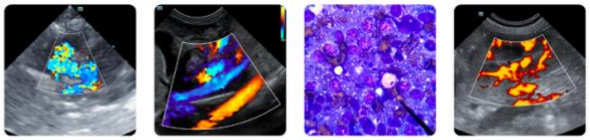


PATIENT

Lucy Vogtle

SPECIES

Canine

BREED

Beagle Mix

SEX

Spayed Female

AGE

13 Years

WEIGHT

24.80

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Grace Jayne, CVT

HOSPITAL NAME

Ark Animal Homecare

REFERRING VET

Dr. Shalette Dingle

INVOICE

36290

DATE

3/19/26

PRESENTING CLINICAL SIGNS

- Presented for diarrhea and decreased appetite since last visit. Was on biome but stopped eating it, so O cannot say how helpful it was. P once in a while will vomit, but diarrhea is the primary ongoing issue. Some days Lucy has a good appetite, but others she does not. She will sometimes have solid stool, but today the owner described her stool as "raspberry jam."
- Telmisartan 20mg SID in the evening.
- Gabapentin 2 in AM, 1 in PM
- 1 methocarbacol BID -
- Weight loss - about 9 pounds in the last year
- Abnormal PE/Chem/CBC/UA Results: Hematocrit 40.4 Hemoglobin 14.0 Platelets 988 Potassium 6.1 Na: K Ratio 24 Chloride 107 ALP 174

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. The left kidney measures 4.9 cm. The right kidney measures 5.3 cm.

Adrenal Glands

Left adrenal gland is normal in size (0.44 cm at cranial pole and 0.61 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

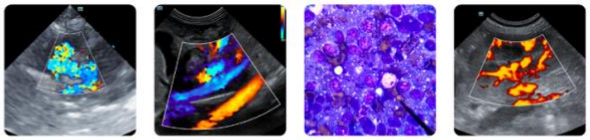
The right adrenal gland is unable to be visualized in these images.

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). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

In the mid to cranial aspect of the liver, adjacent to the gallbladder, is a large/expansive mixed mass measuring 4.6+ cm x 5.7+ cm in size. The mass contains some small anechoic/cystic areas. Some more normal appearing hepatic parenchyma is visible very caudally but it's difficult to determine whether this is a focal mass versus diffuse involvement of the majority of the liver.



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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 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 very prominently 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 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.

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

Primary Findings

- Marked/significant inflammatory bowel disease 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.

- The liver mass/possible diffuse hepatopathy changes could represent a benign process such as nodular hyperplasia, chronic inflammatory hepatopathy, extramedullary hematopoiesis, other. Having said that, especially given the more focal appearance of a mass-like lesion in some images, infiltrative neoplasia such as hepatocellular carcinoma, sarcoma, round cell neoplasia, other, can't be ruled out without tissue sampling.

Secondary Findings

- Age-related kidney changes

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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.

Fine needle aspirates of the liver are recommended if patient's coagulation status is appropriate.

Having said that, the liver may be in part incidental in terms of patients reported presenting complaint, and given the bowel changes, additional gastrointestinal workup is also recommended including a routine fecal slash Giardia exam.

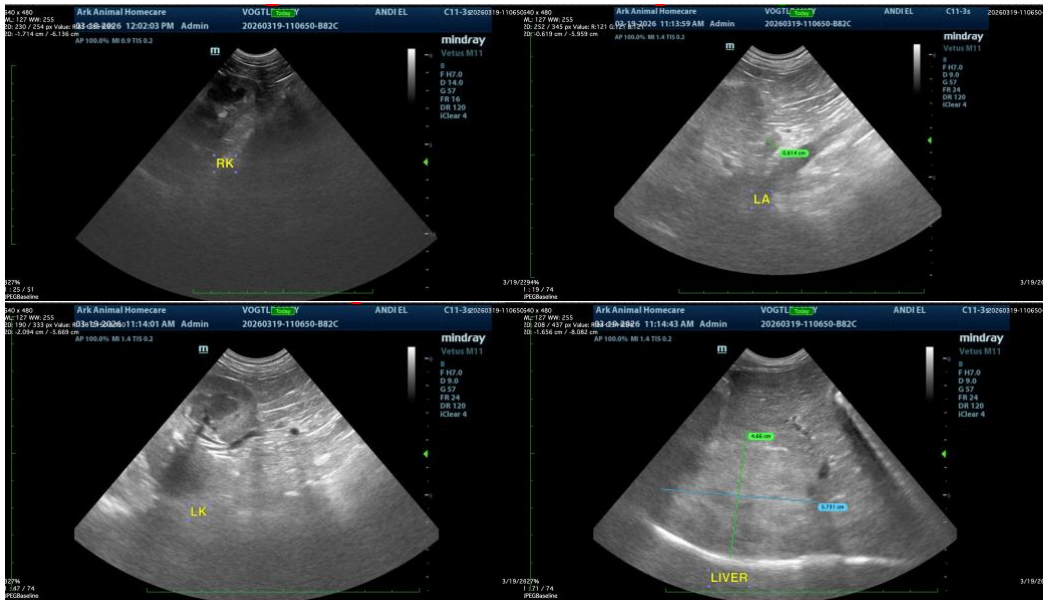
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

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.

A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

Ultimately, pending results of above, biopsies of the GI tract may be necessary for definitive diagnosis and therefore to further guide medical management.

In the meantime, however, supportive/symptomatic medical management of clinical signs is recommended, including a probiotic (such as visbiome or proviable), empirical deworming with a 5-day course of Panacur and, if tolerated, a transition in diet, based on trial-and-error response, beginning possibly with a gastrointestinal biome diet vs a hydrolyzed protein diet vs other. Some patients respond to one brand/version of a hydrolyzed protein diet better than another brand, so several brand attempts may be required.



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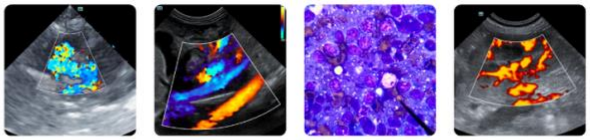

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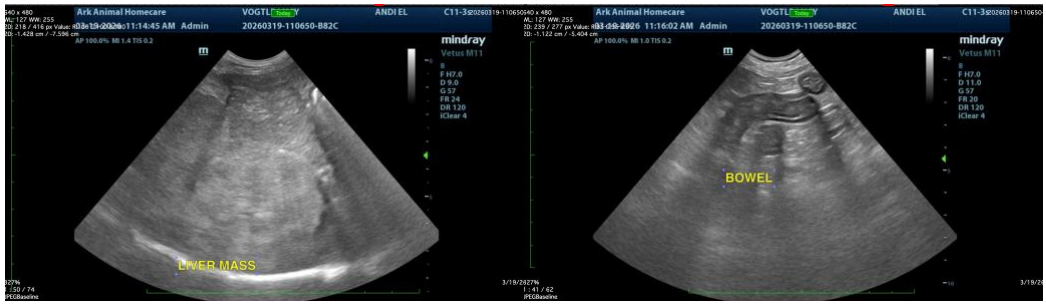

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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