



## PATIENT

Bear Bentley

## SPECIES

Canine

## BREED

Boxer x

## SEX

Neutered Male

## AGE

9 Years 7 Months

## WEIGHT

36.6 kg

## INTERPRETED BY

Beth Johnson, DVM  
DACVIM

## IMAGING PERFORMED BY

Renee Trionfetti, VMD

## HOSPITAL NAME

Brandywine Valley  
Veterinary Hospital

## REFERRING VET

Karen Clark-Rubin,  
DVM

## INVOICE

75617

## DATE

6/2/26

## PRESENTING CLINICAL SIGNS

AUS to further evaluate chronic progressive frequent vomiting, topline muscle loss with stable weight, chronic ALP elevation with normal ALT.

Abnormal PE/Chem/CBC/UA Results: CBC: Hct 49.9%, Plts 297-n, remainder NSF - Chem: Alb 3.4-n, ALP 708 H, ALT 83-n, remainder NSF - T4: 2.4-n - 4Dx: Neg x 4 - CXR: pending

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with a moderate amount of echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The prostate is normal for a neutered dog, except for a discrete homogeneous 0.50 cm in diameter hyperechoic density/nodule.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. Left kidney measured 7.24 cm. Right kidney measured 7.38 cm.

### Adrenal Glands

The right adrenal gland is plump/swollen in size, measuring 1.5 cm at the cranial pole and 1.0 cm at the caudal pole. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.59 cm at cranial pole and 0.68 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

### Spleen

Spleen is subjectively large in size (3.1 cm thick at the hilus) with normal smooth margins. Parenchyma is normal in echogenicity with a diffusely coarse/heterogenous echotexture. No discrete sizable 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 of the gallbladder appears as a thin hyperechoic/calcified rim casting a distinct distal acoustic shadow. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.



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## Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with a small to moderate amount of echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is 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 is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta/chyme. There is 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 appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

## Free Abdomen

There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

## PRIMARY FINDINGS

- 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.
- Pancreatic age-related remodeling/Chronic pancreatitis – Mild irregularities are consistent with benign age-related change. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs.
- Coarse 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.
- The mild/subjective right adrenomegaly should be interpreted in combination with clinical history, and if clinically indicated could warrant further evaluation for emerging or underlying adrenal disease.

## SECONDARY FINDINGS

- Porcelain gallbladder – Porcelain (calcified) gallbladder is an uncommon finding in companion animals and has been observed as both an incidental finding and associated with biliary neoplasia. In humans, porcelain gallbladder can be a manifestation of chronic gallbladder disease, chronic cholecystitis, intramural hemorrhage with subsequent calcification,



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imbalances in calcium metabolism, and even giardiasis. This finding should be interpreted in combination with any clinical signs and/or laboratory changes suggestive of biliary disease and/or calcium dysregulation, etc.

- Mild to moderate age related kidney changes.
- Moderate amount of echogenic urinary bladder debris.
- The prostatic density likely represent a benign process, fibrosis, or calcification, potentially as a result of previous prostatitis, with infiltrative neoplasia considered less likely but unable to be definitively ruled out.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes described above may or may not be contributing to patient's reported clinical presentation of vomiting. Further gastrointestinal workup recommendations include:

- A routine fecal/giardia exam if not recently evaluated.
- 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.

In the meantime, additionally if not recently evaluated, a 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 ratio is recommended.

Fine needle aspirates of the spleen could be considered if patient's coagulation status is appropriate.

While continuing workup, supportive/symptomatic medical management of clinical signs is recommended, including anti-emetics, gastroprotectants (+/- sucralfate, especially with any history of hematemesis), an appetite stimulant and fluid therapy if indicated, etc.

Additionally, empirical deworming with a 5-day course of Panacur is recommended as is a full course of empirical Helicobacter triple therapy.

Finally, if tolerated, a transition in diet could be considered, based on trial-and-error response with some options to consider including a gastrointestinal biome diet vs a hydrolyzed protein diet (sometimes several trials with different brands are necessary) vs an easy to digest, bland or low-fat diet vs other.





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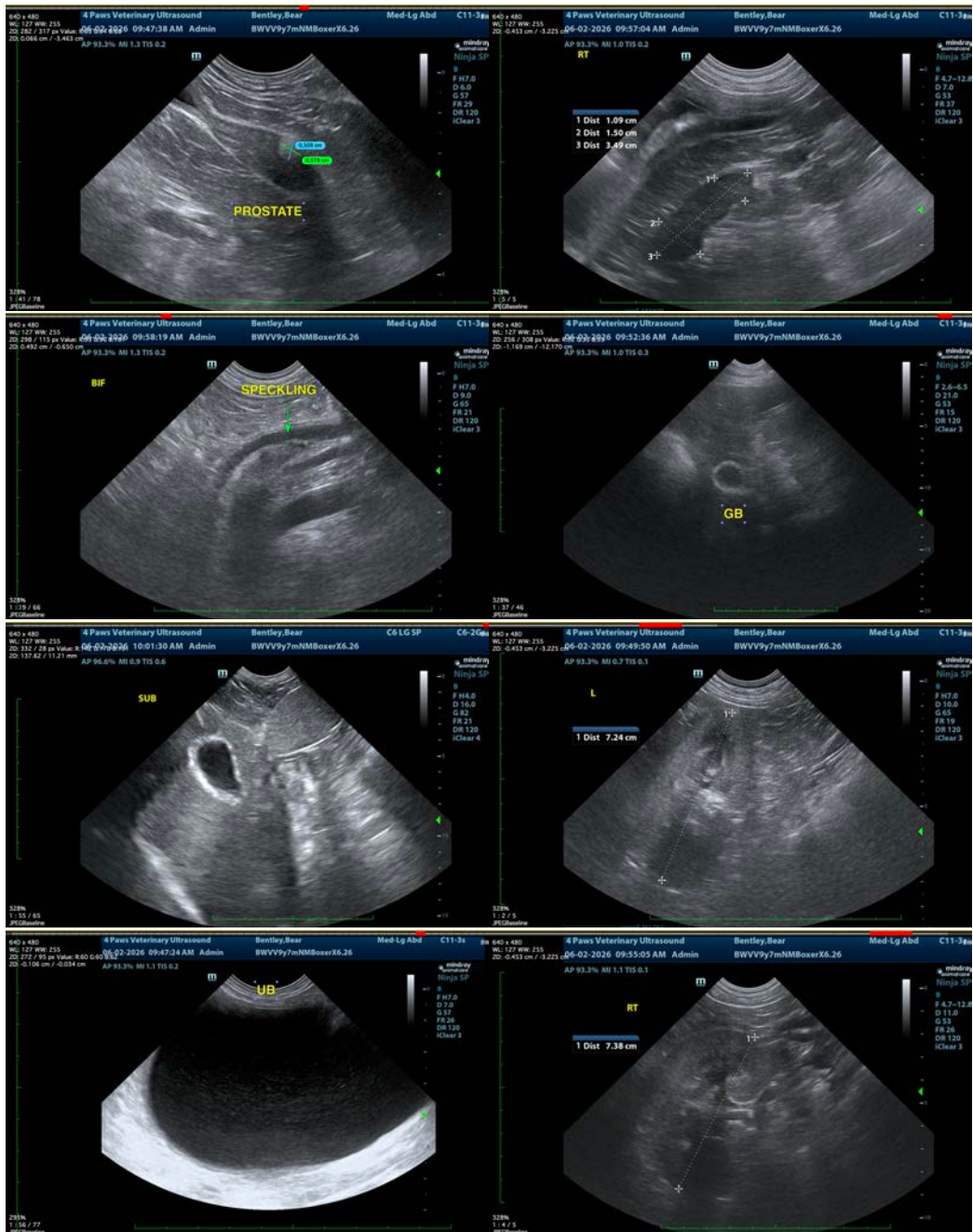
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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** info@sonopath.com