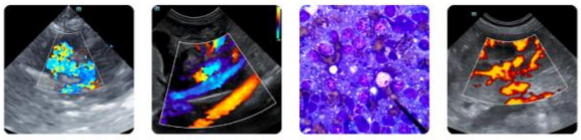


DATE

03/10/26

PATIENT

Marley Elliott

SPECIES

Canine

BREED

Yorkiepoo

SEX

Neutered Male

AGE

11/25/14

WEIGHT

14.8 pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Chadwell Animal Hospital

REFERRING VET

Dr. Heydt

INVOICE

14220

PRESENTING CLINICAL SIGNS

Patient History: P presented on 2/22/26 to ER for shaking, hunched posture, increased RR and yelping when touched near ribs. On exam, p was reactive on cranial abdominal palpation, but rest of exam was WNL. O declined diagnostics and elected to try gabapentin for pain.
P presented to our office on 2/23/26 for ER follow-up. O notes p still having quick breathing but still active and running around yard. O notes p appetite has always been finicky so hard to tell if reduced. O only feeds chicken, steak and salami. On examination, p had a grade III/ VI HM; no arrhythmia; RR WNL and normal bronchovesicular lung sounds. P was painful on deep palpation of upper L quadrant. Bloodwork WNL.
On 2/24/26, O notes that p is eating normally for p and active but seems to have a fast RR. Further imaging recommended to investigate heart due to murmur heard in exam and previous abdominal pain.

Current Medications: Cerenia (16mg) - 1 tab PO SID (P is finished course of medication), Gabapentin (50mg) - 1-2 tab PO q 8-12 hr PRN pain. (P is finished course of medication)
Labwork Results: Labwork attached, reported as: CBC: WNL, Chem: WNL
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed by: Stephanie Warga RDCS, RVT.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic contents. There are a very few, very subtle echogenic density/small bumps noted along the dependent inner dorsal wall that could represent debris although tissue can't be definitively ruled out. No definitive distinct masses or other inflammatory changes or cystoliths are observed. The urinary bladder wall, trigone and visible pelvic urethra are otherwise normal in thickness with a smooth mucosal surface.

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

Left kidney is normal in size (4.03 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.

Right kidney is normal in size (4.47 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

Left adrenal gland is normal in size (0.48 cm at cranial pole and 0.65 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.54 cm at cranial pole and 0.56 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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). Multifocal well-demarcated hyperechoic homogenous nodules are noted. Splenic vasculature appears normal.

Liver

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.

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

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

- A mildly irregular inner dorsal wall to the urinary bladder as described above could represent some mild subtle debris although, irregular mucosa trending in appearance toward benign i.e. cystitis, polypoid cystitis cannot be ruled out. While thought less likely, infiltrative neoplasia cannot be definitively ruled out.
- Hyperechoic splenic nodules- 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

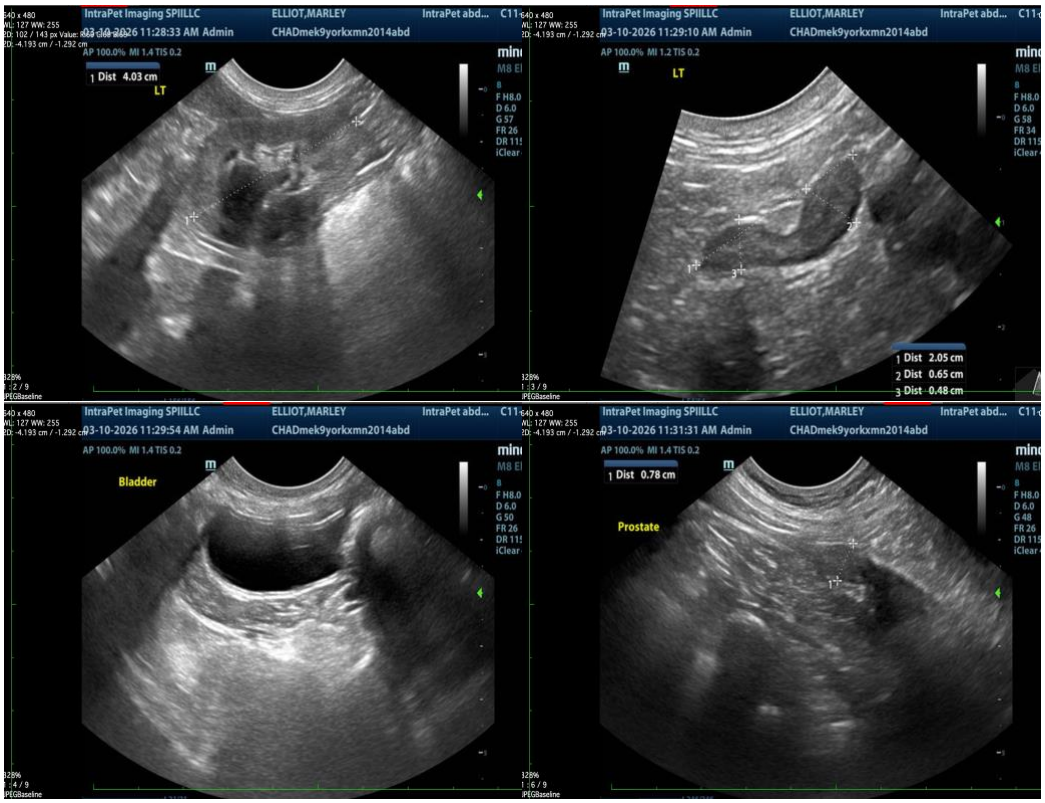
If not recently evaluated, urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

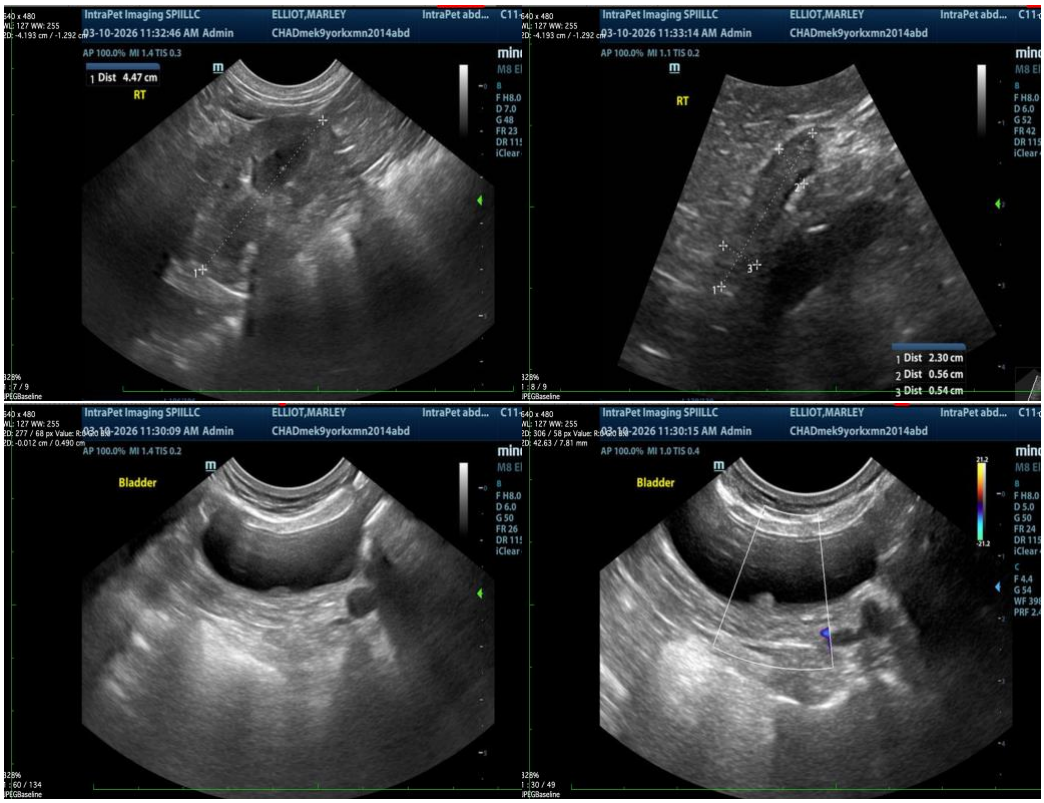
As is reportedly already in place, cardiac evaluation is recommended.

Given patients reported history, appetite, etc., a baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

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, as there is not a definitive ultrasonographically visible intra-abdominal explanation for patient's reported pain response, additional orthopedic and/or neurologic/spinal evaluation to further investigate possible referred pain is recommended.





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

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