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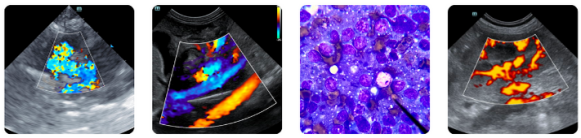

Clinical Sonography & Telecytology
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PATIENT

Copper Panici

SPECIES

Canine

BREED

Catahoula Leopard Dog

SEX

MN

AGE

11 years 10 months

WEIGHT

55 lbs

INTERPRETED BY

Beth Johnson, DVM, DACVIM

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Barnes Veterinary Services

REFERRING VET

Dr. Kim Barnes

INVOICE

11820

DATE

4/29/2026

PRESENTING CLINICAL SIGNS

Pet presented for abdominal ultrasound. Owner feels that pet has had digestive issues starting after dental prophy on 3/23/26. Pet was switched from regular kibble to a different canned dog food. Currently, pet has a poor appetite despite trying several different foods including boiled chicken, ground chicken, Hills i/d Digestive Care etc. Historically, pet has always had a good appetite. Previous BW done at Alpine Animal Hospital and Marqueen Pet Emergency & Specialty were unremarkable. Radiographs performed at Alpine Animal Hospital on 4/17/26 showed a splenic nodule and abdominal u/s was recommended. Thoracic radiographs performed on 3/19/26 were compared to previous radiographs dated on 9/16/25- Conclusion- No pulmonary nodules or abnormal thoracic lymph nodes seen. No evidence of thoracic neoplasia. Note: Pet is seen regularly by oncologist at Marqueen Emerg & Specialty due to previous hx of soft tissue sarcoma. (See Hx). 4/1/26 Oral melanocytic neoplasm biopsy report attached. Excision complete. Lymph Nodes: Inguinal l.n's appear mildly enlarged bilaterally. Poor Appetite, weight loss Complaint: Vomiting and diarrhea.

Abnormal PE/Chem/CBC/UA Results: *Housecall- no sedation, compliant sweet dog, thin BCS

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.

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

The right kidney is normal is size (7.49 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. Very subtle but multiple, too numerous to count, hypoechoic densities/nodules are noted throughout both kidneys. A representative nodule measures approximately 0.9 cm x 1.5 cm in size.

The left kidney is normal is size (7.37 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. Very subtle but multiple, too numerous to count, hypoechoic densities/nodules are noted throughout both kidneys. A representative nodule measures approximately 1.1 cm x 1.4 cm in size.

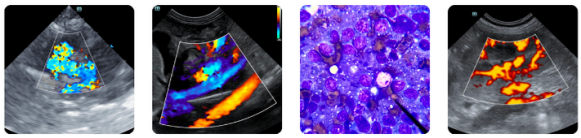
Adrenal Glands

The right adrenal gland is normal in size (0.74 cm at cranial pole and 0.68 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.49 cm at cranial pole and 0.64 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



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(hyperechoic to liver). Mid spleen, there is an approximately 2.5 cm x 2.8 cm mixed non-capsular disrupting mass noted. 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. There are several subtle, multifocal changes throughout the liver including an approximately 1.0 cm in diameter, anechoic cystic area, several discrete homogenous approximately 1.0 cm in diameter, hyperechoic densities, and the most concerning change is an approximately 2.0 cm in diameter mildly heterogenous, but largely hyperechoic density/mass in the right cranial liver. 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.

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 mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction or foreign material noted.

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

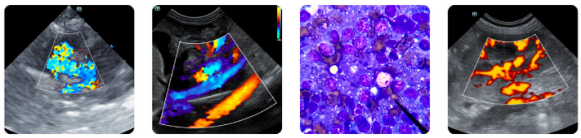
There is no visible free peritoneal effusion noted in these images.

Portal lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

Additionally, the reportedly enlarged inguinal lymph nodes are imaged.

ULTRASONOGRAPHIC FINDINGS

- The diffuse kidney nodules could represent a benign change such as a typical appearing cortical cysts. Although an infiltrative infectious, inflammatory, or even neoplastic process is a differential and warrants tissue sampling.



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- Similarly, the splenic mass could represent a benign cystic area, hematoma, extramedullary hematopoiesis, etc. although infiltrative neoplasia including primary or metastatic neoplasia can't be ruled out without tissue sampling.
- The variety of liver changes described above, largely trend toward benign, but especially the largest more heterogenous right cranial density could represent other benign or infiltrative neoplastic disease and can't be differentiated without tissue sampling.
- Moderately reactive portal lymph nodes, as well as inguinal lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated, a general metabolic health screen (CBC, chemistry panel with electrolytes and urinalysis) is recommended.

Ultimately, sampling is recommended. Therefore, Fine needle aspirates of the kidneys, the splenic mass, the liver, as well as the enlarged lymph nodes could all be considered if patient's coagulation status is appropriate.

In the meantime, additionally, given patient's reported presenting complaint, a routine fecal/giardia exam is recommended if not recently evaluated.

As is 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.

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

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 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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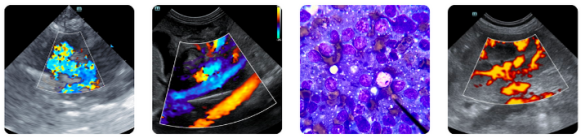

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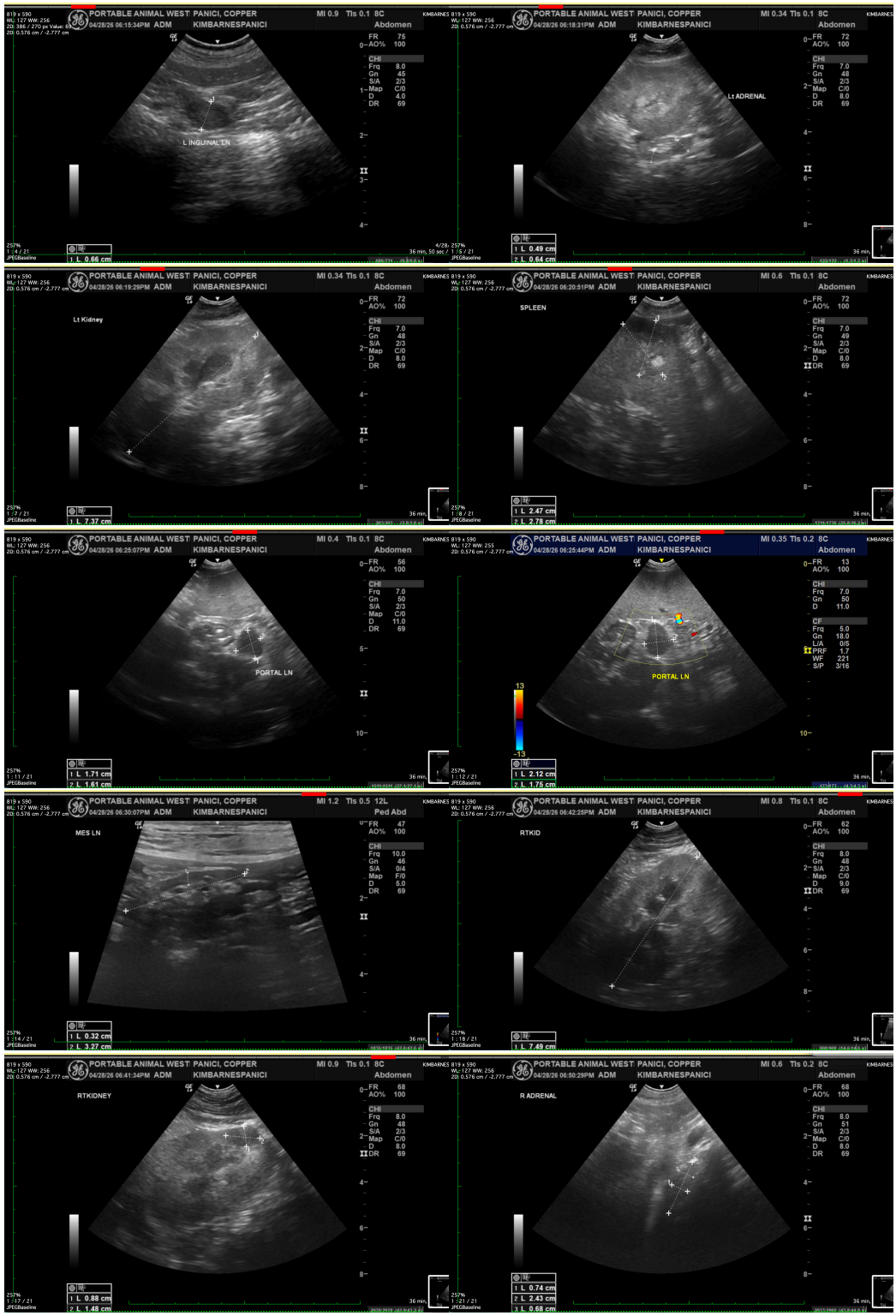

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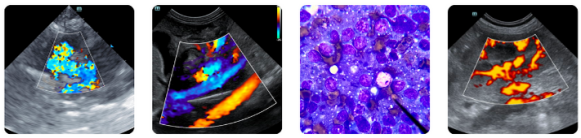

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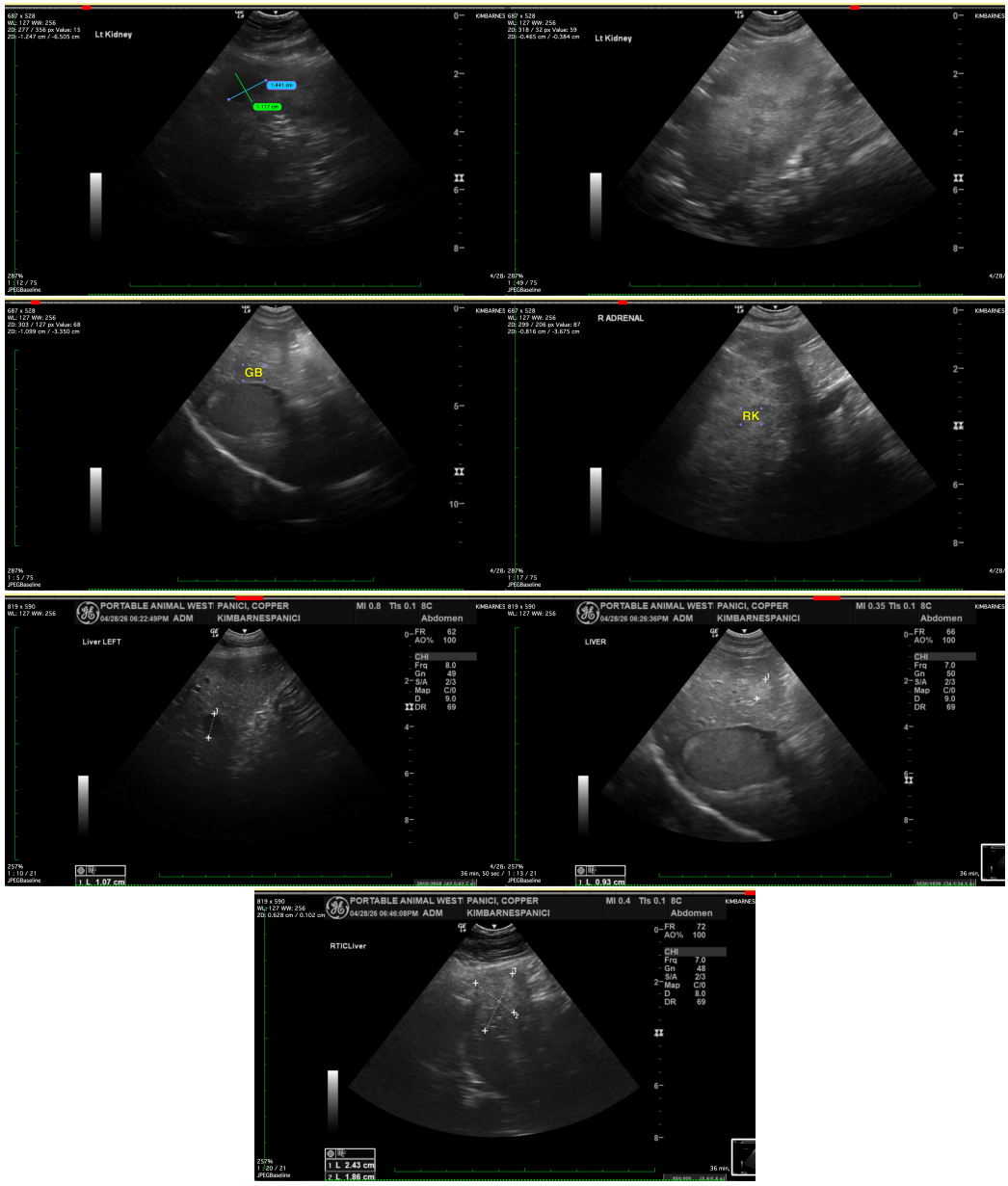

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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