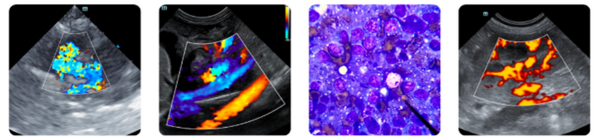


PATIENT

Egypt Mohn

SPECIES

Canine

BREED

Great Dane

SEX

Intact Male

AGE

8 months

WEIGHT

104.5 lbs

INTERPRETED BY

Eric Lindquist, DMV, DABVP(CFM), Cert. IVUSS

IMAGING PERFORMED BY

Dr. Mary Pearce

HOSPITAL NAME

Chambersburg Animal Hospital

REFERRING VET

Dr. Mary Pearce

INVOICE

10740

DATE

11/13/2025

PRESENTING CLINICAL SIGNS

Hx intermittent GI signs with diarrhea since he was a young puppy, occasional regurgitation. This was occuring prior to gastropexy which was done at 6 months of age (August). Symptoms worsened for a few weeks after gastropexy. Immediately after pexy surgery, he also developed a fever. OP tx provided at that time. In August p also was having limping, started in one hind leg then transferred to the other hind leg. Previous radiographs at that time found no concerns for developmental orthopedic diseases. Limping has not been a persistent problem. Gastrointestinal radiographs taken in October which were unremarkable. Due to chronic regurgitation, a barium study was planned but not pursued yet. No current medications. Diarrhea had resolved, but over the last couple days began again with soft stools, no blood. Eats consistently through all episodes but is a grazer. Normal this morning then this evening noted p was laterally recumbent, lethargic and febrile. Brought in for evaluation. No concerns for FB ingestion or other dietary indiscretion. UPC and FUO comprehensive panel pending.

Abnormal PE/Chem/CBC/UA Results: P presented dull, tacky MM, pink. HR/RR normal, mild abdominal tension. Once stabilized with fluids and IV Unasyn, p was able to stand and walk but appeared stiff, generalized decreased ROM in joints and neck. No CP deficits noted. Did urinate on his own. BW: HCT 33.1%, WBC 18.34, neutrophils 15.64, immature neutrophils 0.22, monocytes 1.14 Phos 6.9, ALP 248 (likely both age related) Otherwise normal chem, lytes, PLI, and T4 4Dx negative UA: proteinuria, 100mg/dL USG 1.032, pH 7.0, quiet sediment Radiographs: Possible increased effusion in the stifles bilaterally. No evidence of panosteitis or HOD. Thoracic structures unremarkable, no sign of megaesophagus. Prominent/large spleen. No evidence of FB or obstructive pattern. Scant formed fecal material in colon. Large/full bladder.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes were noted. Ureteral papillae were normal. The pelvic urethra was imaged 1.0 cm beyond the cystourethral junction.

The **kidneys** revealed normal size and structure, corticomedullary definition and ratio for this age. The cortices presented largely uniform texture with normal echogenic relationship to liver and spleen. Medullary structure differed distinctly from the cortex and no evidence of pelvic dilation was present. The capsules were acceptably uniform without significant irregularities. Left kidney measures 9.0 cm and the right kidney measures 9.0 cm.

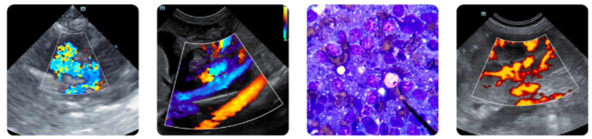
Adrenal Glands

The **left adrenal gland** was subnormal in size, measuring 3.12 cm x 0.36 cm.

The region of the **right adrenal gland** was imaged, no evident pathology.

Spleen

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes were noted. The spleen was folded upon itself.



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Liver

The **liver** images submitted revealed subjectively normal liver size, contour, and structure. Parenchymal echogenicity was naturally coarse and hypoechoic to the spleen. Vascular and biliary tracts were of normal volume with no evidence of congestion. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal. No pathological hepatic lymphadenopathy was evident. No overt structural evidence of inflammatory, infiltrative or regenerative pathology was evident.

Gastrointestinal

Examination of the **gastrointestinal tract** revealed a stomach and intestine free of stasis, of normal wall thickness, acceptable curvilinear mural detail, and peristaltic activity. Small and large intestine demonstrated normal luminal chyme and stool consistency respectively. No obstructive or overt infiltrative disease was noted. No associated abnormal lymphatic activity was noted.

Pancreas

The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

Free Abdomen

Reactive mesenteric lymph node measuring 3.3 cm x 1.07 cm/juvenile.

ULTRASONOGRAPHIC FINDINGS

- Structurally unremarkable abdomen.
- Subnormal left adrenal, non-visible right adrenal.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Screening for underlying congenital Addison's indicated. The gastric angle appeared to be normal. No evidence of retention of ingesta.

Differentials for diarrhea include occult parasitism. Dietary indiscretion, dietary intolerance, antibiotic responsive colitis, intestinal dysbiosis and occult Addison's should all be considered as causes of diarrhea in this patient. A hydrolyzed diet trial may be in this patient's best interest +/- probiotics. 24-hour NPO and reintroduction of bland diet indicated. I recommend a baseline cortisol or ACTH stimulation test, a fresh fecal smear and fecal floatation analysis if not already performed

SonoPath.com info@sonopath.com 1.800.838.4268

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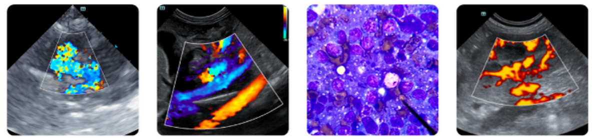

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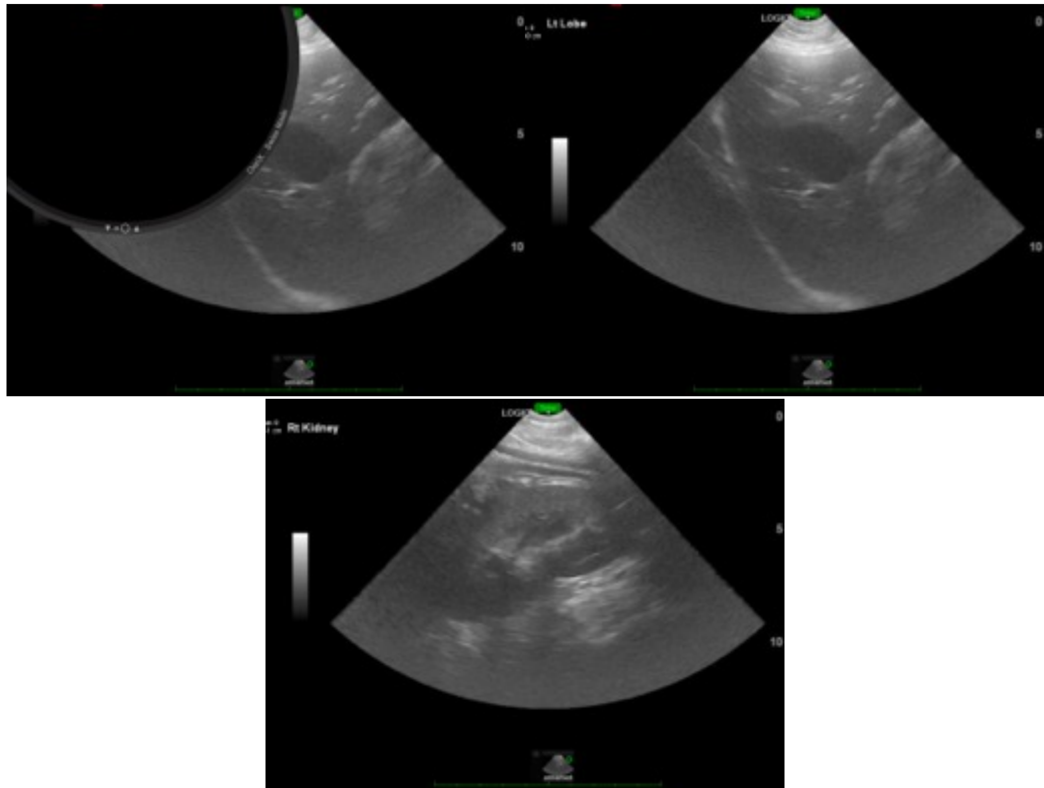

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com

info@SonoPath.com