



PATIENT

Stewie Hughes

SPECIES

Cnaïne

BREED

Schnauzer Mix

SEX

MN

AGE

13 years

WEIGHT

27.1

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Kristen Carpenter

HOSPITAL NAME

Penridge AH

REFERRING VET

Dr. Jen Makem

INVOICE

11987

DATE

5/20/2026

PRESENTING CLINICAL SIGNS

Sedated with Butorphanol. Hx of heart murmur first ausculted in 2025. Hx of hypoalbuminemia since 2023 with no associated clinical signs. More recent presentation for diarrhea with no response to metronidazole. Patient was started on prednisone for suspected PLE and diarrhea resolved but reoccurred when prednisone was tapered. Here today for AUS for a more definitive diagnosis and to help formulate a plan moving forward.

Current meds: Prednisone 5 mg PO BID x 5 d, now on prednisone 5 mg PO SID

Current Diet: GI biome dry + i/d wet

Diagnostics: 4/29/26 Full bloodwork: CBC WNL. Chem: tCa 8.2 (L), TP 3.6 (L), Albumin 1.6 (L), Glob 2.0 (L), Chol 104 (L), T4 1.2. 4dx neg x4. Fecal NOS. Spec CPL 76 (normal)
- 5/9/26 UPC: < 0.2 UA - USG 1.025, quiet sediment - 5/11/26: TP 4.1 (L), Alb 1.6 (L), Glob 2.5 (low normal.)

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 (5.87 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 (4.81 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 (0.77 cm at cranial pole and 0.71 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.8 cm at cranial pole and 0.67 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

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



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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.

Small intestine is diffusely mildly thick with a relatively thick mucosa compared to other layers. Normal wall layering is preserved; however, the mucosa is more echogenic than normal and contains hyperechoic striations perpendicular to the lumen. 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

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.

Free Abdomen

There is a mild amount of free fluid noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Lymphangiectasia – Small bowel findings are most consistent with lacteal dilation. These findings can be observed with protein-losing enteropathies caused by either primary lymphangiectasia or primary infiltrative inflammatory disease with secondary lymphangiectasia. Infiltrative neoplasia is possible but considered less likely. Histopathology is necessary to definitively determine underlying cause.
- Concurrent chronic low grade smoldering pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.
- The free fluid is likely secondary to hypoalbuminemia +/- diffuse gastrointestinal disease with other pathologic causes unable to be definitively ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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

Ideally, biopsies of the GI tract are recommended to definitively diagnose and therefore manage the infiltrative bowel process.



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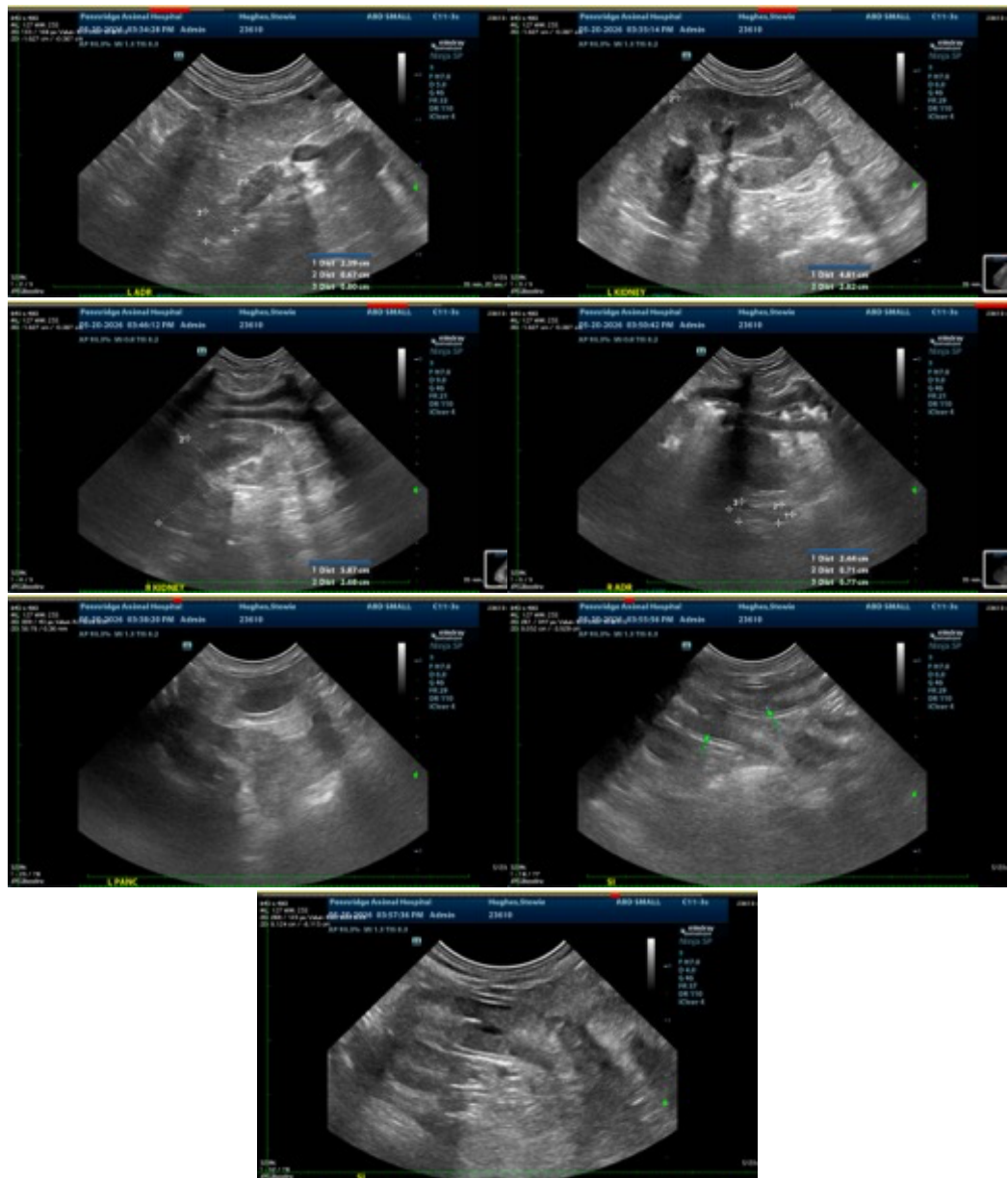
DATE

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If biopsies cannot be obtained safely due to low albumin or patient stability, etc., empirical therapies could include diet change to an ultra-low-fat diet, empirical deworming with a 5-day course of Panacur, cobalamin supplementation (unless cobalamin level is evaluated and supplementation is not warranted) a probiotic and prednisolone (if not contraindicated based on patient contraindications, co-morbidities, etc.).

Calcium monitoring, and supplementation, if necessary, is also recommended.

Additionally, if patient's coagulation status is otherwise appropriate, anti-thrombotics such as clopidogrel or low dose aspirin may also be warranted.





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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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