



PATIENT

Piper Avena

SPECIES

Canine

BREED

Bulldog Mix

SEX

FS

AGE

9 years

WEIGHT

42 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Alexandra Pasaturo

HOSPITAL NAME

Greater Staten Island
Veterinary Service

REFERRING VET

Dr. Alexandra Pasaturo

INVOICE

11651

DATE

4/9/2026

PRESENTING CLINICAL SIGNS

Piper presented to GSIVS after owner noticed she was shaking, restless reluctant to go up/down stairs. The past few weeks owner noticed her eyes appeared glazed over, and she stares into space. Decrease appetite the past 3-4 weeks. No interest in food at all today. Vomited up water after drinking a whole bowl of water. On and off diarrhea. Owner reports over the past few months she has become more aggressive, and anxious. Primary prescribed fluoxetine and trazodone PRN. The fluoxetine was discontinued after a few days due to owner feeling it made Piper sick. Owner feels the Trazodone is not as effective as when owner started the medication. UTD on vaccines and prevention. No current meds. Presented for further eval.

Abnormal PE/Chem/CBC/UA Results: Febrile 103.F Tense/painful thoracolumbar region Large dermal to SQ mass left dorsum CBC/chem: eos 0.01 (0.06-1.23), mpv 13.4 (8.7-13.2), alt 143 (10-125), alpk 489 (23-212), ggt 14 (0-11) PSL: 50 (0-200) 4Dx: negative.

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.

The right kidney is normal is size (5.9 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 (5.1 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 caudal pole, the cranial pole is difficult to fully visualize in these images), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.53 cm at cranial pole and 0.44 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). An approximately 0.8 cm in diameter mildly heterogenous, largely hypo- to anechoic, non-capsular disrupting nodule is noted mid spleen. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged (swollen contour) with a diffusely mildly coarse architecture and subtly increased portal markings. Mildly mixed echogenic changes are noted diffusely. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.



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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. 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, in the area of the distal descending colon, is moderately thick ranging between 0.4 cm and 0.6 cm thick, with normal intact layering. The lumen is empty, to mildly gas distended.

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

- An obvious cause for the subtle liver changes is not identified in these images. Microscopic disease such as Leptospirosis, bacterial cholangiohepatitis, chronic active hepatitis, copper-associated hepatotoxicity, other hepatotoxicity, other reactive hepatopathy, infiltrative neoplasia (considered unlikely), etc. cannot be definitively ruled out.
- Hypo to anechoic splenic nodule – likely represents a benign lesion such as a cyst, hematoma, nodular hyperplasia, extramedullary hematopoiesis, etc., however while considered less likely, infiltrative neoplasia can mimic benign lesions, and cannot be ruled out.
- The colon changes trend in appearance toward benign, as is seen with parasitic, infectious, other benign inflammatory or potentially dietary related versus other colitis. Infiltrative neoplasia is possible but considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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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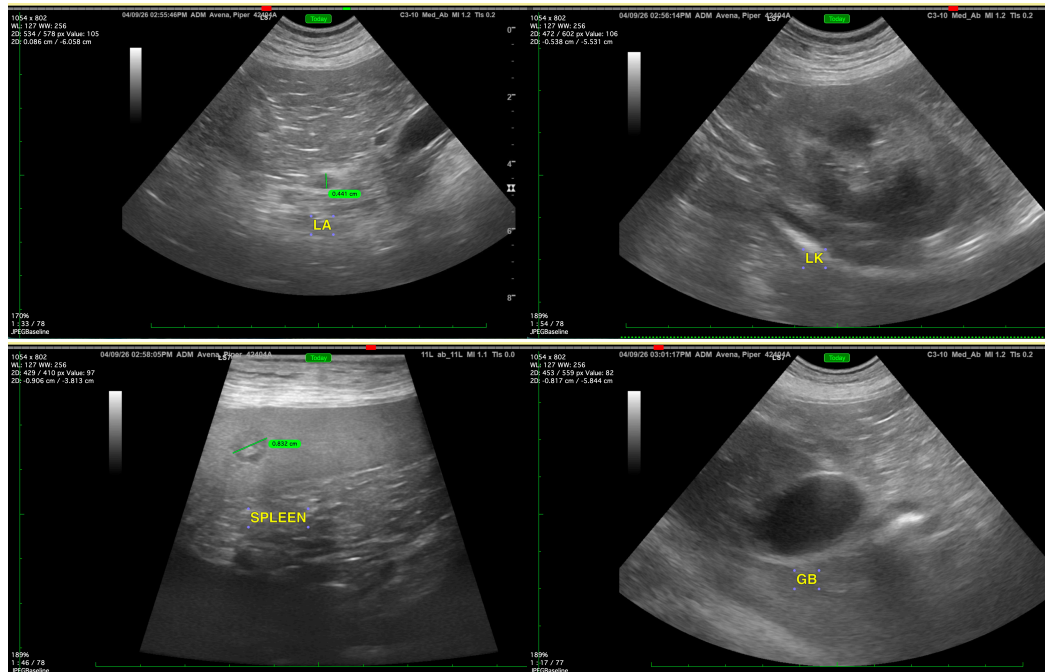
A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

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

In the meantime:

- 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.

The gastrointestinal signs and colonic changes may respond to the above. However, given patient's reported behavior changes, mild fever, etc., additional orthopedic and/or neurologic/spinal workup may also be indicated.





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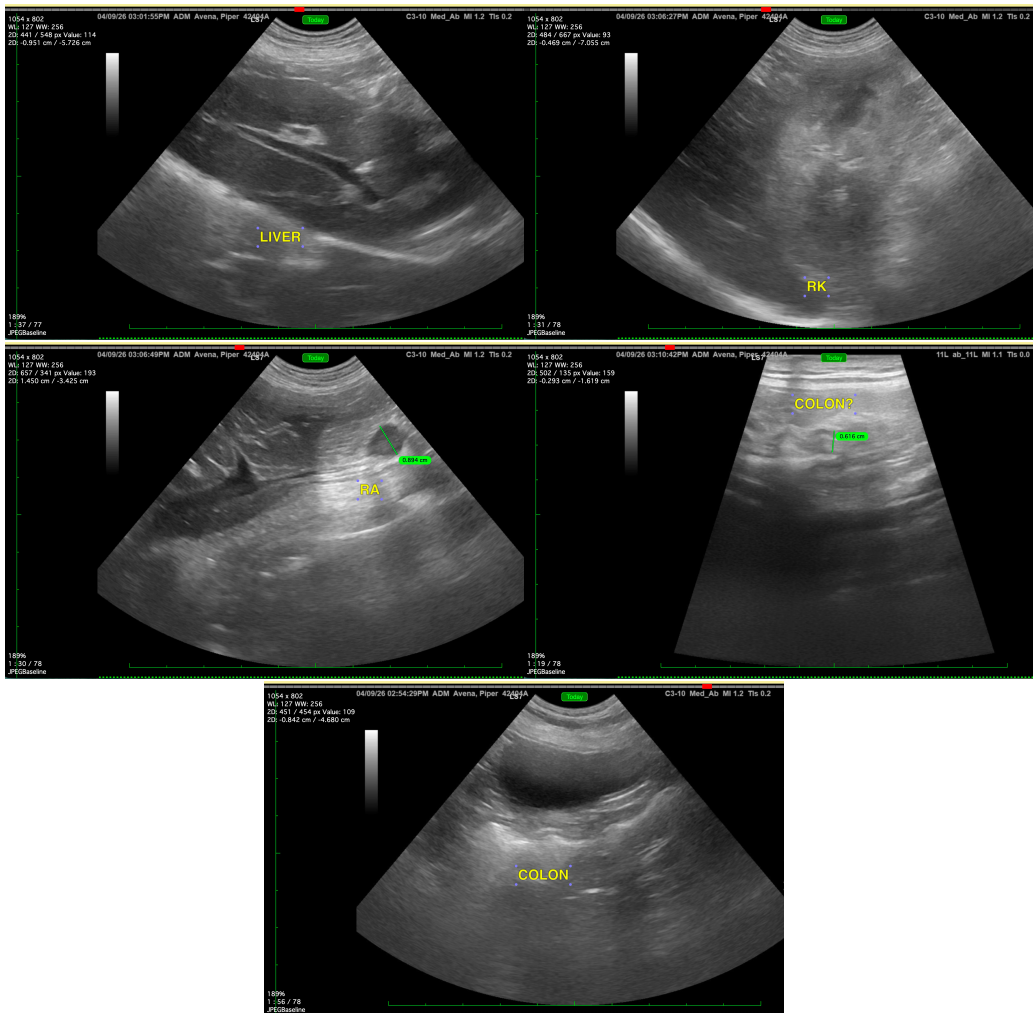
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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