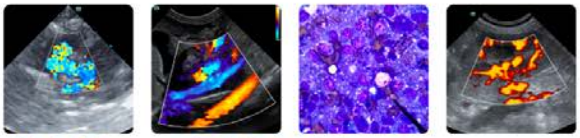




SonoPath www.thefocalzone.com info@thefocalzone.com 289.808.2608

**PATIENT**

Arya Di Tomaso

**SPECIES**

Canine

**BREED**

Golden Doodle

**SEX**

Spayed Female

**AGE**

7 Years

**WEIGHT**

~28 kg

**INTERPRETED BY**

Beth Johnson, DVM DACVIM

**IMAGING PERFORMED BY**

Crystal Hill

**HOSPITAL NAME**

Beamsville Animal Hospital

**REFERRING VET**

Dr. Hagar

**INVOICE**

75425

**DATE**

5/26/26

## PRESENTING CLINICAL SIGNS

Has been having gastric upset on and off since July 2025. April 2026 visit for inappetance, lethargy, dark mucousy stools. Fecal was NEG. Was eating Purina Pro Plan sensitive skin and stomach. Rechecked 2 weeks later, still lethargic and not eating well and loose stools continue. Ruled out Cushings/Addisons ACTH stim normal. Switched to chicken and rice from lamb and rice. Diarrhea and vomiting off and on continue. Has been on Tylosin.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

Urinary bladder is adequately distended with primarily anechoic contents and occasional echogenic non-shadowing debris. Apical urinary bladder wall is diffusely thick (0.88 cm). 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 (7.58 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 (5.65 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 adrenal glands are unable to be well visualized in these images.

### *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*

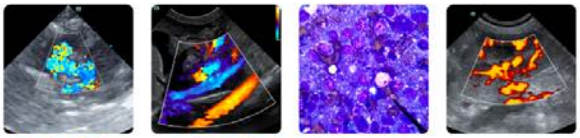
The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal 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 mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material, or infiltrative disease; however, visualization is partially inhibited by gas.

The visible small intestine demonstrates areas of moderately thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic. Multifocally there are focal areas of thicker wall and loss of layering with one





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area measuring 1.1 cm thick, and in the right cranial abdomen a 2nd area of loss of layering measures 2.6 cm thick x 5.0+ cm in length. The lumen of the small intestine is largely empty.

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 a trace amount of anechoic free fluid as well as enhanced hyperechoic mesentery and fat throughout the mid abdomen surrounding an approximately 7.5 cm x 5.5 cm irregular, homogeneous, hypoechoic mass that I believe is enlarged mesenteric lymph nodes, although given the diffuse bowel changes, part of a bowel mass can't be ruled out.

## PRIMARY FINDINGS

- Multifocal areas of loss of layering throughout the small bowel and the marked mesenteric root lymphadenopathy versus bowel mass as described above are concerning for infiltrative neoplasia such as round cell neoplasia i.e., lymphoma versus carcinoma versus other. Having said that, a benign inflammatory process cannot be ruled out without tissue sampling.

## SECONDARY FINDINGS

- 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

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.

Fine needle aspirates of the mesenteric root mass/suspect enlarged lymph nodes as well as the focal bowel wall thickening, especially in the right cranial abdomen, could be considered if patient's coagulation status is appropriate.

Ultimately, however, if a cytologic diagnosis is unable to be obtained, an exploratory laparotomy for planned excisional biopsies may be necessary for definitive diagnosis.

In the meantime, especially given the eosinophilia, 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 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.

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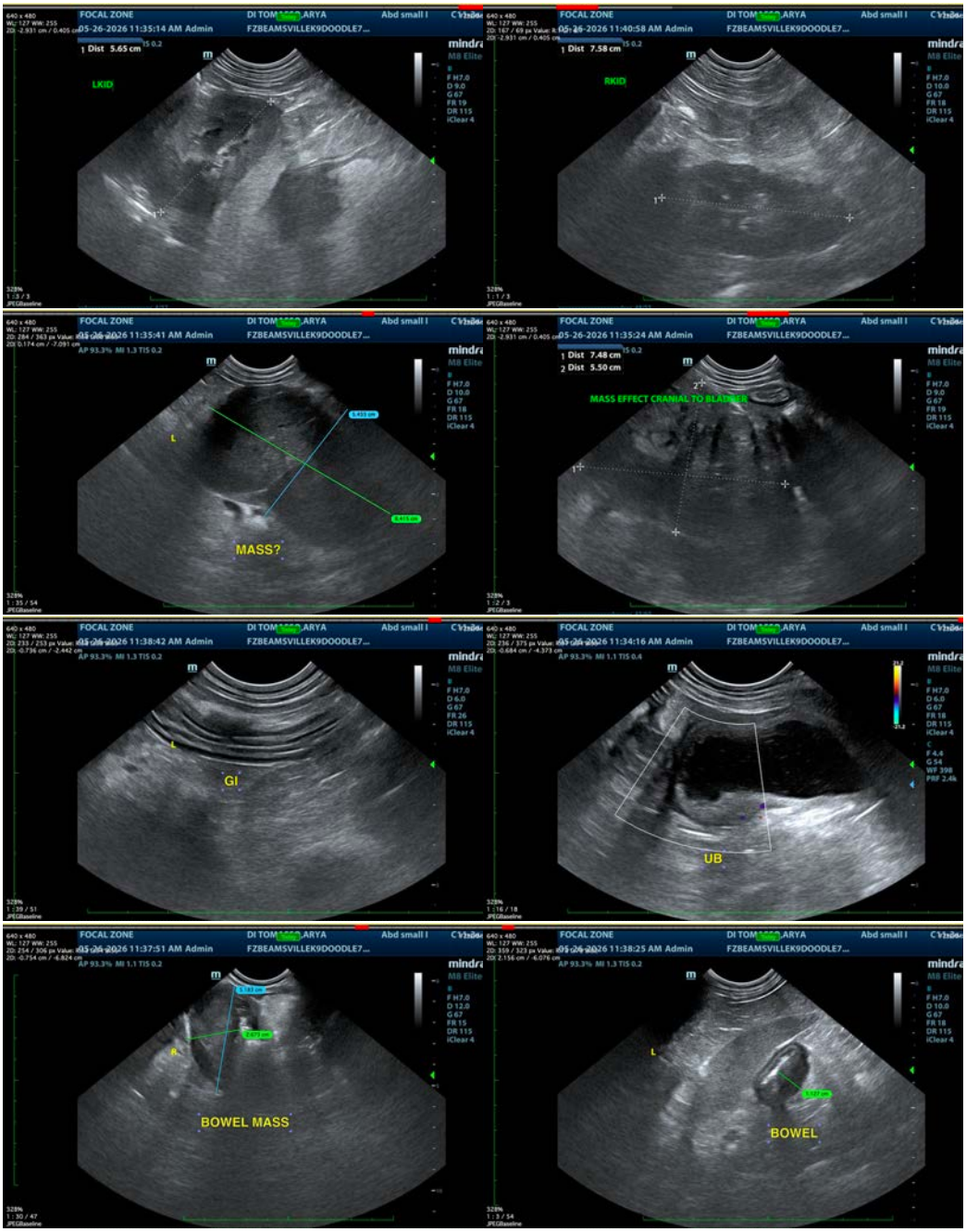
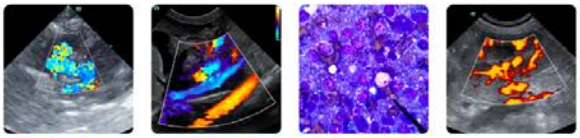
While continuing workup, if not recently evaluated, empirical deworming with a 5-day course of Panacur is recommended.

If tolerated, a transition in diet is recommended, based on trial-and-error response.

Some options to consider include a gastrointestinal biome diet vs a hydrolyzed protein diet (sometimes several trials with different brands are necessary) vs a fiber response/colitis diet vs a bland, easy to digest 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