



PATIENT

Whiskey Jones

SPECIES

Canine

BREED

Mixed

SEX

Neutered Male

AGE

11.8 Years

WEIGHT

57.7 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Kristen Carpenter

HOSPITAL NAME

Pennridge Animal
Hospital

REFERRING VET

Dr. Alex Peters

INVOICE

74959

DATE

5/5/26

PRESENTING CLINICAL SIGNS

Hx: Patient was sedated with Butorphanol. Patient has a history of newly noted elevated ALT. Chronic hx of a "sensitive stomach" and took many years for owner to find a food that does not cause GI issues. Currently has been stable with no v/d on present diet. Elevated liver enzymes were an incidental finding on pre-op bloodwork. Presented for evaluation for a dental on 3/26/26 - ALT elevation noted. Patient was treated with a 2 week course of Amoxicillin and liver protectants. Here today for recheck liver enzymes and further workup since ALT has not improved. O would also like to eventually proceed with dental cleaning if able. Meds: Hepatosupport, Trazodone for pre-visit pharmaceuticals. Diet - Purina sensitive skin and stomach lamb.

Abnormal PE/Chem/CBC/UA Results: Diagnostics - 3/26/26 Bloodwork - NSF except ALT 197 (10-125) - 5/5/26 Recheck liver panel - ALT 244 (10-125), ALP 109, tbili 0.2 - 5/5/26 Bile Acids performed after AUS- results pending

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 area of the prostate is examined without evident prostatic pathology.

The right kidney is normal is size (6.55 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 (5.82 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 (0.55 cm at cranial pole and 0.47 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.35 cm at cranial pole and 0.51 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size with a mildly swollen but smooth capsule. Parenchyma is normal and homogenous in echogenicity and echotexture. 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, except for along the caudal edge of what I believe is the mid to left liver,



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where there is an approximately 2.0 cm in diameter homogeneous, iso- to slightly hypoechoic bulge/nodule. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

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

The observed pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and irregular in shape with a swollen undulating contour. Enhanced hyperechoic ill-defined surrounding fat is noted.

Free Abdomen

There is no apparent pathologic lymphadenopathy noted in these images.

Throughout the cranial abdomen there is a very trace amount of anechoic free fluid and enhanced hyperechoic fat and mesentery that I believe, based on location, is associated most likely with chronic low-grade smoldering pancreatitis and potentially an acute on chronic flare up, although especially given patient's reported clinical history, inflammatory changes associated with more diffuse bowel disease can't be ruled out.

ULTRASONOGRAPHIC FINDINGS

- Suspect mild acute pancreatitis, likely a flare up of chronic low-grade smoldering pancreatitis. Concurrent chronic low-grade smoldering bowel disease can't be ruled out.
- Moderate gallbladder debris - Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.
- 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, etc. cannot be definitively ruled out.



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- Splenomegaly- can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

As is reportedly already pending, bile acids are recommended if patient's total bilirubin is not increased.

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.

In the meantime, fine needle aspirates of the liver and spleen could be considered if patient's coagulation status is appropriate.

Other than supportive/symptomatic medical management of clinical signs, further diagnostic and treatment recommendations are largely dependent on results of the above.





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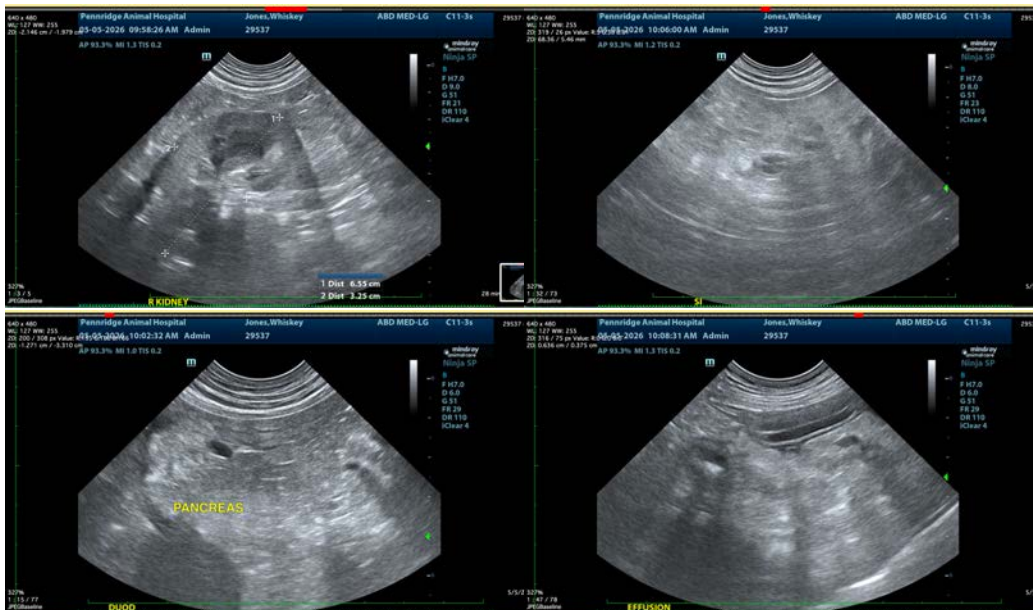
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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