

PATIENT

Poco Smith

SPECIES

Canine

BREED

Chihuahua

SEX

Intact Male

AGE

14 Years

WEIGHT

11.4

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Justin Eckenrode

HOSPITAL NAME

Carlisle Small Animal
Veterinary Clinic

REFERRING VET

Dr. Hillary Morrison

INVOICE

15883

DATE

05/07/26

PRESENTING CLINICAL SIGNS

Previous large inguinal hernia repair. History of sensitive stomach and intermittent diarrhea, as well as low blood proteins. Intact male. cPL came back normal, mild elevation in BUN (pre renal?), mild hypoglycemia with normal resting cortisol. Negative fecal. During ultrasound patient was painful on palpation of abdomen, regurgitated fair amount of yellow/green tinged fluid, and leaked yellow diarrhea.

Chem: glucose 51 (70-143) *sat for about 1.5 hours, alpha track 66 ** sDMA 21, creat 1.1, BUN 64 TP 5.2 (5.2-8.2)* was 5.5, alb 2.2 (2.2-3.9) * was 2.6, glob 3 (2.5-3.9) * was 2.9 Amylase 1,761 cpl: 118 (0-200)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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 symmetrically enlarged with smooth margins that are well differentiated from surrounding tissue. Normal bilobed shape is maintained. Parenchyma is diffusely hyperechoic. Several small anechoic cysts are noted. Nonobstructive mineral densities were present bilaterally.

The left kidney is normal in size (4.2 cm) and the right kidney is small normal in size (3.5 cm, irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed.

Adrenal Glands

The adrenal glands are unable to be well visualized in these images.

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). No focal nodules or masses are observed. Splenic vasculature appears normal.

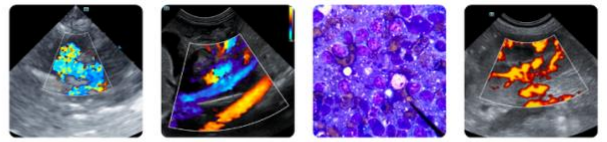
Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is markedly heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. 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 mildly distended with primarily fluid as well as some echogenic non-shadowing luminal contents and gas



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consistent with normal chyme. There is 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 mildly distended with primarily fluid as well as some echogenic non-shadowing luminal contents and gas consistent with normal chyme. There is no evidence of obstruction, foreign material, or infiltrative disease.

The colon is mildly thick measuring 0.3 cm thick with normal intact layering and diffusely mildly fluid distended.

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.

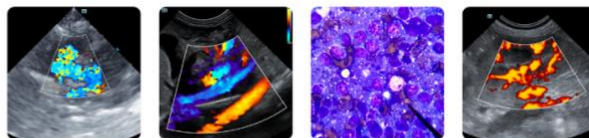
Free Abdomen

There is a mild amount of free fluid in these images as well as diffusely enhanced hyperechoic fat and mesentery. There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Suspect moderate to severe acute pancreatitis.
- Concurrent 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.
- The markedly heterogeneous liver could represent a benign process such as nodular hyperplasia, steroid or vacuolar hepatopathy, extramedullary hematopoiesis or even chronic inflammatory disease. However, infiltrative neoplasia including round cell neoplasia, metastatic disease, etc. can't be ruled out without tissue sampling.
- 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.
- Mild to moderate bilateral chronic kidney changes with nonobstructive nephroliths bilaterally.
- Benign prostatic hyperplasia with cysts- Prostatic findings are most consistent with Benign Prostatic Hyperplasia (BPH) and concurrent benign prostatic cysts. Active prostatitis cannot be ruled out. Infiltrative neoplasia cannot be ruled out but is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS



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Given patient's reported borderline hyperalbuminemia, if not recently evaluated, 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.

Given the concurrent hypoglycemia, both gastrointestinal evaluation as well as hepatic function evaluation could be considered.

Therefore, bile acids could be considered if patient's total bilirubin is not increased.

Ultimately however, given the bowel changes, I suspect diffuse gastrointestinal disease combined with pancreatitis, Therefore, 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, medical management of pancreatitis with anti-emetics, gastroprotectants, appetite stimulants or nutritional support as needed, pain management, broad spectrum antibiotics, and fluid therapy is recommended. Monitoring of the pancreas with power doppler is recommended to identify possible necrosis as well as other potential sequelae such as abscesses, etc.

Ultimately, pending patient's response, follow-up imaging is recommended but biopsies of the GI tract may be necessary for a definitive diagnosis and to further guide additional management.





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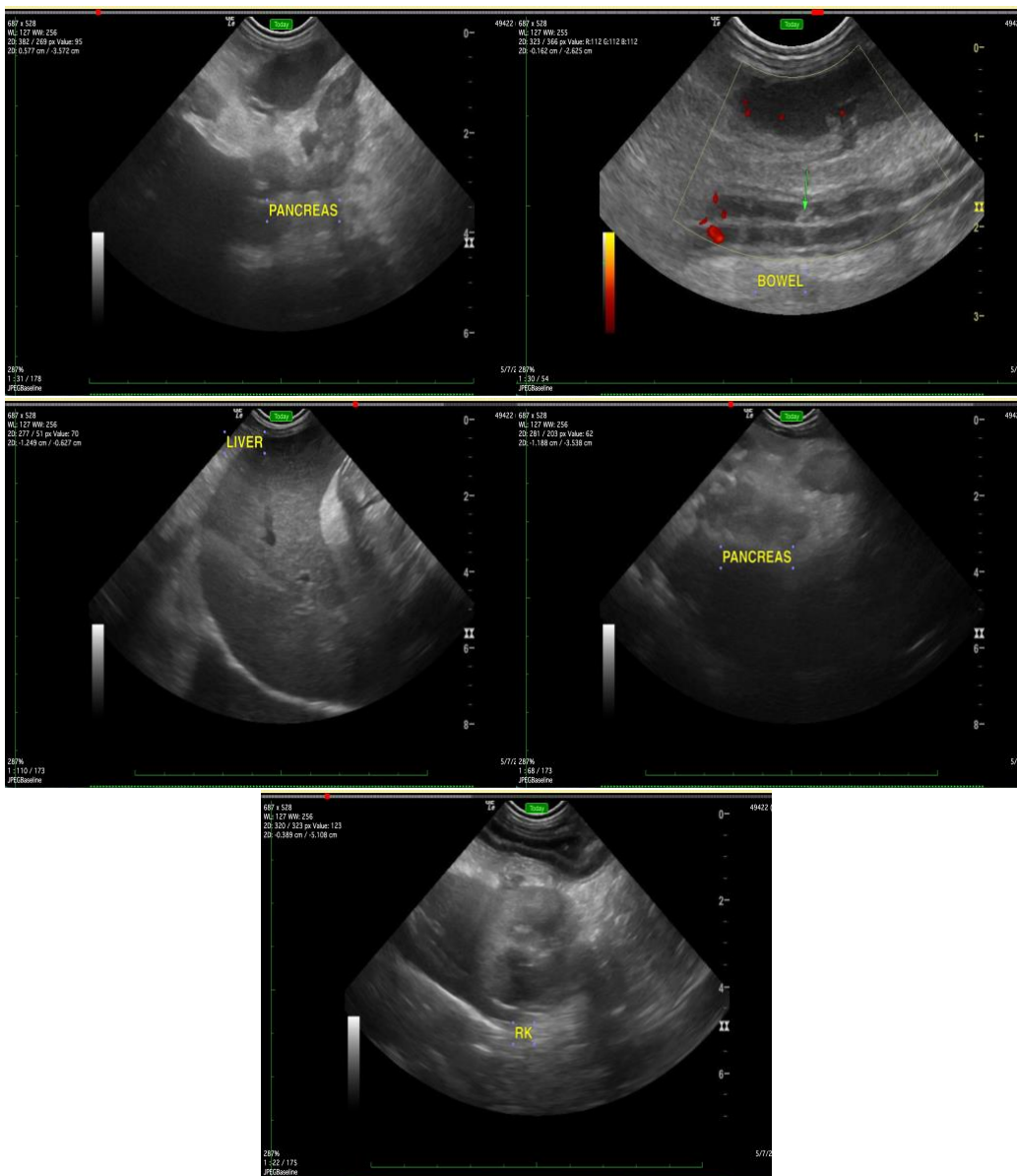
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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