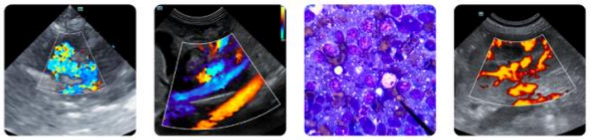

PATIENT

Little McSharar

SPECIES

Canine

BREED

Min Pin

SEX

Spayed Female

AGE

7 Years 9 Months

WEIGHT

5.33 kgs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Blue Pearl Wyomissing

REFERRING VET

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INVOICE

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5/11/26

PRESENTING CLINICAL SIGNS

History: AUS to further evaluate chronic Intermittent Vomiting/Nausea since adoption in 2019. Current decreased appetite. No specific pattern or frequency to the episodes. Appetite decreases for about 1 day around the episode then returns to normal after. Vomit is mostly yellow bile, occasionally undigested food or grass. She does have a behavior to lick the carpet and eat grass when she feels nauseous. In the past, owner has also tried pepcid, omeprazole, and switching the protein in her food. These changes would help for a short time, then she would go back to acting like she was nauseous again. Within the last month, Little has vomited up undigested food, a hairball, and yellow bile. Diet changed to HA wet & dry w/ sweet potatoes 3/19 no significant changes. Now is starting to refuse the food and only interested in Sweet Potatoes since Saturday - No visible nausea or vomiting. Prev AUS Feb 2025 for elevated LES/intermittent V+

Meds/Diet: Dasuquin w/ MSM Chew, Just Food for Dogs Probiotic Chew

Abnormal PE/Chem/CBC/UA Results: March 2026: - CBC: Hct 53%, Pkts 366-n, remainder NSF - Chem: Alb 3.2-n, normal LES, GGT and renal values, remainder NSF - T4: 1.3-n - Resting Cortisol was 1.0 L - ACTH Stim - WNL Prev AUS (2/25/25): shadowing material within the stomach is suspected to be foreign. •The small intestinal dilation may represent a functional ileus, however, an additional or concurrent small intestinal foreign material cannot be definitively ruled out. • The echogenic contents within the gallbladder and mild shadowing within the biliary tree is likely biliary tree mineralization.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia or infarcts observed. The left kidney measures 3.67 cm. The right kidney measures 3.82 cm. Pinpoint nonobstructive nephroliths were noted bilaterally.

Adrenal Glands

Left adrenal gland is normal in size (0.45 cm at cranial pole and 0.47 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

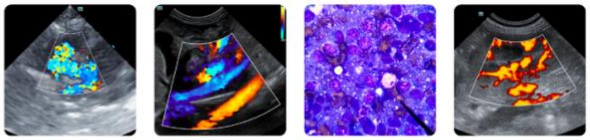
Right adrenal gland is normal in size (0.43 cm at cranial pole and 0.45 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

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

Liver is subjectively potentially very mildly decreased in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately



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mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

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 is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

Pancreas is prominent (enlarged) in size and mildly irregular in shape with a slightly undulating contour. Parenchyma is coarse in echotexture and heterogenous to hypoechoic in echogenicity. This change is very subtle/mild and most visibly noticeable in the right limb.

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

Primary Findings

- Chronic low grade smoldering pancreatitis can't be ruled out, but as described above, the changes are very mild/subtle.
- Similarly, the liver changes are very subtle/subjective but microhepatica can't be ruled out. Ultrasound is not the most specific diagnostic for assessing liver size, and radiographic imaging may be helpful.

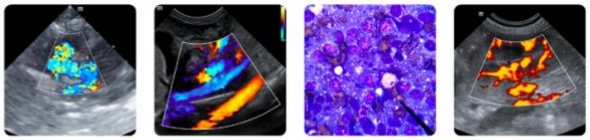
Secondary Findings

- Moderate age relate kidney changes with pinpoint nonobstructive mineral densities bilaterally.

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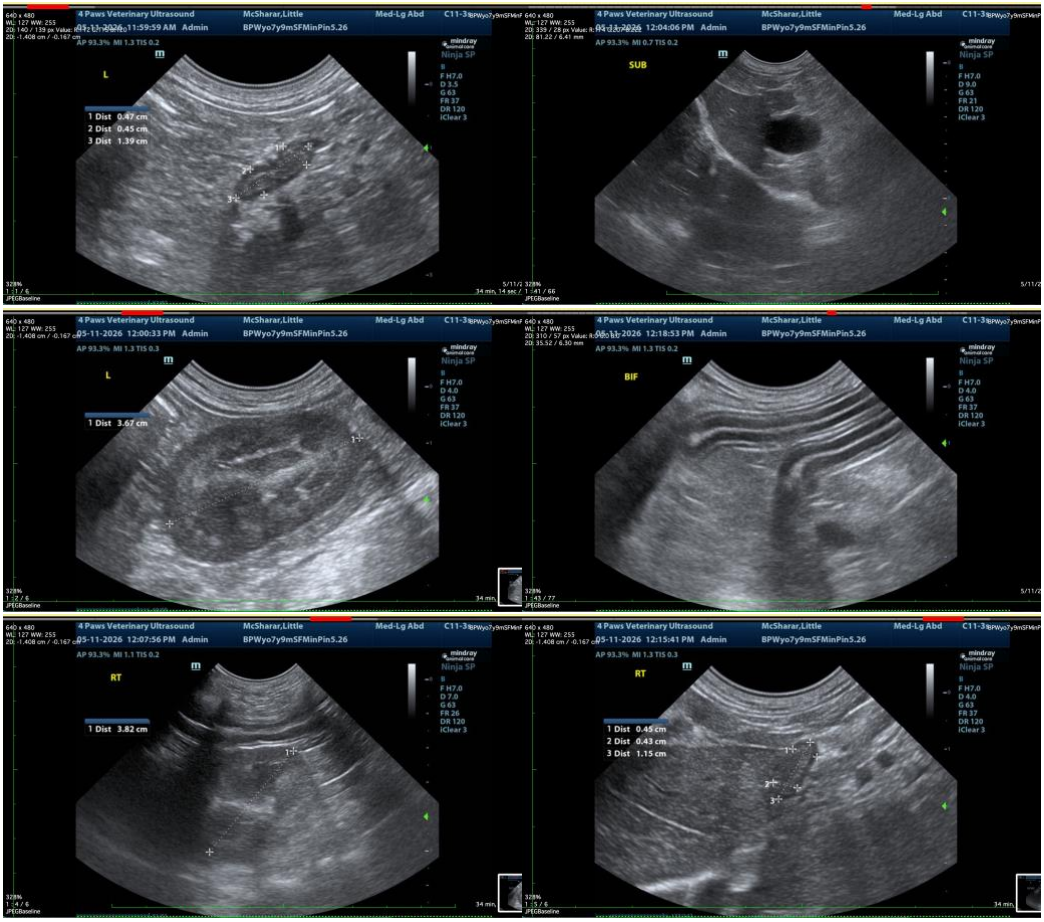
A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

Bile acids could also be considered if patient's total bilirubin is not increased.

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 as is a full course of empirical Helicobacter triple therapy.

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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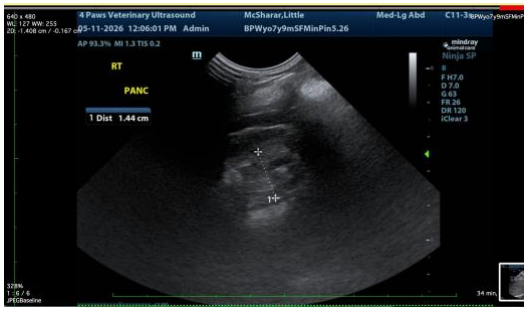

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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