



PATIENT

Marley Boudreau

SPECIES

Canine

BREED

Golden Retriever

SEX

Intact Male

AGE

10 years

WEIGHT

42 kg

INTERPRETED BY

Beth Johnson, DVM
 DACVIM

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Beatties PH Stoney
 Creek

REFERRING VET

Dr. Song

INVOICE

11505

DATE

3/18/2026

PRESENTING CLINICAL SIGNS

- Presented 3/13/26 for inappetance and vomiting for 4 days, diagnosed with FB and went to surgery overnight. Gastrotomy only - string like material removed from stomach.
- Recovery uneventful and was discharged 3/15
- Presented for recheck 3/17 with concerns as he was not eating much, increased thirst and lethargic. No vomiting.
- AFAST in our clinic revealed what was thought to be a pocket of free fluid but too small to aspirate.
- Wanted to hospitalize overnight but was declined.
- Has been on Sulcrate, Cerenia, gabapentin and Clavaseptin.

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.

Prostate is symmetrically enlarged with smooth margins that are well differentiated from surrounding tissue. Normal bilobed shape is maintained. Parenchyma is heterogenous with scattered hyperechoic foci present. No mineral or cysts are noted. The prostate measures 4.0 cm wide in the sagittal view.

The right kidney is normal is size (6.83 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 (7.46 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 unable to be well visualized in these images.

The left adrenal gland is normal in size (0.62 cm at cranial pole and 0.56 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 homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.



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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

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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.

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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.

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

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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.

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Free Abdomen

Both testicles are visualized without evident testicular pathology.

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There's a small pocket of free fluid in the caudal abdomen near the prostate.

There is no apparent pathologic lymphadenopathy noted in these images.

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Caudal to the stomach in images labeled "right", there is diffusely enhanced hyperechoic mesenteric fat and omentum that I believe is associated with the mildly prominent hypoechoic pancreas. However, inflammatory changes surrounding bowel and the stomach from the previous surgery and/or other current ongoing gastrointestinal bowel disease, can't be ruled out.

PRIMARY FINDINGS

- Suspect mild to moderate acute pancreatitis, although as stated above, the hyperechoic enhanced tissue in the cranial abdomen and in images labeled "right", which I suspect is right cranial abdomen, is non-specific and could also indicate some ongoing gastritis or gastroenteritis. Dehiscence and/or leakage from the stomach isn't thought likely but can't be ruled out.

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SECONDARY FINDINGS

- Benign Prostatic Hyperplasia – Prostatic findings are most consistent with Benign Prostatic Hyperplasia (BPH) and hyperechoic foci consistent with increased vascularity and fibrosis often associated with BPH. Active prostatitis cannot be ruled out. Infiltrative neoplasia cannot be ruled out but is considered less likely.

REFERRING VET

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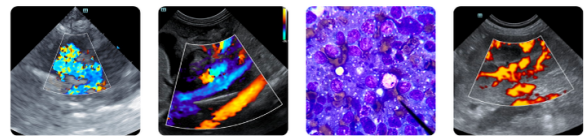
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated, a general metabolic health screen (CBC, chemistry panel with electrolytes and urinalysis) is recommended.



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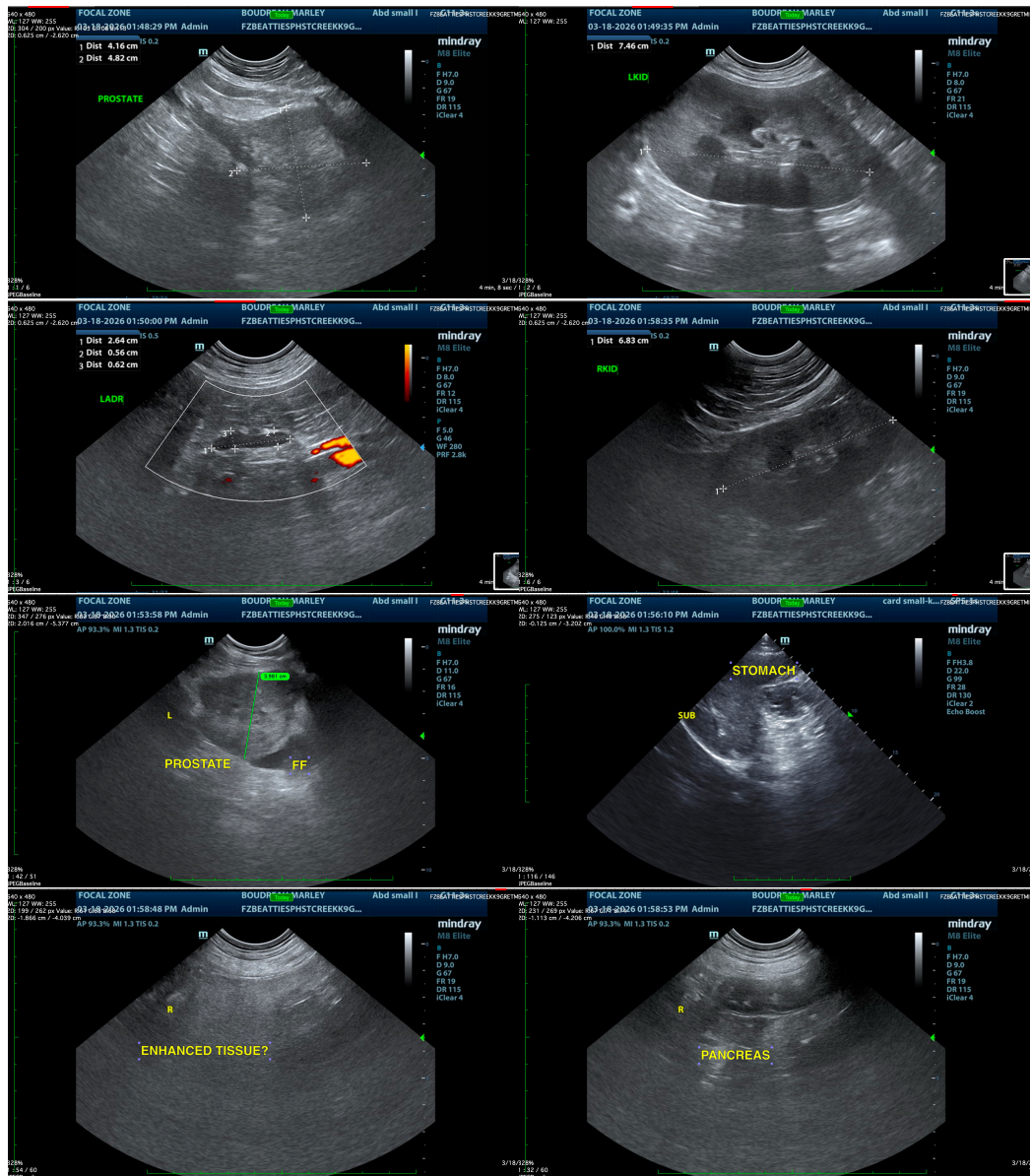
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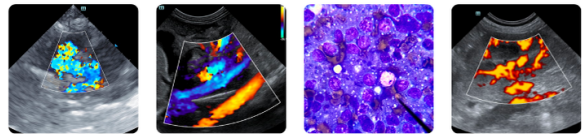
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A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

If possible, sampling of the free abdominal fluid can be considered if patient's coagulation status is appropriate. If the pocket of fluid is too small to sample and it's clinically indicated, etc., a peritoneal lavage to obtain the fluid may be helpful. In the meantime, medical management of pancreatitis with anti-emetics, gastroprotectants, appetite stimulants or nutritional support as needed, pain management, broad spectrum antibiotics, and fluid therapy is recommended. Monitoring of the pancreas with power doppler is recommended to identify possible necrosis as well as other potential sequelae such as abscesses, etc.



The information and recommendations provided are based on the images presented by the referring



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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