



PATIENT

Binx Sitz

SPECIES

Canine

BREED

Great Dane

SEX

FS

AGE

7 years

WEIGHT

135 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Julia Bakker

HOSPITAL NAME

Orange Blossom
Veterinary Imaging

REFERRING VET

Dr. Randi Gibson

INVOICE

11551

DATE

3/24/2026

PRESENTING CLINICAL SIGNS

- Episodes began in September following initial pneumonia diagnosis- Recent episodes: February 25th and March 4th (one week apart)- Episodes characterized by tachypneic breathing, trembling, drooling, grunting at rest- Episodes resolve when on Clavamox; recur when off antibiotic- Previous pneumonia diagnoses with treatment at referral hospital- Currently on Clavamox (started again due to recent episodes)- History of Cerenia use for episodes (given at 6am on March 4th, episode recurred by 8pm)- Previous lab work normal except elevated WBC with left shift (during pneumonia treatment)- Recent clear chest radiographs (February 19th.)
- Currently uses tacrolimus (DLS) and clavamox (staph sensitive per culture) for nasal lesions.

Abnormal PE/Chem/CBC/UA Results: Albumin 2.6 Globulin 4.1 Record attached.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with a moderate amount of echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or cystoliths are observed. The 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 8.51 cm, and the right kidney measures 8.22 cm.

Adrenal Glands

Adrenal glands are small/flattened contour, for a large dog. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. Left adrenal measures 0.59 cm at the cranial pole and 0.51 cm at the caudal pole. Right adrenal measures 0.52 cm x 0.54 cm.

Spleen

Spleen is subjectively large in size (2.8 cm thick at the hilus) with normal smooth margins. Parenchyma is normal in echogenicity with a diffusely coarse/heterogenous echotexture. No discrete sizable 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 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.

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.

PRIMARY FINDINGS

- Subjectively, mildly flat adrenal glands – This can be a normal patient variant and/or a sign of exogenous cortisol administration. If exogenous steroids are not being administered, hypoadrenocorticism (either relative or absolute) should be considered.
- Coarse splenomegaly – can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.

SECONDARY FINDINGS

- Mild age-related kidney changes.
- A moderate amount of echogenic urinary bladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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

Fine needle aspirates of the spleen could be considered if patient's coagulation status is appropriate.

If a diagnosis is not obtained, further gastrointestinal workup recommendations, in case of subclinical nausea resulting in the drooling and aspiration, etc., could include a routine fecal/giardia exam is recommended if not recently evaluated, and a gastrointestinal malabsorption panel (including



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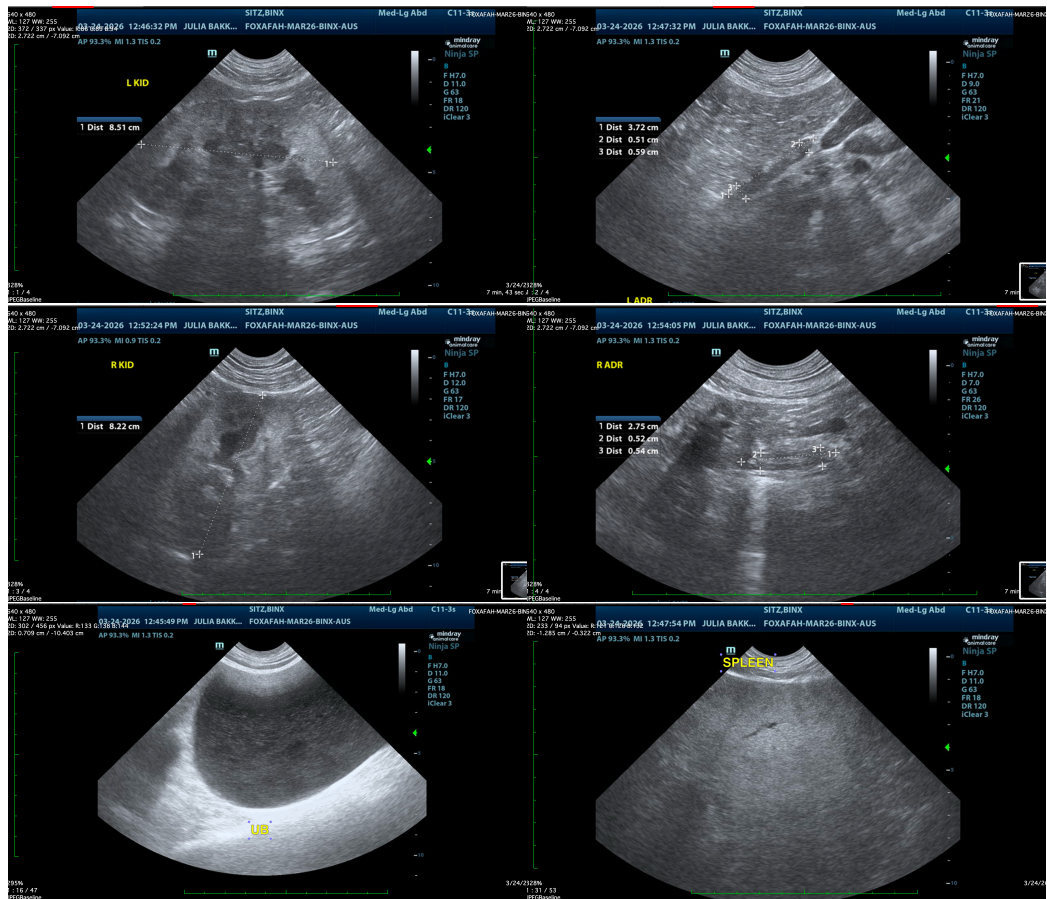
cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

If clinical signs still persist, further evaluation of the esophagus and swallowing could be considered via a swallow study +/- upper GI endoscopy for further visual evaluation of the esophagus, stomach, and proximal small bowel as well as biopsies of the stomach and proximal small bowel.

In the meantime, supportive/symptomatic medical management of clinical signs is recommended, including anti-emetics, gastroprotectants (+/- sucralfate, especially with any history of hematemesis), an appetite stimulant and fluid therapy if indicated, etc.

Additionally, empirical deworming with a 5-day course of Panacur is recommended as is a full course of empirical Helicobacter triple therapy.

Finally, if tolerated, a transition in diet could be considered, based on trial-and-error response with some options to consider including a gastrointestinal biome diet vs a hydrolyzed protein diet (sometimes several trials with different brands are necessary) vs an easy to digest, bland or low-fat diet vs other.



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.



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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