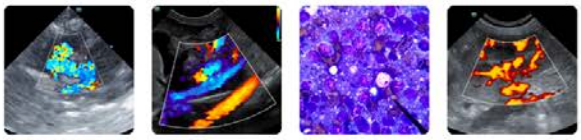


DATE

5/7/26

PATIENT

Carl Bell

SPECIES

Canine

BREED

Miniature Schnauzer

SEX

Neutered Male

AGE

1/14/17

WEIGHT

16.6 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Everhart Veterinary Hospital

REFERRING VET

Dr. Betta

INVOICE

75036

PRESENTING CLINICAL SIGNS

Patient History: Doing well with no GI signs or other issues at home. Severe dental disease but otherwise nsf on exam. Hx of borderline hypoalbuminemia (~2.3-2.4). Recheck labs prior to dental consideration and albumin now 1.4. Has been on Hill's GI low fat. Fasted maldigestion panel pending

Current Medications: N/A.
Labwork Results: Labwork attached, reported as: 4/21/2026: alb 1.4, ca 8.5, chol 91, platelets 699k. 5/20/2025: alb 2.4, alp 206, ca 9.1, chol 109, platelets 603k. fasted maldigestion panel pending
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed by: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic contents. No masses or inflammatory changes are observed. Several cystoliths are noted, with two representative ones measuring 0.34 cm and 0.53 cm. 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.

Kidneys are normal in size but bilaterally irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. Pinpoint non-obstructive nephroliths are noted bilaterally. There is no pyelectasia noted. The kidneys measure 4.5 cm each.

Adrenal Glands

The right adrenal gland is normal in size (0.67 cm at cranial pole and 0.57 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.58 cm at cranial pole and 0.61 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 homogenous in echotexture. No focal lesions are observed. 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. Hyperechoic mucosal fogging or speckling is noted. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction or foreign material, except for in one mid abdominal bowel loop where there is an approximately 0.40 cm in diameter homogeneous, isoechoic density. The appearance of the density is the same as the bowel wall and appears to potentially be tissue adhered to the inner wall, although an intraluminal structure, even ingested content, while thought less likely, can't be ruled out.

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 very trace amount of anechoic free fluid and diffusely mildly subjectively enhanced hyperechoic mesenteric fat.

There is no apparent pathologic lymphadenopathy noted in these images.

PRIMARY FINDINGS

- Subtle/mild mucosal speckling – Mucosal speckling is often present with inflammatory bowel disease (IBD). It is not specific for type or severity of disease. Mild speckling change can occur as a normal patient variant in the post-prandial state. *A bowel wall tissue density/polyp or even emerging infiltrative neoplasia, as described above, can't be ruled out.

- Concurrent chronic low-grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.

- Mild 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.

- The trace free fluid is likely secondary to patient's reported hypoalbuminemia.

SECONDARY FINDINGS

- Mild chronic kidney disease changes bilaterally with punctate non-obstructive mineral densities bilaterally and several urinary bladder cystoliths.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Gastrointestinal workup recommendations include a routine fecal/giardia exam if not recently evaluated.

As is reportedly already pending, 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.

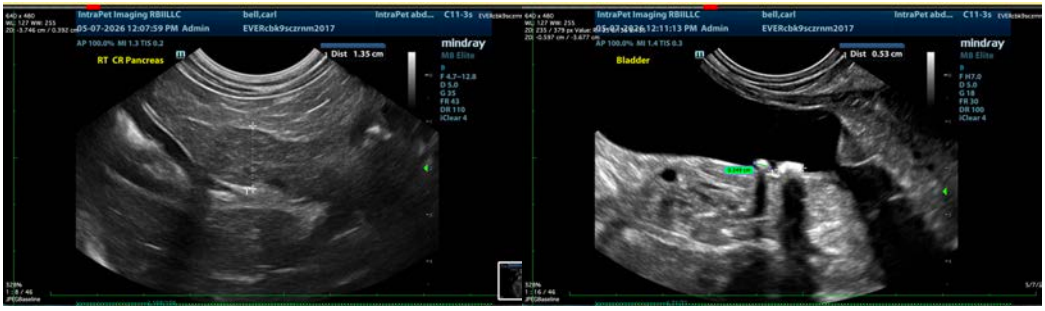
A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

Ideally, biopsies of the GI tract are recommended to definitively diagnose and therefore manage the suspected infiltrative bowel process. If pursued, close attention to the density described above to see if it can be found and biopsied is recommended.

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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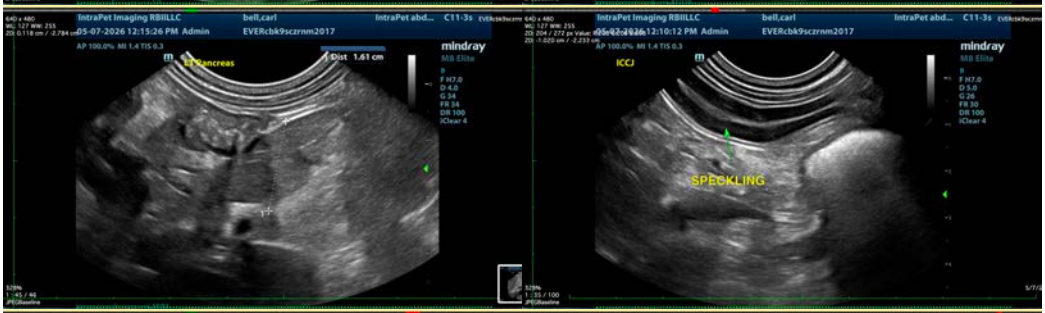
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SPECKLING


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GI

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