis is suspected.

SECONDARY FINDINGS

- Trace bilateral pyelectasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Based on imaging alone, the top differential for patient's reported intermittent vomiting is chronic low-grade smoldering pancreatitis. Having said that, concurrent bowel disease can't be definitively ruled out.

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.

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.

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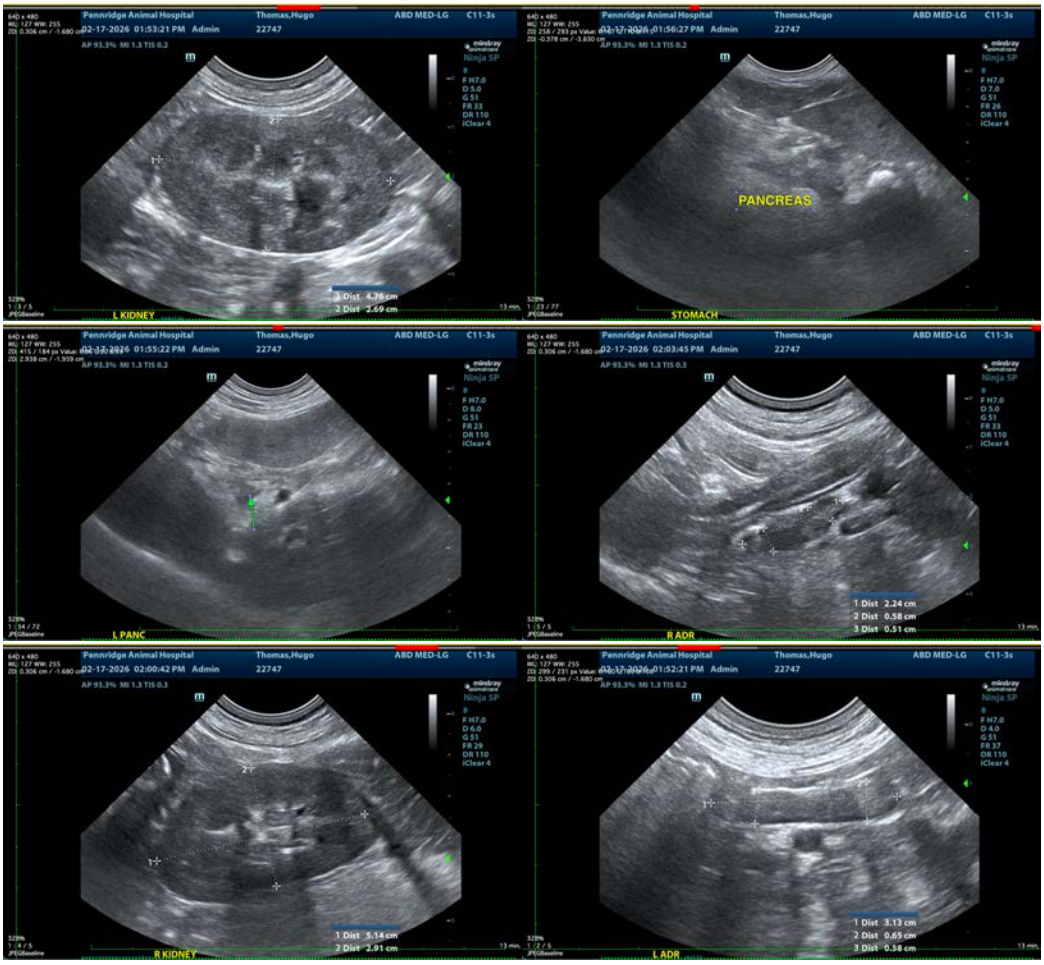
Additionally, empirical deworming with a 5-day course of Panacur is recommended as is a full course of empirical Helicobacter triple therapy.

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.

If patient's clinical signs respond to one of the above mentioned diets, a permanent vs temporary transition may be necessary if this is a food responsive condition.



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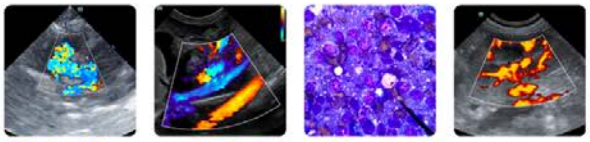

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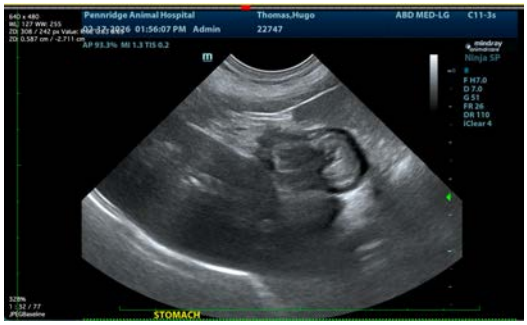

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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