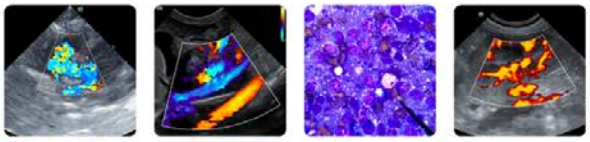


PATIENT

Fever Nyvold

SPECIES

Canine

BREED

Springer Spaniel

SEX

Female

AGE

2 Years 9 Months

WEIGHT

17.4 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Chrissy Krell, DVM

HOSPITAL NAME

Iron Range Veterinary Clinic

REFERRING VET

Dr. Julia Fry

INVOICE

73547

DATE

3/10/26

PRESENTING CLINICAL SIGNS

Fever presented on Thursday, March 5th, after being sick and hyporexic starting on Wednesday. A housemate was sick with GI symptoms recently but has recovered. There is no known dietary indiscretion, toxin exposure, or diet changes. The patient has otherwise been very healthy and stable.

The patient did vomit twice with some bloody, foamy material in the vomit. Diarrhea did not start until over the weekend. The patient has been very slow and has limited interest in food. Has tried a bland diet with no interest, but does seem to want some kibble.

The patient was seen at their primary veterinarian on Thursday, the 5th, and blood work and x-rays were completed. CBC, chemistry, and abdominal x-rays were generally unremarkable. The patient was started on famotidine and omeprazole but did not improve by Saturday, March 7th and was evaluated at an ER.

3/7/26: ER completed a PE and diagnostics but did not identify any significant changes. She patient was continued on Omeprazole, Cerenia, and Sucralfate. Suspected diagnosis was gastroenteritis.

Abnormal PE/Chem/CBC/UA Results: 3/5/2026 PDVM • CBC: WNL. Hct 51.4%, WBC 11k, PLT 195k • Chem/Lytes: BUN 27 (Crea 0.8), ALP 11 (low), Glob 2.2 (low), remainder WNL • Radiographs (abd): Reportedly unremarkable aside from splenomegaly; recheck showed reduction in splenic silhouette and "no evidence of pyometra". 3/7/2026 AEVS • PCV/TP: 46% / 6.8g/dL • CBC: NSF. Hct 49.6%, WBC 13.1k (Neu 10.8, Lym 1.6, Mono 0.6), PLT 171k • Chem8: WNL. BUN 17, Crea 0.7, Na 142, K 3.8, Cl 113, Glu 108, iCa 1.31 • cPL: <30 (RR 0-200) • Cortisol: 4.89 • UA (Cysto): USG 1.038, pH 7, Pro 30, Glu/Ket neg, Blood 10, Bili 1, Urobili 1, LeuEst neg. WBC 9/HPF, RBC <1/HPF, Cocci none, Rods Present • POCUS: colon filled with fluid, abd ownl 3/9/26: • Fecal parasite screen normal (neg HW, RW, TW, Giardia), tick disease neg, Heartworm neg.

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.

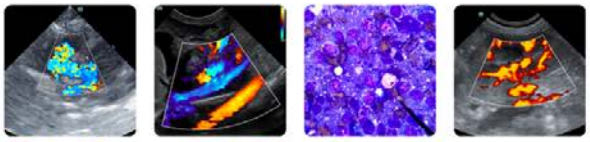
The right kidney is normal is size (5.5 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal is size (5.3 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 0.75 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.55 cm at cranial pole and 0.41 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.



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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 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 gastric wall is diffusely mildly to moderately thick measuring 0.74 cm thick with normal intact layering preserved. 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 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.

Mesenteric 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.

No ovarian or uterine pathology is noted in these images at this time.

ULTRASONOGRAPHIC FINDINGS

- The gastric wall thickening trends in appearance toward a benign gastritis, consistent with possible irritation secondary to dietary indiscretion or intolerance, infection such as bacterial or viral or other infectious disease, parasitic or protozoal disease, toxin, metabolic disease, other.

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Micro ulceration cannot be ruled out. Similarly, while thought less likely, infiltrative neoplasia can't be definitively ruled out without additional information.

- Mildly to moderately reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

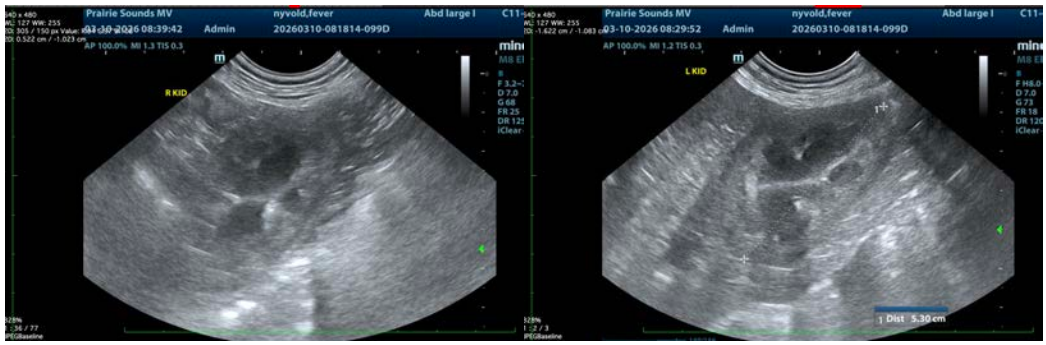
A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

A 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.

Pending results of above, fine needle aspirates of the stomach as well as the enlarged lymph nodes could be considered if patient's coagulation status is appropriate. Or, if clinical signs persist and a diagnosis can't be obtained cytologically, upper GI gastroscopy/endoscopy could be considered for further visual evaluation of the stomach and proximal small bowel as well as biopsies of the areas.

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 considerd.
- 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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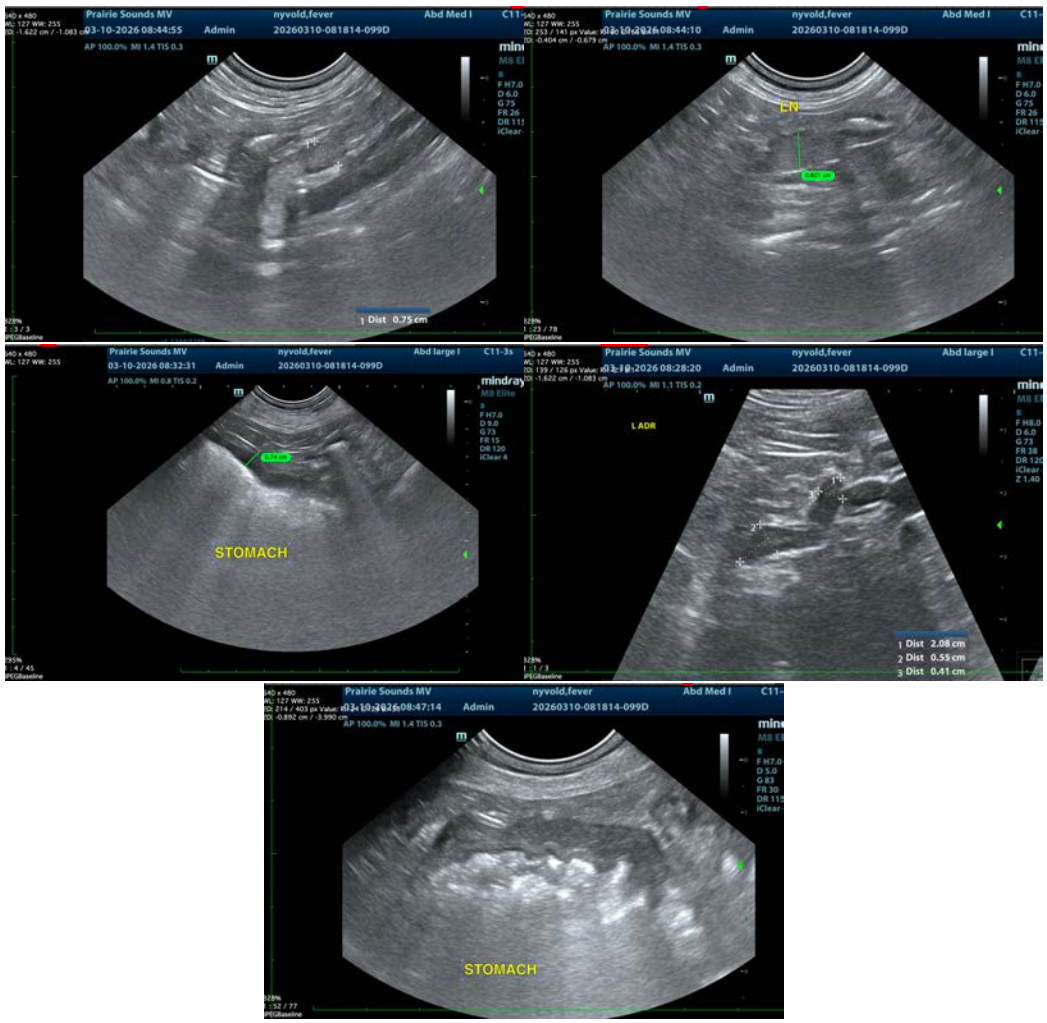

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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