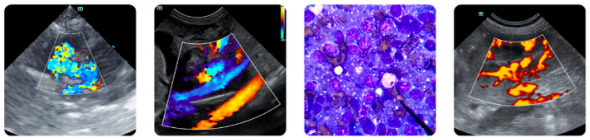


PATIENT

Aspen Stauffer

SPECIES

Canine

BREED

Pitbull Mix

SEX

SF

AGE

11.7 years

WEIGHT

58 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Kristen Carpenter

HOSPITAL NAME

Pennridge AH

REFERRING VET

Dr. Beth Mehaffey

INVOICE

11560

DATE

3/24/2026

PRESENTING CLINICAL SIGNS

- Hx: Patient was sedated with butorphanol.
- Patient presented for wellness exam on 2/28/26. O noted PU/PD and weight loss. Since then her signs have progressed to vomiting, diarrhea, inappetence.
- Bloodwork performed initially showed anemia, low albumin, and low T4. CBC was rechecked and anemia resolved. Michigan State thyroid panel pending.
- Here for AUS, chest rads as ongoing work up. Chest rads show mild pleural effusion and a widened mediastinum. No heart murmur.

Abnormal PE/Chem/CBC/UA Results: Bloodwork 3/2/26: HCT 30% (L), Albumin 2.5 (L), Globulin 3.0 (N). UA: USG 1.021, quiet sediment. Total T4: 0.7 (L), 4dx neg x4. Fecal NOS. - Bloodwork 3/15/2: CBC: HCT 43% (N) - Chest and abd rads 3/24/26: Widened cranial mediastinum, cardiac silhouette and pulm vasculature NSF, mild - mod pleural effusion, no pulm edema. Abdomen - reduced serosal detail especially around intestines (fluffy appearance.)

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.

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. Left kidney measures 5.29 cm, and the right kidney measures 4.72 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.93 cm at cranial pole and 0.59 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

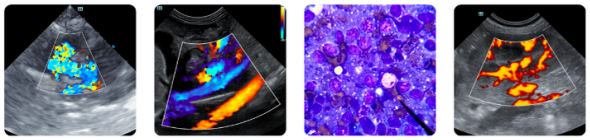
The left adrenal gland is normal in size (0.63 cm at cranial pole and 0.61 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material, or infiltrative disease; however, visualization is partially inhibited by gas. Pyloric outflow tract appears patent.

In the cranial mid abdomen is a 6.0+ cm long loop of small bowel with a markedly thick, approximately 1.0 cm thick wall and loss of layering consistent with a focal bowel mass. The area is surrounded by hypoechoic structures/suspect lymph nodes, enhanced hyperechoic mesentery and fat as well as free fluid. The remaining small bowel is 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

Bicavitary effusion is noted in these images.

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 bowel mass described above is most concerning for infiltrative neoplasia such as round cell neoplasia i.e. lymphoma versus carcinoma versus other. Especially given the adjacent lymphadenopathy. A benign inflammatory process is possible but considered less likely.
- Adjacent to the mass, aggressive lymph nodes – concerning for infiltrative round cell or metastatic neoplasia. A benign aggressive inflammatory response cannot be ruled out without tissue sampling +/- culture.
- Bi-cavitary free fluid is of unknown origin. Differentials (unless already ruled out) could include increased hydrostatic pressure (cardiac disease and/or vascular or lymph blockage), decreased oncotic pressure (low albumin), vasculitis, paraneoplastic fluid, rupture/leakage of/from an organ (GI, GB, UB, other), blood (hemoabdomen), other.

SECONDARY FINDINGS

Age related kidney changes.

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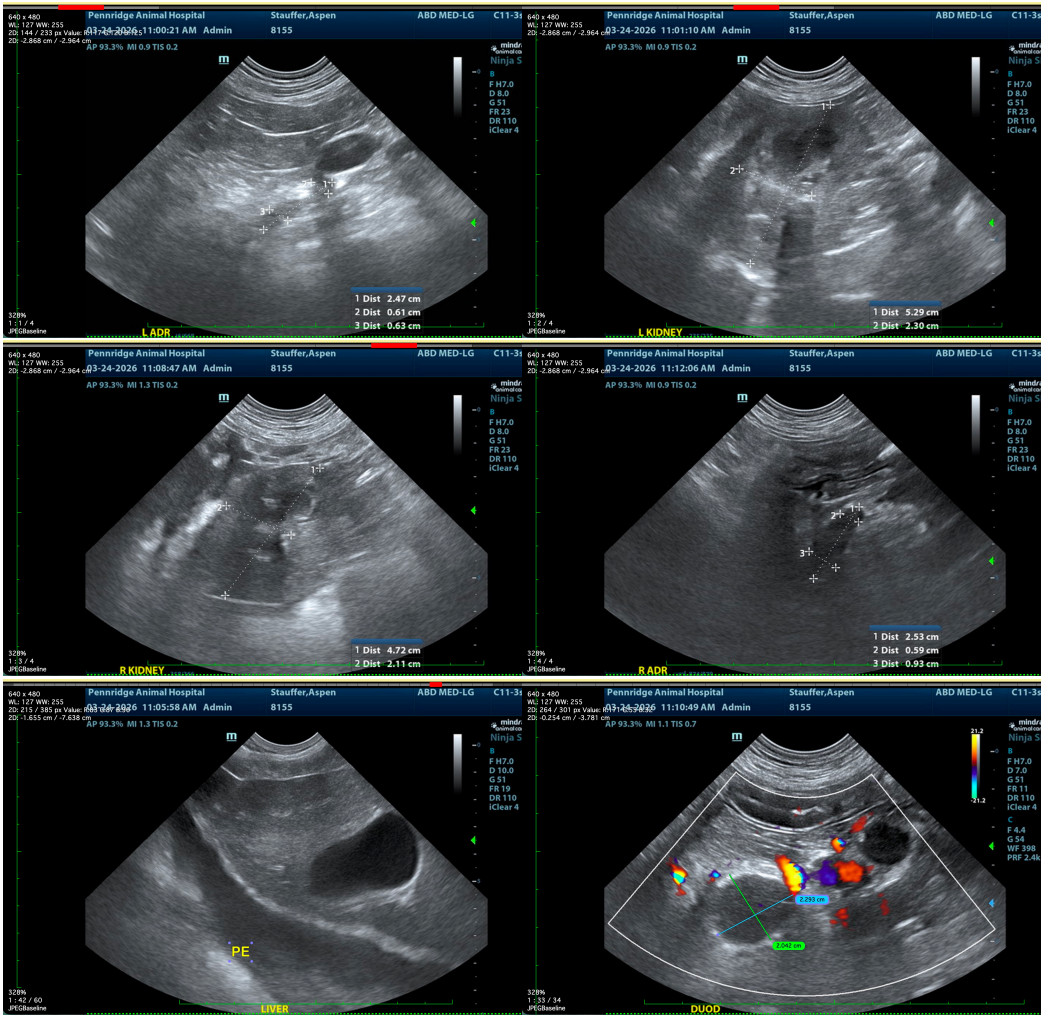
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Sampling of the pleural effusion, the free abdominal fluid, fine needle aspirates of the bowel mass, as well as the enlarged lymph nodes could all be considered if patient's coagulation status is appropriate.

Pending results, cardiac evaluation including an echocardiogram may be warranted.

If not recently evaluated, urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

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



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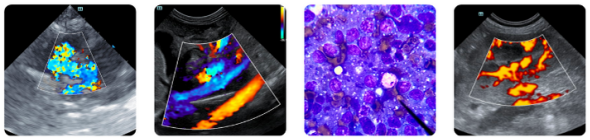

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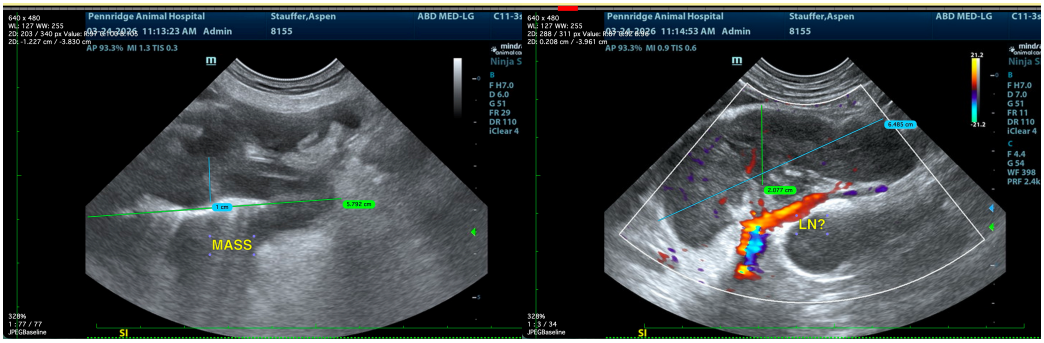

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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