PATIENT

Pippa Stanley

SPECIES

Canine

BREED

Lab Ret

SEX

FS

AGE

11 years

WEIGHT

44.4 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

MountainView Animal Hospital

REFERRING VET

Dr. Ashlie Brown

INVOICE

11628

DATE

4/6/2026

PRESENTING CLINICAL SIGNS

Patient started vomiting on 3.11, and a week prior was refusing food. Owner normally feeds a raw food diet but has switched to homecooked since vomiting started. Physical examination was unremarkable.

Abnormal PE/Chem/CBC/UA Results: Blood work was as follows: Monocytes 1.218 ALT 1,942 AST 365 ALP 1,180 T bili 1.8 Unconjug 0.7 Conj bili 1.1 Concurrent urinary tract infection with cocci Radiographs which were as follows were performed: Small amount of gastric soft tissue material, representing food and/or foreign material. A postprandial changes prioritized. A cause for the reported hyporexia is not identified. Considerations may include gastroenteritis and/for pancreatitis. Given the advanced age of the patient, neoplasia may also be possible. Primary non-gastrointestinal causes for the patient\'s clinical signs may also be possible. Medications: -Denamarin Advanced Chewable Tablets: -Ursodiol Tablets 250 mg, -Clavamox 250mg.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with a mild amount of echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or cystoliths are observed. The trigone is normal in thickness with a smooth mucosal surface, but the visible pelvic urethra is subjectively mildly symmetrically thick with a wall measuring 0.26 cm thick.

The right kidney is normal is size (5.5 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.

The left kidney is normal is size (5.81 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 (0.51 cm at caudal pole, and the cranial pole is unable to be visualized in these images), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.55 cm at cranial pole and 0.53 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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Liver is subjectively enlarged with mildly irregular margins. Parenchyma is moderately 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. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation. Several non-visibly obstructive cholecystoliths are suspected including one that measures approximately 1.2 cm in size.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach contains a moderate amount of echogenic non-shadowing contents consistent with normal ingesta/chyme, fluid, and gas. However, additionally, there is an approximately 1.6 cm x 1.8 cm round, homogenous, hypoechoic non-visibly shadowing, non-definitively vascular density within the stomach as well. 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.

There is no apparent pathologic lymphadenopathy noted in these images.

Assessment of heart base images is included when/if a splenic nodule/mass is present (as a complimentary add on). They are also assessed when a specific request is made for assessment of a limited second cavity (heart base and/or thorax) for an additional charge. Images of the heart (and/or) thorax were not assessed for this study. Please contact us if you would like a second cavity.

ULTRASONOGRAPHIC FINDINGS

- The hypoechoic, round density within the stomach is difficult to fully identify. Differentials include an atypical ingested kibble or food source versus a non-shadowing foreign object versus a tissue nodule or mass can't be ruled out without additional information. Reassessment following an additional 12-24 hours of fasting would be helpful given the concurrent ingesta, fluid, and gas.

- Moderately heterogenous liver – These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or

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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. Several non-visibly obstructive cholecystoliths are suspected.

- A mild amount of echogenic urinary bladder debris with a subjectively mildly thick urethra could be a benign inflammatory change, especially given patient's reported suspect urinary tract infection although early infiltrative uroepithelia neoplasia can't be ruled out without additional information.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Submission of urine to look for BRAF gene mutation could be considered.

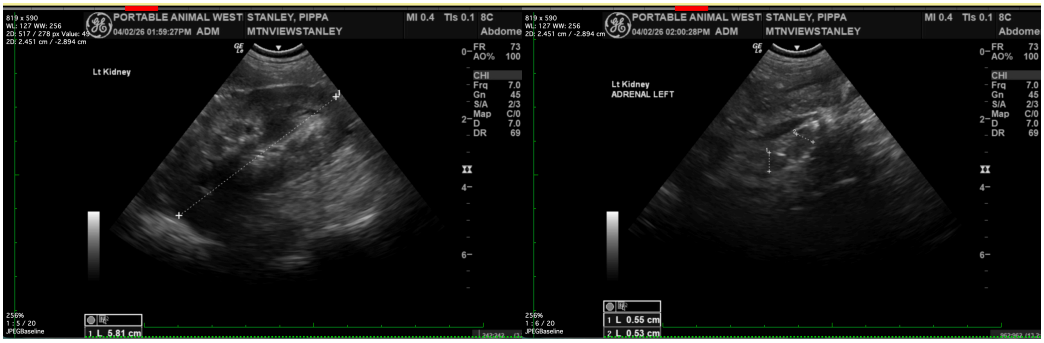
Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

As mentioned above, reassessment of a more fasted stomach could be considered if possible. Additionally, or alternatively, alternative imaging such as contrast radiography or even upper GI gastroscopy could be considered for further visual evaluation of the object, and sampling if indicated.

Fine needle aspirates of the liver could be considered if patient's coagulation status is appropriate.

Pending results of above, infectious disease testing could be considered, including testing for leptospirosis, and especially given patient's history of raw diet, 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.

Other than supportive/symptomatic medical management of clinical signs, further diagnostic and treatment recommendations are largely dependent on results of the above.



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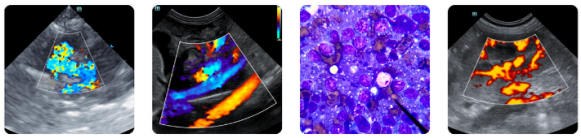

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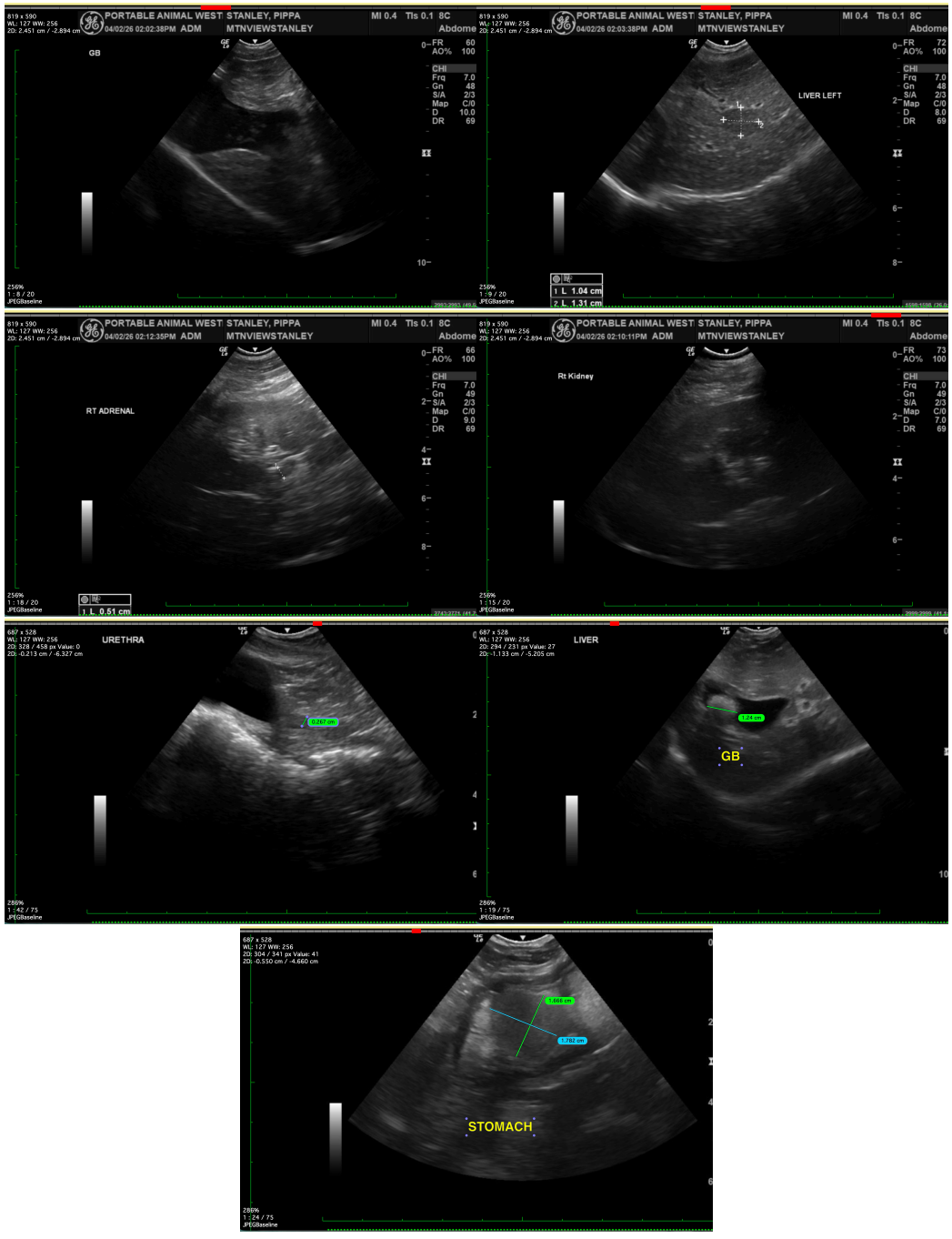

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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