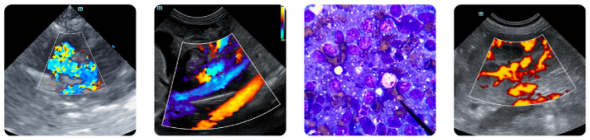


PATIENT

Hershey Carlson

SPECIES

Canine

BREED

Poodle Mix

SEX

MN

AGE

11 years 10 months

WEIGHT

34.3 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Kristen Carpenter

HOSPITAL NAME

Pennridge Animal Hospital

REFERRING VET

Dr. Kristen Carpenter

INVOICE

11885

DATE

5/6/2026

PRESENTING CLINICAL SIGNS

Patient was pre-medicated with trazodone. Presented 5/2/26 for evaluation of hyporexia. Patient had no other clinical signs other than poor appetite. Mild nausea was noted on abd palpation. Afebrile. Otherwise NSF. Full bloodwork sent out for screening. Bloodwork consistent with hypoproteinemia, hypocalcemia, low T4 (suspect sick euthyroid.) O reports worsening of appetite, new onset diarrhea, no vomiting, and possible abdominal distension when calling with bloodwork. Here for AUS and further workup as next step.

Chronic meds: Simparica trio, Cytopoint.

Diagnostics: 5/4/26 Full Bloodwork: HCT 56%, mild neutrophilia 10 k/uL (3-9.7 k/ul), Lymphocytes 1.8 (0.98-4.2). Chem: Creat 0.7,Glu 70, tCa 7.4 (8.4-11.8), Na:K ratio 30, TP 3.4 (5.5-7.5), Albumin 1.5 (2.7-3.9), Glob 1.9 (2.4-4.0), ALT 35, Chol 67 (131-345). Total t4 0.7 (1-4). 4dx neg x4. 5/6/26 Fecal and urine obtained and sent out. 5/6/26 Thoracic rads: Scant pleural effusion. Cardiac silhouette WNL, pulmonary vasculature normal, no pulmonary edema.

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 (5.9 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 (5.6 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

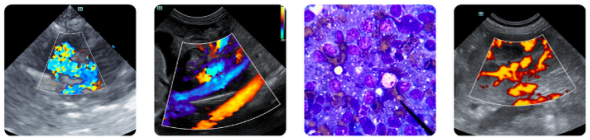
The right adrenal gland is normal in size (0.71 cm at cranial pole and 0.56 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.45 cm at cranial pole and 0.62 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). Multifocal well-demarcated hyperechoic homogenous nodules are noted. 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 moderately distended by an intraluminal echogenic density with strong acoustic shadow consistent potentially with ingesta and reverberation artifact from gas, although foreign material can't be ruled out. 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 mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction or foreign material noted.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. The lumen is diffusely moderately distended with soft/liquid stool.

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 a mild amount of free fluid within the abdomen and noted pleural effusion.

There is no apparent pathologic lymphadenopathy noted in these images.

PRIMARY 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.

- Gastric foreign material can't be ruled out but should be interpreted in combination with when patient last ate, as well as potentially recheck imaging following an additional 12-24 hours of fasting as normal ingesta is also possible.

- Concurrent mild to moderate acute pancreatitis is suspected. Having said this, some of the "inflammatory changes" Such as the free fluid and enhanced hyperechoic mesentery and fat throughout the abdomen are likely secondary to the suspected bowel disease and may be visibly demonstrating pancreatic inflammation that's less significant.

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- Free fluid is of unknown origin. Differentials (unless already ruled out) could include increased hydrostatic pressure (cardiac disease and/or vascular or lymph blockage), decreased oncotic pressure (low albumin), vasculitis, paraneoplastic fluid, rupture/leakage of/from an organ (GI, GB, UB, other), blood (hemoabdomen), other.

SECONDARY FINDINGS

- Hyperechoic splenic nodules – most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.

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.

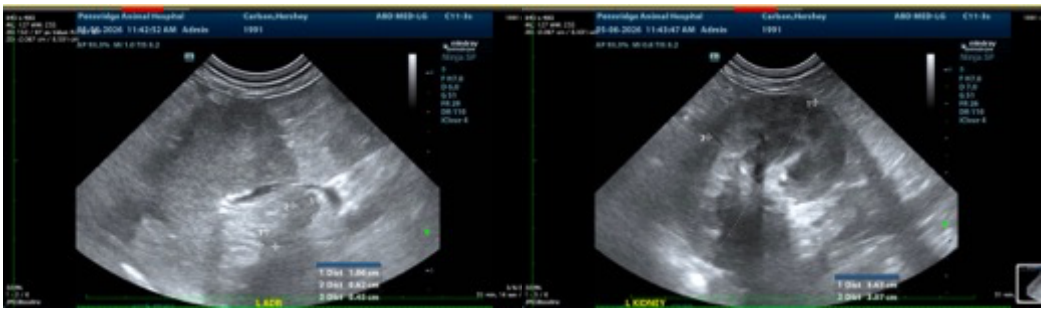
Ideally, biopsies of the GI tract are recommended to definitively diagnose and therefore manage the infiltrative bowel process.

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.

Additionally, as is reportedly already pending, ruling out concurrent proteinuria is recommended via urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.



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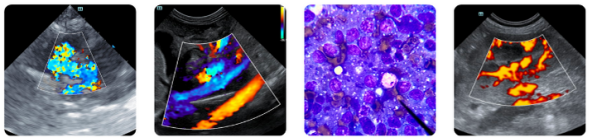

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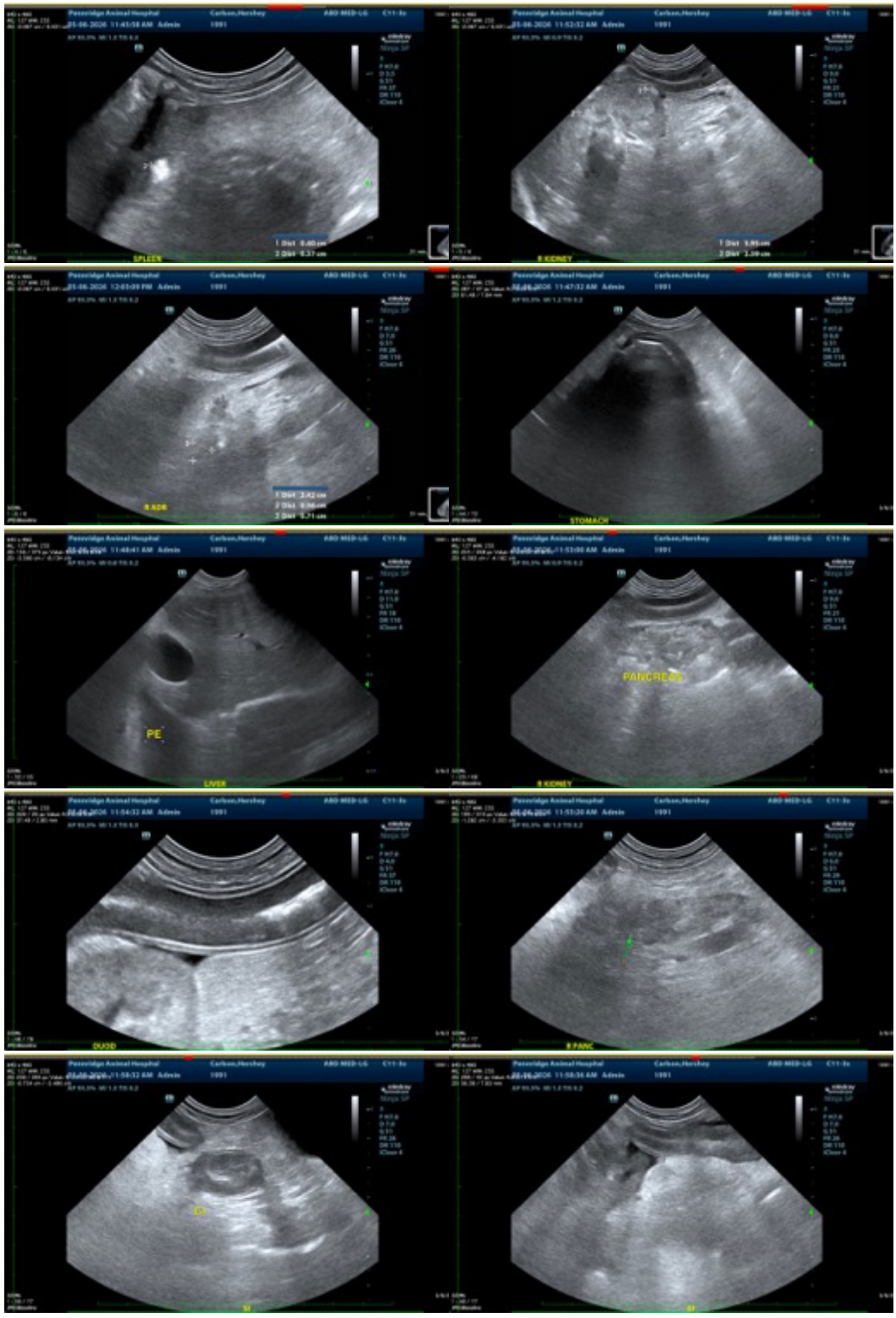
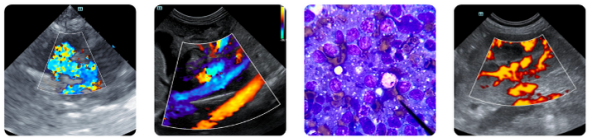


The information and recommendations provided are based on the images presented by the referring



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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