

PATIENT

Lily Bartlett

SPECIES

Canine

BREED

German Shepherd

SEX

Spayed Female

AGE

8 Years

WEIGHT

27.6 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Melissa Randolph

HOSPITAL NAME

Shores Veterinary
Emergency Center

REFERRING VET

Dr. Logan Law

INVOICE

14786

DATE

04/02/26

PRESENTING CLINICAL SIGNS

P was seen at rDVM for vomiting. For approximately 7 days before she was seen at rDVM on 3/26; P had vomited 5 times (all fluid). P also was noted to have increased thirst. at RDVM appt P had senior blood work, urinalysis and rads done. rDVM PE: mild muscle atrophy over spine; abdomen soft, non painful, cranial abdomen palpates full. weight loss noted. 4/3/24 P weighed 71.4 pounds; 3/26/26 P weight 60.8 pounds. P was not on any medications and did not have any additional treatments for the vomiting. P has not had any vomiting since 3/26, concern for gastroenteritis (resolved) vs mass like lesion vs other

PE: unremarkable rDVM 3/26 rads: potential mass effect in cranial abdomen (pylorus vs liver vs spleen); CBC: WNL; chem: WNL u/a: dark yellow color, cloudy, USG 1.049, pH 9.0, protein 2+, glucose negative, ketones trace; sediment: lipid droplets present, otherwise unremarkable 4dx: Lyme positive, Lyme quant C6 >10 U/mL, Anaplasma positive

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.

Left kidney is normal in size (6.3 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.

Right kidney is normal in size (6.5 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

The adrenal glands are unable to be visualized in these images.

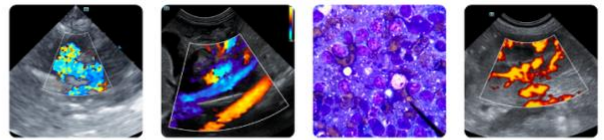
Spleen

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

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.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. 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 mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material or infiltrative disease; however, complete visualization of far wall is partially inhibited by gas. What I believe is the pylorus is mildly fluid distended.

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 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.

The colon is subjectively moderately distended with shadowing stool 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 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.
- Otherwise, this is a largely unremarkable normal structural abdomen without a definitive ultrasonographically visible intra-abdominal explanation for patient's reported clinical signs.

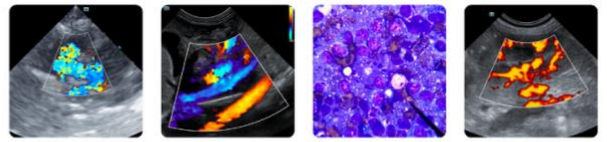
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There's not a visible mass present in these images at this time. Although full evaluation is significantly limited by a large amount of artifact from gas throughout the abdomen and rib artifact within the cranial abdomen. Therefore, while significant pathology is not visible, especially subtle or mild changes can't be definitively ruled out.

Having said that, given patient's reported history for their gastrointestinal workup, recommendations include a routine fecal/Giardia exam if not recently evaluated.

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

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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+/- pending results of above, 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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In the meantime, in addition to addressing reported infectious disease or diseases, 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.

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

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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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If clinical signs persist and a diagnosis is not obtained and especially if continued concern for a possible mass is present, advanced imaging such as an abdominal contrast CT scan may be helpful.

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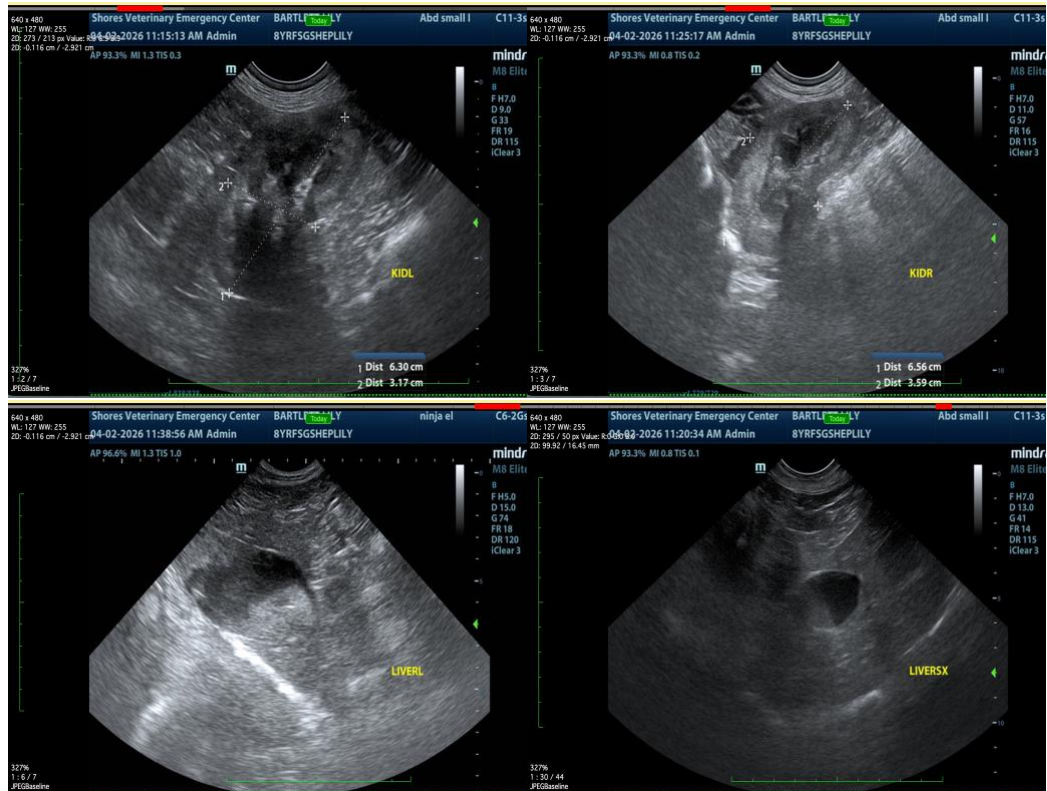
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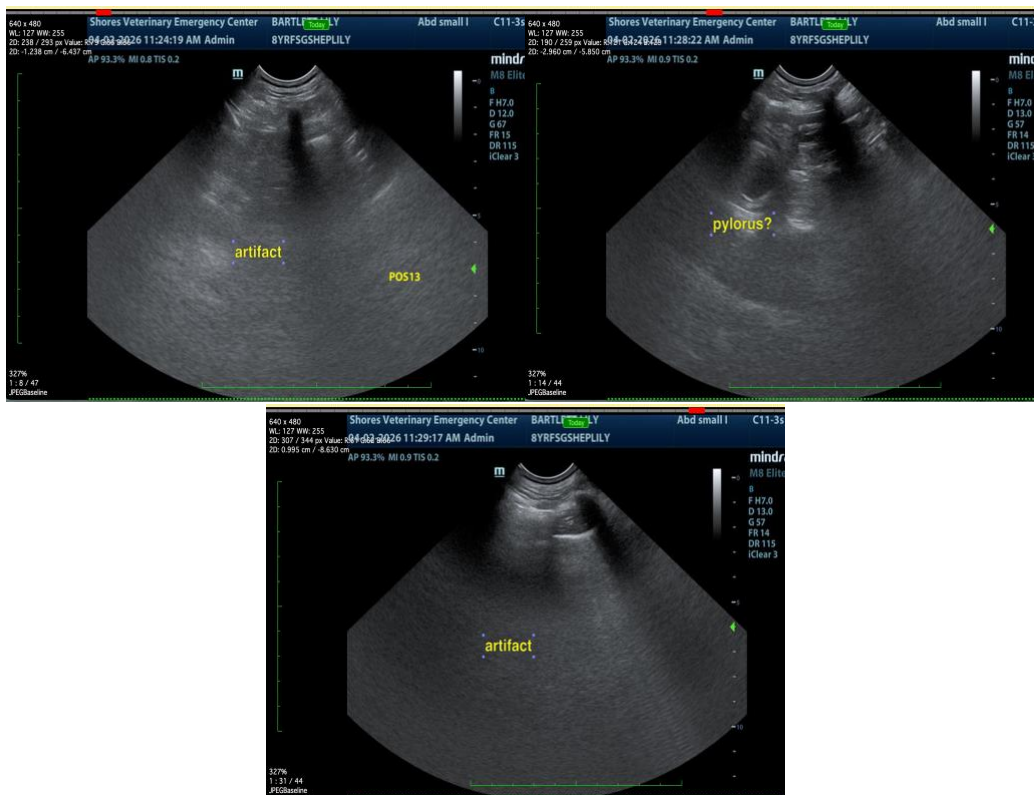
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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