



## PATIENT

Dixie Lakas

## SPECIES

Canine

## BREED

Mini Dachshund

## SEX

Spayed Female

## AGE

14 Years

## WEIGHT

10.9 lbs

## INTERPRETED BY

Beth Johnson, DVM  
DACVIM

## IMAGING PERFORMED BY

Brandit Kurzowski

## HOSPITAL NAME

Corfu Veterinary Clinic

## REFERRING VET

Dr. Nicole Kelter

## INVOICE

74479

## DATE

4/15/26

## PRESENTING CLINICAL SIGNS

P presented 4/3/26 for back/neck pain and inappetence. P started on meloxicam and was rec'd to recheck a CBC in 1-3 months. P came back 4/15/26 for continued inappetence. O gave meloxicam for 10 days. O has tried to feed her different foods to encourage her to eat and p developed diarrhea. P even hesitant to eat chicken and is now vomiting within an hour of eating. Repeat BW revealed increased liver enzymes and increased WBC/neut. P has historic 5% heart murmur and is on pimobendan. Radiograph: Cardiomegaly, but appears better from 12/24, scant congestion, open for possible cranial density near thoracic inlet. Abdomen had radiopaque mass cranial ventral abdomen- has historically been there. Mid abdomen loss of serosal detail, but not overt mass seen. P treated as outpatient with cerenia and SQ fluids, came back today for abdominal ultrasound.

Abnormal PE/Chem/CBC/UA Results: 4/3/26 CBC: Neut 12.86 K/uL, Mono 1.66 K/uL, PLT 134 K/uL (148-484) L Chem 17: Glucose 63 mg/dL, Glob 4.6 g/dL, ALP 283 U/L Lytes: WNL 4/15/26 CBC- WBC 23.77 K/uL, NEU 20.11 K/uL, MONO 1.74 K/uL, Rest WNL GLU 58 mg/dL, GLOB 5.0 g/dL, ALT 664 U/L, ALKP >2000 U/L, GGT 36 U/L, TBIL 2.8 mg/dL, Rest WNL

## 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 3.66 cm. Right kidney measures 4.37 cm.

### Adrenal Glands

The areas of the adrenal glands are examined without evident adrenal gland pathology.

### 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

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is mildly heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. 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. Some non-visibly obstructive cholecystoliths are noted. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.



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## *Gastrointestinal*

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with 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

- Mildly heterogenous liver – These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.
- 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.  
\*Non-visibly obstructive cholecystoliths are noted.

## SECONDARY FINDINGS

- Mild age related kidney changes bilaterally.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes described above are subtle/mild without a definitive ultrasonographically visible intraabdominal explanation for patient's reported clinical signs and/or laboratory changes. Given patient's reported hypoglycemia combined with the GI signs, a baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

Additionally, a paired insulin to glucose ratio obtained at a time when the glucose is <50mg/dl is recommended.



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Pending results of above, if/when patient's total bilirubin is not increased, bile acids could also be considered if a diagnosis is not made and hyperglycemia persists.

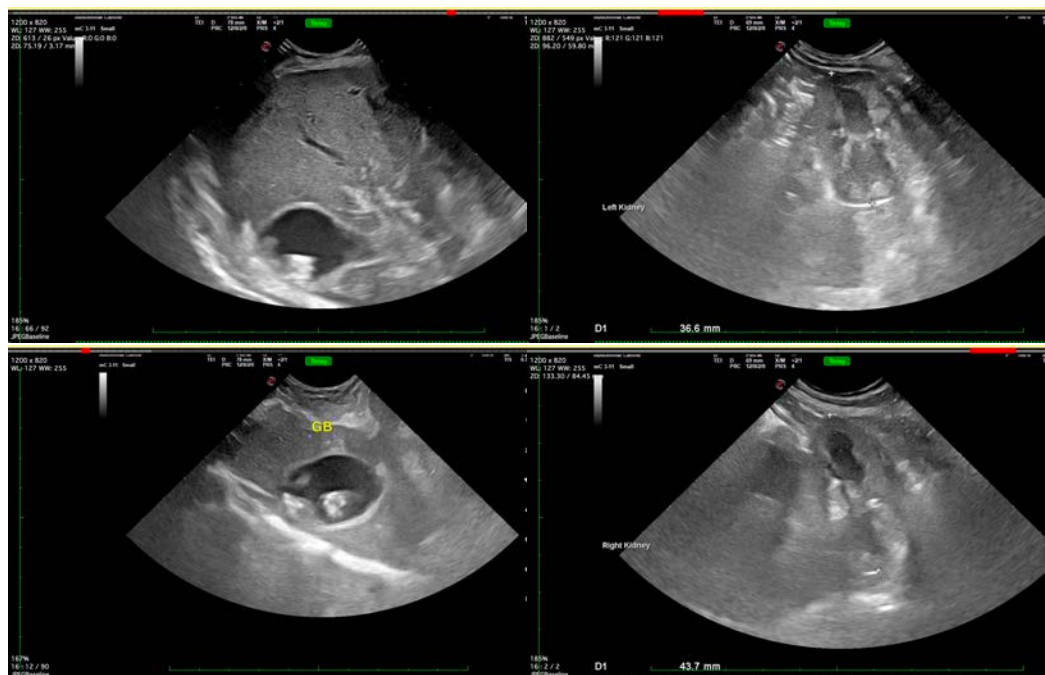
In the meantime, a routine fecal/giardia exam is also recommended.

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.

While continuing workup:

- 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.
- A full course of empirical Helicobacter triple therapy could be considered.
- A probiotic, such as a visbiome or proviable, may be helpful.
- 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.





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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**  
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