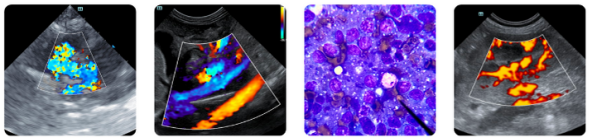


PATIENT

Chief Hutchison

SPECIES

Canine

BREED

Rottweiler

SEX

MN

AGE

7 years 7 months

WEIGHT

117.7 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Kristen Carpenter

HOSPITAL NAME

Pennridge Animal Hospital

REFERRING VET

Dr. Jennifer Makem

INVOICE

11826

DATE

4/29/2026

PRESENTING CLINICAL SIGNS

Patient was sedated with Dexdomitor and Butorphanol. Hx of intermittent vomiting since October 2024. Patient does occassionally eat a large amount of food at one time and have regurgitation but mostly patient is actively vomiting/active abdominal contractions. Patient does have a history of one bout of suspected pancreatitis. Patient was previously eating a large variety of table food /higher fat food items and owners have recently been strict with current diet and cut out other food items. Patient has not had any instances of vomiting since this change. Current diet: Fresh pet, boiled chicken, sweet potato.

Current meds- none. Has been treated with cerenia and omeprazole for past episodes of vomiting.

Diagnostics: 10/21/24 Rads and bloodwork. NSF with rads. NSF with bloodwork except snap cpl "abnormal" 3/13/26 Bloodwork - NSF except mildly elevated ALP 249 (23-212). cpl 92 (0-200.)

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.

Prostate is normal in size, echotexture, and echogenicity for a neutered male.

The right kidney is normal is size (7.33 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.

The left kidney is normal is size (7.34 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 right adrenal gland is normal in size (0.9 cm at cranial pole and 0.7 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

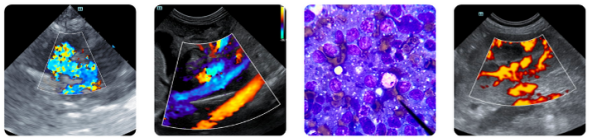
The left adrenal gland is normal in size (0.68 cm at cranial pole and 0.67 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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



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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

Fundic mucosal hypertrophy with hyperechoic mucosa and some mucosal remodeling is noted. There is no loss of mural detail. Layering is normal. There is mild luminal fluid accumulation. No evidence of masses/nodules or foreign material present.

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 mildly thick in the cranial to mid descending colon measuring 0.42 cm thick with normal intact layering. The lumen is mildly distended with normal to potentially some soft stool.

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

- Gastritis – Consistent with irritation secondary to dietary indiscretion or intolerance, infection (bacterial, viral, other), parasitic or protozoal disease, toxin, other metabolic disease such as pancreatitis, other. Microulceration cannot be ruled out. Infiltrative neoplasia affecting the stomach wall while considered less likely, can't be definitively ruled out.
- Concurrent colitis is suspected. Infiltrative neoplasia affecting the colon is possible but considered much less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given patient's current reported lack of clinical signs, further intervention since the resolution of the suspected previous episode of pancreatitis may not be indicated. Having said that, if gastrointestinal signs do return, given the changes noted above recommendations include:

- A routine fecal/giardia exam is recommended if not recently evaluated.
- 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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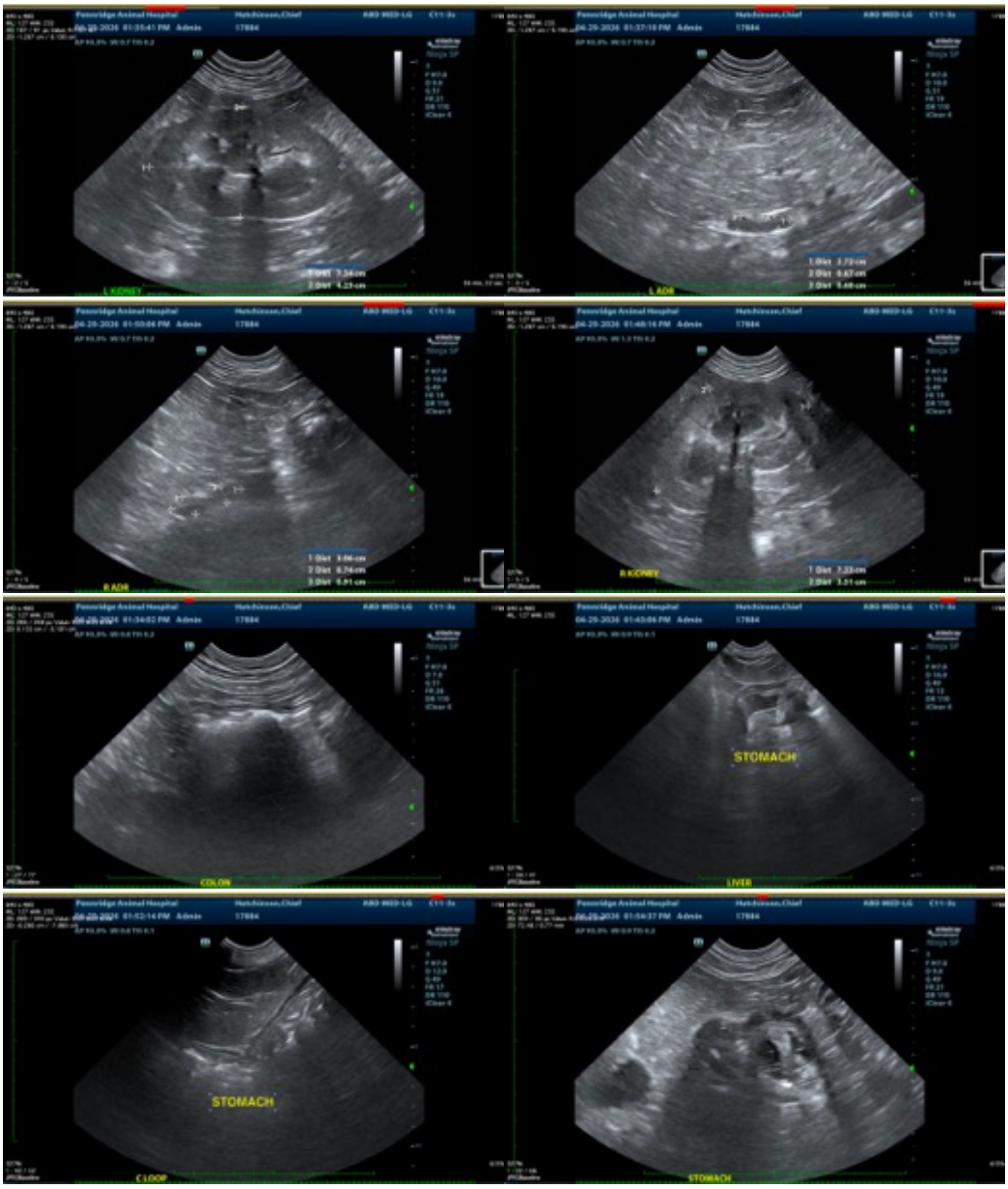
- A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

In that scenario, recheck imaging of the stomach and colon could also be considered.



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

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can be of any further assistance please contact me.

Beth Johnson, DVM, DACVIM
info@sonopath.com