



PATIENT

Remmington Asher

SPECIES

Canine

BREED

Labrador x

SEX

Spayed Female

AGE

11 Years

WEIGHT

67 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Sara Hansen

HOSPITAL NAME

Animal Care Center

REFERRING VET

Dr. Harbord

INVOICE

73787

DATE

3/18/26

PRESENTING CLINICAL SIGNS

Newly noted HM 3/6 on 3/11/2026. Episodes of seizure type activity vs syncope (neuro reaction to Librela?). Excessive excitement, last about 5-10 seconds is all, and she comes back quickly. Full body tremors. will get so excited and then fall and seize.. Bloating concerns. Per Asher House seemingly bloated abdomen after eating even after resting for 2+ hours. She went to ER a few months back for bloot, where they found bones in her tummy.

ABNORMAL Labwork Values - 3/2026 Senior Profile nsf, 10/2025 @ ER - AMYL 416 (500-1500), 8/2025 @ ACC - AMYL 440 (500 - 1500) LIPA 2068 (200 - 1800)

Current Medications: Gabapentin 600mg BID, Incurin 0.5mg EOD, Proin 50mg BID, Carprofen 50mg BID, Adequan Injection: 1.2mL SQ SIM - next due: 3/11, Librela injection monthly next due 3/18

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 (7.66 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 (7.26 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 plump/swollen in size. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. Left measures 0.62 cm at the cranial pole and 0.92 cm at the caudal pole. Right measures 1.9 cm at the cranial pole and 0.99 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.

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.



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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The stomach is moderately distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. If patient was appropriately fasted, delayed gastric emptying could be considered. Non-shadowing foreign material is considered less likely but cannot be definitively ruled out.

If clinical signs are consistent (vomiting, etc.), recommendations include supportive medical care, 24 hours fasting and re-image.

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

- Mild bilateral adrenomegaly – In a patient diagnosed with hyperadrenocorticism, this finding is most consistent with adrenal hyperplasia secondary to pituitary dependent hyperadrenocorticism. This finding can also be seen with stress and/or normal patient variant. Interpret in combination with clinical signs of hyperadrenocorticism and/or other adrenal disease.
- This appears to be a partially post-prandial stomach with no visible evidence of obstruction noted in these images at this time. Having said that, a small amount of remaining or residual non-obstructive foreign material can't be definitively ruled out. Reassessment following an additional 12-24 hours of fasting could be considered.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

As is reportedly already planned, cardiac evaluation is recommended.

Given patient's reported historical bloating, additionally 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.



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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.

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

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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