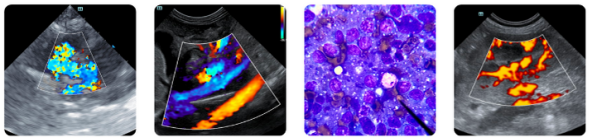


PATIENT

Pebbles Cary

SPECIES

Canine

BREED

Mixed

SEX

FS

AGE

8 years 10 months

WEIGHT

41.5 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Kristen Carpenter

HOSPITAL NAME

Pennridge Animal Hospital

REFERRING VET

Dr. Beth Mehaffey

INVOICE

11984

DATE

5/20/2026

PRESENTING CLINICAL SIGNS

Patient was sedated with Butorphanol. Patient had a screening ultrasound in 9/2025 (no clinical concerns, was just a baseline) and scant abdominal effusion and and an IBD pattern was recognized. There was also some recent weight loss noted by owner. Patient was referred to an internal medicine specialist and workup completed (Maldigestion panel, PCR panel, repeat US, eventual GI biopsy.) Patient was diagnosed with IBD and started on prednisone. Patient developed diarrhea when pred was tapered. Here for follow up screening US to check GI tract and monitor effusion. Patient overall doing well and gained weight.

Current meds: Prednisone 10 mg PO BID, Visbiome, Trazodone PRN.

Current diet - Annamaet chicken and brown rice

Diagnostics: 7/2025 Full Bloodwork - NSF except low phosphorous. 11/4/2025 Fecal PCR: positive for giardia duodenalis, patient was treated with a course of panacur. Maldigestion panel: Mildly elevated cpl (equivocal), otherwise all normal. GI biopsy: IBD with eosinophilic infiltrate r/o food allergy, chronic giardia, primary IBD.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is under distended with primarily anechoic contents and occasional echogenic non-shadowing debris. Apical urinary bladder wall is diffusely thick (0.7 cm). The almost empty state could in part be contributing to the thick, irregular appearance of the wall, making it difficult to fully assess for wall pathology. Mucosa is hyperechoic and irregular. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.

The right kidney is normal is size (5.97 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 (5.64 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

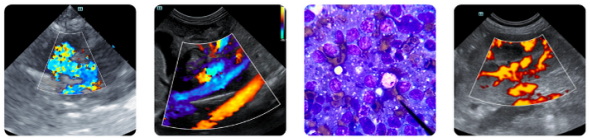
The right adrenal gland is normal in size (0.9 cm at cranial pole and 0.9 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.64 cm at cranial pole and 0.55 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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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. 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

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 intestine demonstrates areas of mildly thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

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 one tiny pocket of free fluid noted mid abdomen adjacent to a bowel loop, as well as some subtly enhanced hyperechoic mesentery and fat in that area.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Mild inflammatory bowel disease (IBD) pattern – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No loss of layering or distinct characteristics of malignancy are present. Therefore, differentials cannot be further ranked without tissue sampling.
- Scant/trace free fluid and enhanced mesenteric fat.
- Possible chronic cystitis - Urinary bladder wall changes are most consistent with chronic cystitis. Infiltrative neoplasia cannot be ruled out but is considered less likely give the location and diffuse nature of the changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The appearance of the bowel and the amount of free fluid are both very subjectively, very mildly improved compared to the previous study. Further recommendations are unchanged from what is reportedly currently already in place, and largely dependent on patient's ongoing clinical status,

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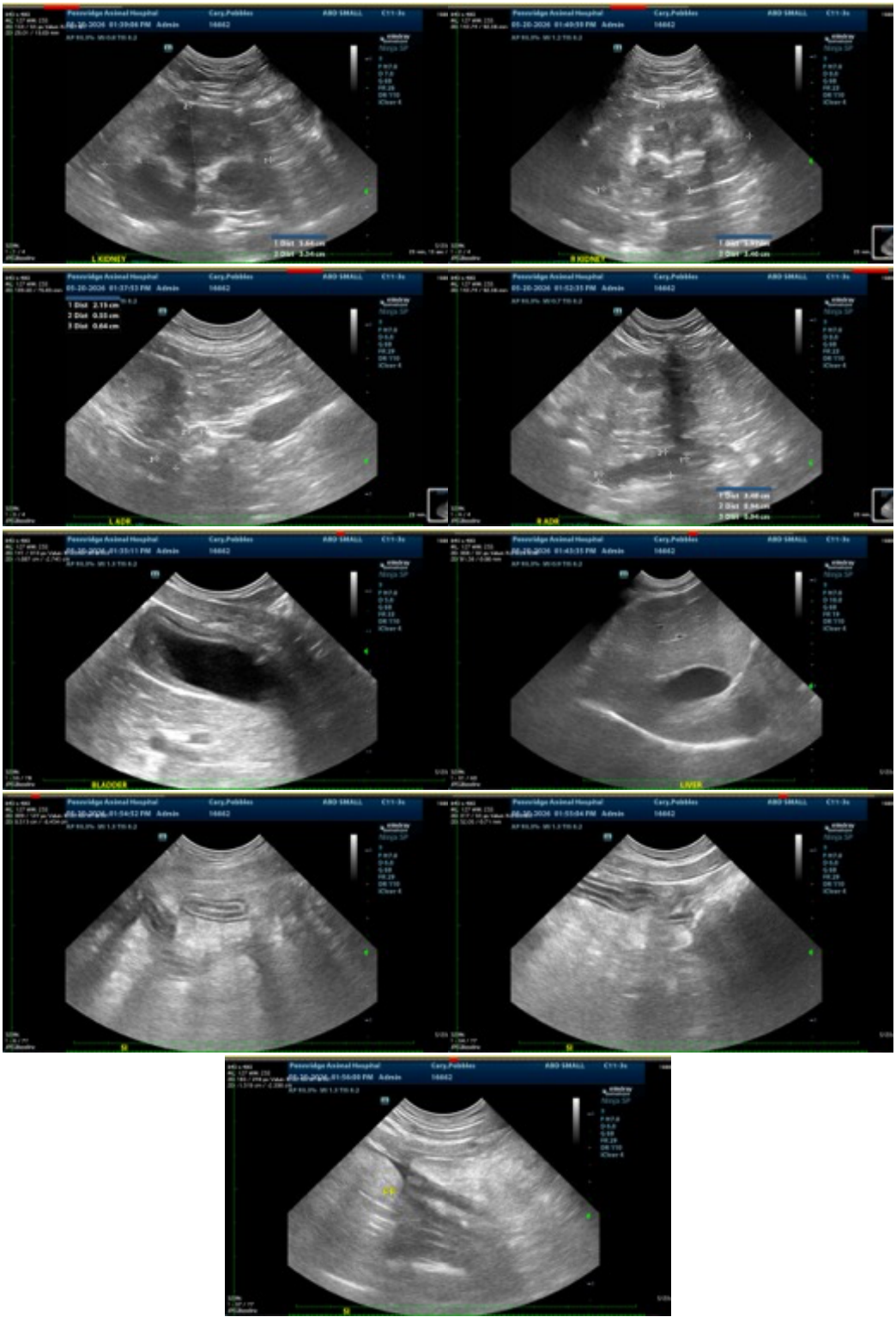
response to treatment for the reportedly recently diagnosed IBD, etc.



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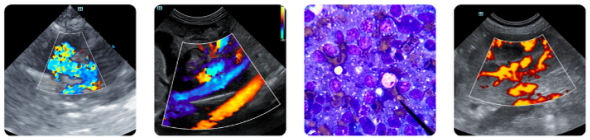

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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