



PATIENT

Lucy Bogan

SPECIES

Canine

BREED

Terrier Mix

SEX

Spayed Female

AGE

10 years 3 months

WEIGHT

37.4 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Kristen Carpenter

HOSPITAL NAME

Pennridge Animal
Hospital

REFERRING VET

Dr. Kristen Carpenter

INVOICE

11246

DATE

2/4/2026

PRESENTING CLINICAL SIGNS

- Hx: Not Sedated. Patient was fasted for 21 hours prior to this study.
- Patient has a hx of Precursor Immune Mediated Anemia with hx of relapse when steroids are weaned. Patient has been stable on current dose of medications for 3 years. Inappetence, chronic diarrhea, and weight loss started 10/3/25 (liver enzymes normal at that time.) Hx of bacterial hepatitis 12/2/25 that responded to 4 weeks of Baytril. Ongoing inappetance and continued weight loss noted by owner despite treatment and resolution of hepatitis. Patient has lost 10 pounds in the last year. Seems to have some degree of delayed gastric emptying but no regurgitation or vomiting.
- Limited to no response with entyce, mirtazapine, omeprazole, cerenia, metronidazole, probiotics.
- Internal Medicine consult during recent bout of hepatitis advised if ongoing hyporexia may need scope/biopsy.
- Chronic Meds: Plavixx, Methylpred, Cyclosporine, mycophenolate, B12, folate, Omeprazole.
- New Meds: Mirtazapine, Cerenia, ** Started today on tylan and azithromycin due to positive fecal PCR.
- GI Panel (tli, pli, cobalamin folate) - PENDING
- Diagnostics: Thoracic and Abds Rads 11/13/25- NSF except hepatomegaly. AUS 11/20/25 - NSF except gastric contents of unknown significance, mild GB debris, splenic mineralization, age related kidney changes. U culture Neg.

Abnormal PE/Chem/CBC/UA Results: Bloodwork after treatment hepatitis: NSF except ALP 317, Chol 97. ALT went from 1,008 down to 72 after 4 weeks baytril. - Fecal PCR panel 1/30/26 - Positive for Cryptosporidium and Clostridium Perfringens with cpa gene quantity 1.2×10^4 .

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with primarily anechoic contents and occasional echogenic non-shadowing debris. Apical urinary bladder wall is diffusely thick (0.51 cm). Mucosa is hyperechoic and irregular. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal 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. Punctate non-obstructive mineral densities are noted bilaterally. There is no evidence of pyelectasia or infarcts observed. Left kidney measures 5.19 cm, and the right kidney measures 5.24 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.71 cm at cranial pole and 0.7 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.56 cm at cranial pole and 0.6 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen



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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. Multifocal mineral foci are noted. Splenic vasculature appears normal.

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.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction or foreign material noted. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Bowel is diffusely mildly fluid distended without evidence of an obstructive pattern, plication and/or visible foreign material. Small intestinal hyperperistalsis is noted.

The visible colon is mildly diffusely thick measuring 0.33 cm thick with normal intact layering and is mildly distended with soft stool.

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.

PRIMARY FINDINGS

- 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,



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cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

- Gastroenteritis – Consistent with irritation secondary to dietary indiscretion or intolerance, infection (bacterial, viral, other), parasitic or protozoal disease, toxin, other metabolic disease such as pancreatitis, other.
- Concurrent colitis is suspected with the same benign differentials most likely. Infiltrative neoplasia possible but considered much less likely.

SECONDARY FINDINGS

- Chronic Cystitis - Urinary bladder wall changes are most consistent with chronic cystitis. Infiltrative neoplasia cannot be ruled out but is considered less likely give the location and diffuse nature of the changes.
- Age related kidney changes with punctate non-obstructive nephroliths bilaterally.
- Spleen mineralization – This is a benign change but can be associated with endocrinopathies, especially hyperadrenocorticism.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes described above largely trend in appearance toward benign and are consistent with patient’s reported history of gastrointestinal signs and underlying infections, etc. Unfortunately, with triple therapy immunosuppression, recurrent multifocal infections are difficult to prevent. Therefore, as is reportedly already in place, ongoing management of the infections as they occur is recommended, but if at all possible, tapering the immunosuppression as much as possible, ultimately trying to discontinue at least one of the medications may help.

In the meantime, supportive/symptomatic medical management of clinical signs is recommended, including a probiotic (such as visbiome or proviable), empirical deworming with a 5-day course of Panacur and, if tolerated, a transition in diet, based on trial-and-error response, beginning possibly with a gastrointestinal biome diet vs a hydrolyzed protein diet vs other. Some patients respond to one brand/version of a hydrolyzed protein diet better than another brand, so several brand attempts may be required.





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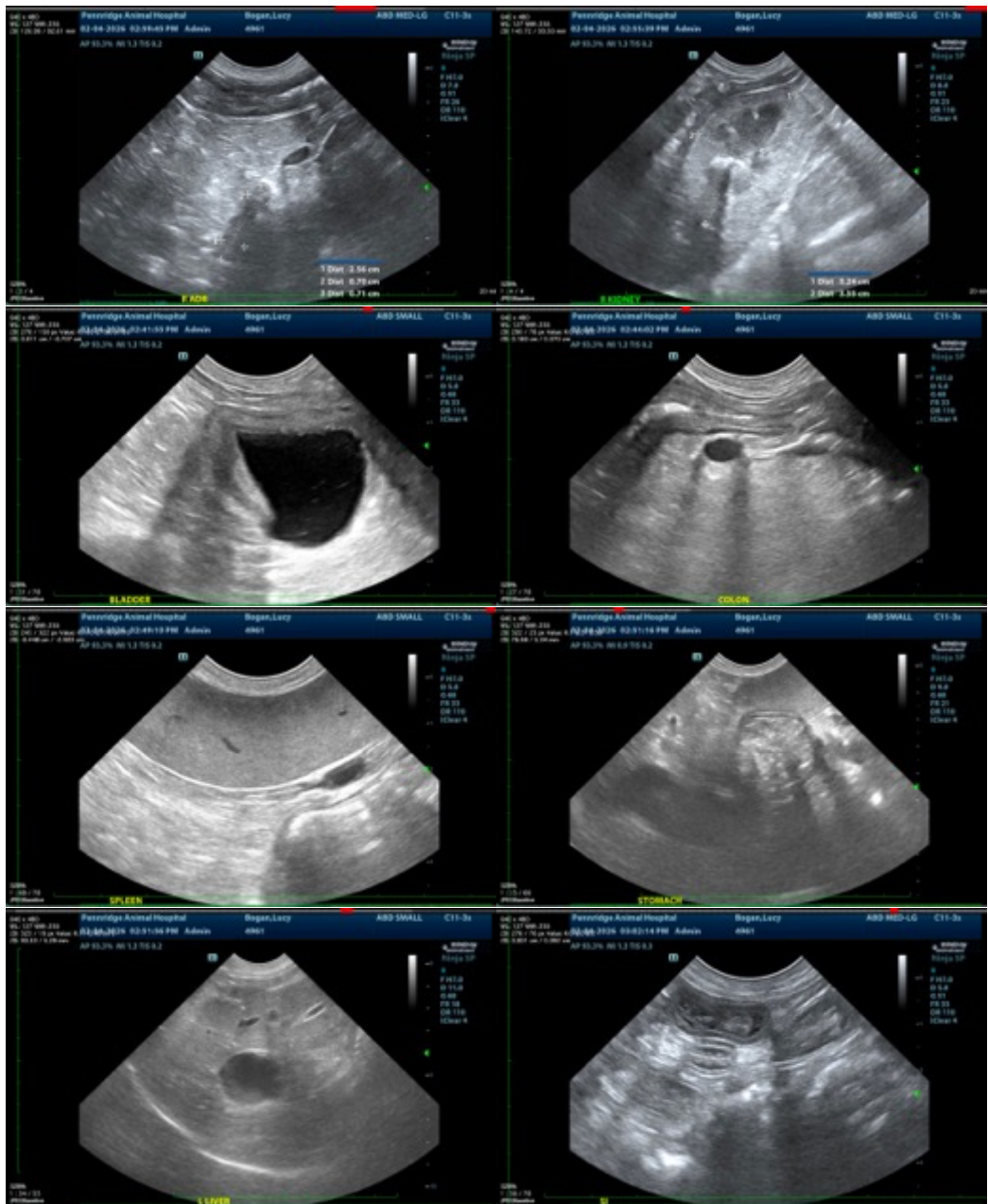
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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