



## PATIENT

Monte Orman

## SPECIES

Canine

## BREED

German Shepherd Mix

## SEX

MN

## AGE

5 years 2 months

## WEIGHT

24.4 kgs

## INTERPRETED BY

Beth Johnson, DVM  
DACVIM

## IMAGING PERFORMED BY

Renee Trionfetti, VMD

## HOSPITAL NAME

Blue Pearl Wyomissing

## REFERRING VET

Dr. Heatherlyn  
McFarlane

## INVOICE

11511

## DATE

3/18/2026

## PRESENTING CLINICAL SIGNS

- AUS to further evaluate hyporexia, elevated temperature at 103.8F, vomiting and lethargy, hypoalbuminemia. Initially presented to rDVM Jan 2026 for ADR, lethargy, BW showed NSF, r/o UIT on UA- started on Cephalexin / Carprofen. Doxycycline was also added. O reported did better on Doxycycline. However, Feb 2026, represented to rDVM for suspected intermittent submandibular lymphadenopathy, lethargy, vomiting. On PE- LN's reported to palpate normally. Recheck UA showed hyposthenuria (1.005) otherwise NSF. O also noted pt was having difficulty eating/ decreased appetite and seemed to have difficulty closing mouth. Started on Prednisone trial for r/o masticatory myositis. Sedated oral exam showed NSF. Starting management with IM.
- Meds: Prednisone SID - last dose on Monday. Restarted Doxycycline on Monday - O reported 20% improvement.
- rDVM: Supportive tx- SQF, Cerenia

Abnormal PE/Chem/CBC/UA Results: FNA SI mass and abdominal LN: pending March 2026: Reported BW shows high neutrophil count & stress leukogram with concurrent high CPL also hypoalbuminemia (2.0). Feb 2026: CXR: NSF recheck UA: USG 1.005 L, NSF Jan 2026: - Chem: ALP < 10 L, ALT 52-n, Alb 3.1-n, normal BUN/Cr/SDMA - UA: USG 1.038, pyuria, hematuria, Pro neg, no bacteria.

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

The right kidney is normal in size (5.97 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 in size (5.44 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

Adrenal glands are small (flattened contour). Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. Left adrenal measures 0.37 cm at the cranial pole and 0.42 cm at the caudal pole. Right adrenal measures 0.59 cm at the cranial pole and 0.37 cm at the caudal pole.

### 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.



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## 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.

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.

In the mid abdomen, suspect jejunum, there's a bowel mass characterized by approximately 1.0 cm thick wall that demonstrates loss of layering in the area. The mass overall measures approximately 2.5 cm x 2.8 cm in size. The remaining bowel is normal with a mildly fluid distended lumen in some areas and empty in others. Suggesting potential partial obstruction from the bowel mass.

The visible colon is normal and is diffusely 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 but there is some subtly enhanced hyperechoic fat adjacent to the bowel mass.

Mesenteric lymph nodes are enlarged with swollen irregular capsular contour and loss of normal length to width ratio (rounded in shape). Nodes are hypoechoic with loss of normal parenchymal detail.

## PRIMARY FINDINGS

- The focal bowel mass could represent a benign inflammatory change but infiltrative neoplasia i.e. round cell neoplasia, carcinoma, other, can't be ruled out without tissue sampling. Given the mild fluid distension of some loops of small bowel, and the stomach, partial obstruction can't be ruled out.
- Aggressive mesenteric lymph nodes – concerning for infiltrative round cell or metastatic neoplasia. A benign aggressive inflammatory response cannot be ruled out without tissue sampling +/- culture.

## SECONDARY FINDINGS



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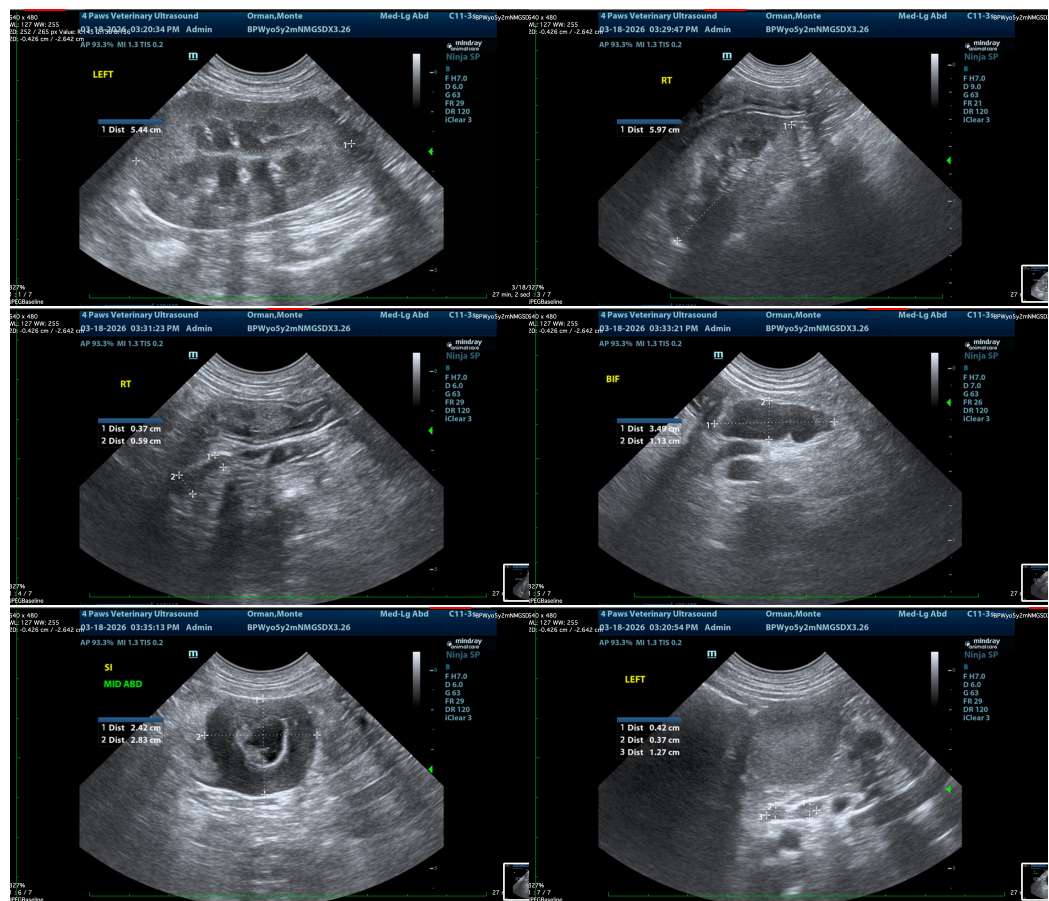
- Moderate gallbladder debris - Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.
- The flat adrenal glands are likely secondary to patient's reported steroid history.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

As is reportedly already pending, fine needle aspirates of the bowel mass and enlarged lymph nodes are recommended if patient's coagulation status is appropriate.

Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.





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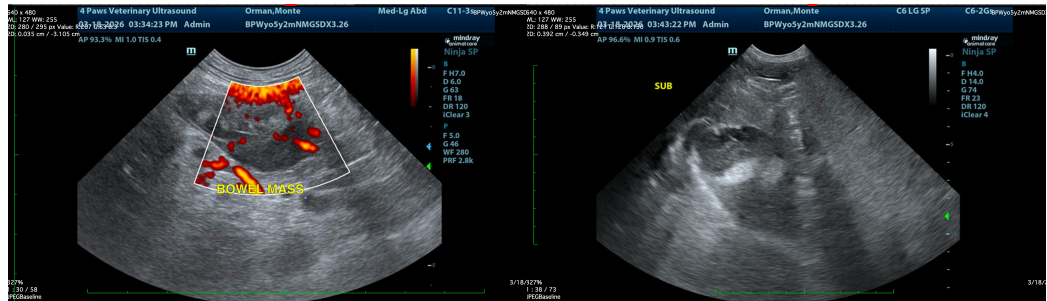
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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