**PATIENT**

Kaeta Dobyms

**SPECIES**

Canine

**BREED**

Australian Shepherd

**SEX**

FS

**AGE**

2 years

**WEIGHT**

23.5 kg

**INTERPRETED BY**Beth Johnson, DVM  
DACVIM**IMAGING  
PERFORMED BY**Loetitia Saint-Jacques,  
LVT**HOSPITAL NAME**Desert Hills Animal  
Hospital**REFERRING VET**

Dr. Vittori

**INVOICE**

11524

**DATE**

3/18/2026

**PRESENTING CLINICAL SIGNS**

- Patient History last week during visit:
- Wheezing and coughing, described as sounding like blockage when breathing
- Signs present both at rest and during activity, more noticeable when relaxed
- Paroxysmal coughing episodes, especially when unable to breathe properly
- Soft cough reflex when pressure applied to neck area (new finding)
- Decreased appetite for approximately 2 weeks, eating less frequently
- Chronic anal scooting despite diet change.
- Current medications: carprofen and galliprant as needed.
- Normal urination and defecation.
- Free-fed diet.
- P DX'D WITH BRONCHITIS, SUSPECTED TO BE ALLERGIC IN NATURE. RX'D DOXYCYCLINE AND TEMARIL-P
- O'S REQUESTED AUS AS PRE-OP SCREENING PRIOR TO DENTAL PROCEDURE, ALSO FOR FURTHER EVAL OF REPORTED HEPATIC CHANGES WITHIN VISIBLE PORTION OF ABDOMEN ON RADS.
- Working diagnosis: R/O Mild vacuolar hepatopathy, hepatitis, or infiltrative neoplasia.

Abnormal PE/Chem/CBC/UA Results: 1/21/2026 LW results: AC750 LW results: Chem panel - ALP 431 (5-131). BUN 48 (6-31), B/C ratio 32 (4-27), pre-renal with adequate USG, see below. Cholesterol 326 (92-324), triglycerides 1126 (29-291), r/o post-prandial value vs. persistent. Amylase 1347 (290-1125). PSL 225 (24-140), no hx of GI upset. Rest WNL CBC - all values WNL T4 WNL at 1.4. UA - USG 1.041. 4+ proteinuria (same as last year), UPC 1.7, last year was 1.6. P historically anxious in hospital, r/o transient vs. persistent value. Fecal O/P NEG Accuplex - 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 (6.19 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. A hyperechoic band parallel to the corticomedullary border is present. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal is size (5.68 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. A hyperechoic band parallel to the corticomedullary border is present. Mild pyelectasia is present in the left kidney. There is no evidence of mineral or infarcts observed.

**Adrenal Glands**

The right adrenal gland is normal in size (0.61 cm at cranial pole and 0.69 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.42 cm at cranial pole and 0.9 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**

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is moderately 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 is mildly distended with primarily fluid as well as some echogenic non-shadowing luminal contents and gas consistent with normal chyme. There is no evidence of obstruction, foreign material, or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestine demonstrates areas of mildly thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

**Pancreas**

The observed pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and irregular in shape with a swollen undulating contour. Enhanced hyperechoic ill-defined surrounding fat is noted.

**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**

- Mild/emerging inflammatory bowel disease (IBD) pattern – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No loss of layering or distinct characteristics of malignancy are present. Therefore, differentials cannot be further ranked without tissue sampling.
- Concurrent chronic low grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs



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- Moderately 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 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, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.
- Bilateral Medullary rim sign with mild pyelectasia in the left kidney - This finding is of unknown clinical significance and can be a normal variant, often idiopathic. Medullary rim sign can be present with renal disease including lymphoma, hypercalcemic nephropathy, Leptospirosis, tubular disease, other and should be interpreted in combination with other more specific indications of kidney disease such as isosthenuria, proteinuria, azotemia, etc. This is a common incidental finding in patients with diabetes mellitus.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The changes described above are all relatively mild and non-specific and largely trend in appearance toward benign. Given patient's history, however, of potentially allergic bronchitis, concurrent allergic or inflammatory GI/bowel disease could be emerging. Further gastrointestinal workup recommendations to consider a 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. +/- 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.

Other than continued medical management of patient's reported presenting complaint of cough, etc. Further diagnostic and treatment recommendations are largely dependent on results of above.



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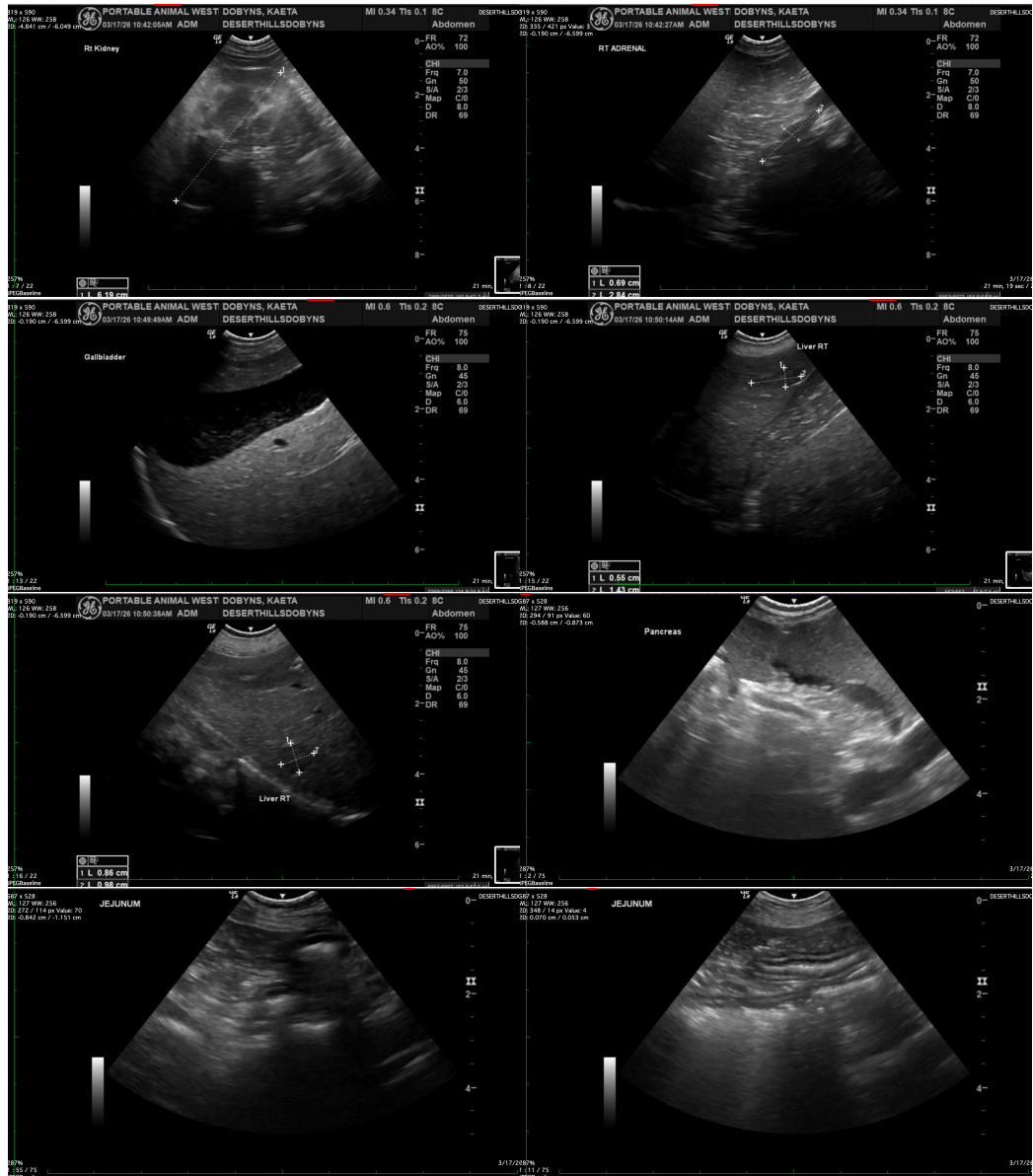
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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