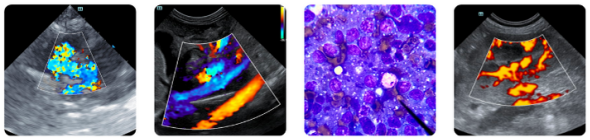


PATIENT

Coconut Esther

SPECIES

Canine

BREED

Shih Tzu Mix

SEX

SF

AGE

3 years 3 months

WEIGHT

4.8 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Anthony Krawitz

HOSPITAL NAME

Calusa Veterinary Center

REFERRING VET

Dr. Anthony Krawitz

INVOICE

11762

DATE

4/22/2026

PRESENTING CLINICAL SIGNS

Long term on and off periodic diarrhea, lethargy and inappetence/poor appetite. Physical examaination WNL. Multiple fecal PCR Keyscreen tests negative. Does respond to either Tylan or Metronidazole but returns soon after stopping. Regular Blood panel WNL. CPL WNL at 30. 1st Texas GI Profile showed B12 of 803 in 3/2024. More recent one showed very low B12 of 150 and mildly low Folate of 5, and cortisol 1.7 in April 2026. ACTH stim WNL pre 2.3 and post 9.9 in April 2026. Bile acid profile in early 2024 was pre 13.2 and post 90.1, then repeated in 5/2024 and was 47.3 pre and 26.6 post. Protein C in 8/2024 was 78 indicating more MVD of the liver. UA WNL including culture negative.

Abnormal PE/Chem/CBC/UA Results: Right now, feeding mainly boiled chicken/rice and sweet potato Taking Proviable Forte, Pro-Pectalin as needed, Apoquel for itching periodically, weekly vitamin B12 shots, and Famotidine. Today we are repeating the Bile acid profile and running a new Protein C Is this from the MVD, or is there IBD and if so what is the best advised therapies?

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is only mildly distended. Visible contents are anechoic. Urinary bladder wall is unable to be fully assessed for pathology without further distension. No visible masses or definitive cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface. In the face of urinary signs and/or suspected urinary bladder pathology, reassessment after complete filling is recommended.

The right kidney is normal is size (4.0 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. A hyperechoic band parallel to the corticomedullary border is present. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal is size (3.5 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. A hyperechoic band parallel to the corticomedullary border is present. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

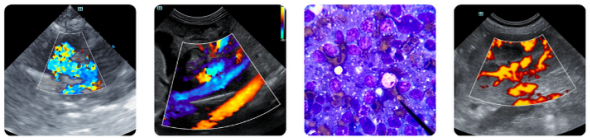
The right adrenal gland is normal in size (0.21 cm at cranial pole and 0.31 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.42 cm at cranial pole and 0.36 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



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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.

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. Hyperechoic mucosal fogging or speckling is noted. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

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

- Very occasional/subtle mucosal speckling – Mucosal speckling is often present with inflammatory bowel disease (IBD). It is not specific for type or severity of disease. Mild speckling change can occur as a normal patient variant in the post-prandial state.
- Subtle bilateral medullary rim sign (canine) - This finding is of unknown clinical significance and can be a normal variant, often idiopathic. Medullary rim sign can be present with renal disease including lymphoma, hypercalcemic nephropathy, Leptospirosis, tubular disease, other and should be interpreted in combination with other more specific indications of kidney disease such as isosthenuria, proteinuria, azotemia, etc. This is a common incidental finding in patients with diabetes mellitus.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given patient's history, my opinion is that the reported gastrointestinal signs/diarrhea are more likely related to gastrointestinal disease, potentially an infectious gastrointestinal disease versus microvascular dysplasia, which typically does not result in significant clinical signs. Having said that, microvascular dysplasia can occasionally cause gastrointestinal upset. My recommendations are to rule

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out other contributing gastrointestinal problems, including infections, especially given patient's reported response to antibiotics. Therefore, 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.

In the meantime, in addition to current therapies, empirical deworming with a 5-day course of Panacur is recommended.

If tolerated, a transition in diet is recommended, based on trial-and-error response.

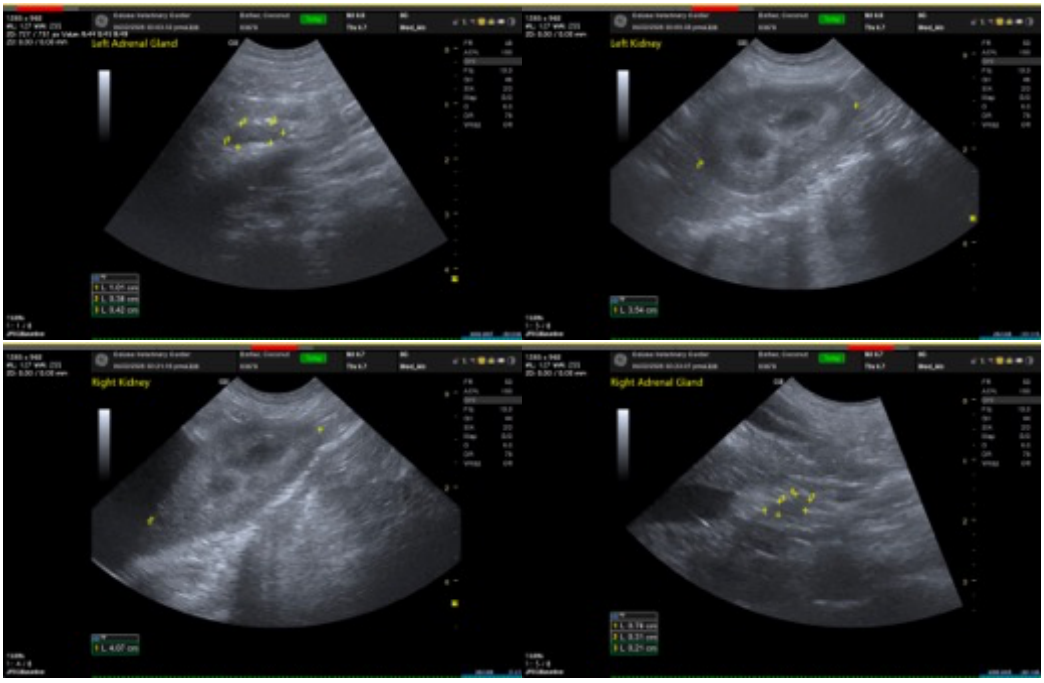
Some options to consider include a gastrointestinal biome diet vs a hydrolyzed protein diet (sometimes several trials with different brands are necessary) vs a fiber response/colitis diet vs a bland, easy to digest or low-fat diet vs other.

Again, especially given patient's reported response to antibiotic therapy, fecal microbe transplant therapy could be considered.

Ultimately, pending patient's response, current pending diagnostic results, etc., a full internal medicine consultation and/or referral may be helpful.

For an additional charge an internal medicine consult can be utilized through Sonopath.com. You can select the internal medicine drop down at http://spa.sonopath.com/.

One of the world's top internists & SonoPath associate Dr. Remo Lobetti BVSc, MMedVet, PhD, DECVIM can evaluate your case through SonoPath. https://sonopath.com/resources/sonopath-services/internal-medicine-teleconsultation-services



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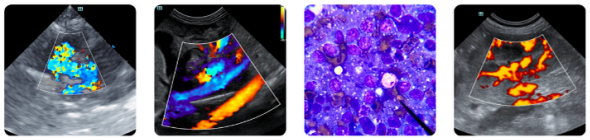

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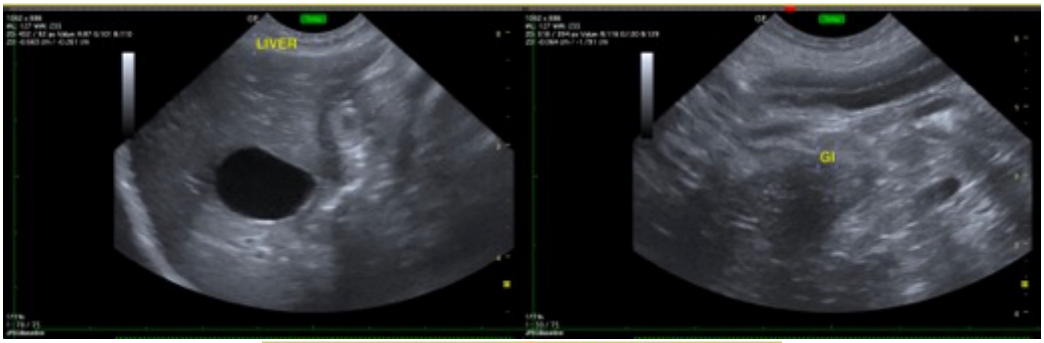

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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