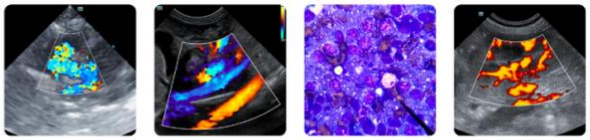


PATIENT

Jaida Landis

SPECIES

Canine

BREED

Pit Bull

SEX

Spayed Female

AGE

13 Years

WEIGHT

23.4 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Lindsay Powell, CVT

HOSPITAL NAME

Hershey AEC

REFERRING VET

Dr. Shally Gastelu

INVOICE

36233

DATE

3/15/26

PRESENTING CLINICAL SIGNS

- Jaida presented to HAEC on 3/14/26 for diarrhea. She has a history of suspected degenerative neuropathy and hyperadrenocorticism (per owner IM decided not to test/treat). She is historically PU/PD per owner.
- PE: Eyes: Nuclear sclerosis OU
- Oral Cavity: moderate tartar/gingival erythema, multiple missing teeth
- Cardiovascular: Arrhythmia noted, pulse deficits appreciated
- Musculoskeletal: slow to rise in hind end
- Nervous system: No cranial nerve deficits, mild ataxia at walk, patient gets very anxious/flails when trying to place in lateral recumbency, slight delay CPs hind end
- CBC: Lymph0.63 (L), Platelet crit 0.47 (H)
- Chem: ALP 1576 (H), Choll 332 (H)
- cPL: 44 (WNL)
- T4: 1.3 (WNL)
- STAT Cardiology ECG: A low grade ventricular arrhythmia is present that is unlikely to result in hemodynamic compromise or electrical instability
- Based on the severity expressed on this ECG, though any ventricular arrhythmia does carry the risk of degenerating into
- A life threatening

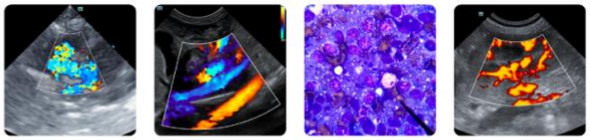
Abnormal PE/Chem/CBC/UA Results: Rads 1. mild cardiomegaly could be due to predominant underlying component of L-sided cardiomegaly from myxomatous mitral valve disease, less likely dilated cardiomyopathy. A concurrent R cardiomegaly is due to underlying pulmonary hypertension, valvular disease . 2. Mild segmental small intestinal diameter variability with some segments slightly dilated. DDx includes segmental functional ileus and less likely a partial/evolving obstruction. Nonspecific GI colitis, pancreatitis, acute on chronic enteropathy suspected. 3. Mild multifocal degenerative intervertebral disc disease and spondylosis. 4. The peritoneal detail is slightly reduced likely from visceral crowding. Mild effusion/peritonitis is not excluded. 5. Mild diffuse pulmonary bronchointerstitial pattern, likely incidental.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder** was overdistended at the time of the sonogram. 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 largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some mild age-related loss of curvilinear patterns



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regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for this age patient. Medullary structure differed distinctly from that of the cortex, and no evidence of pelvic dilation was present. The left kidney measured 6.7 cm. The right kidney measured 7.0 cm.

Adrenal Glands

The **left adrenal gland** was nodular and heterogenous, measuring the upper limits of normal in size (0.75 cm).

The **right adrenal gland** was mildly heterogenous and slightly irregular, measuring 1.6 cm at the cranial pole and 0.9 cm at the caudal pole.

Spleen

The **spleen** was slightly enlarged and slightly heterogenous.

Liver

The **liver** images from right and left intercostal as well as subcostal views revealed subjectively normal liver size, contour, and structure. Some mild age-related parenchymal remodeling was noted but likely not clinically significant at this time. Vascular and biliary tracts were of normal volume, and no evidence of congestion was noted. The gallbladder presented some dependent debris with essentially normal contour. The cystic and common bile ducts were normal. No overt evidence of active inflammatory, infiltrative or regenerative pathology was noted but should be paired with current or past LE elevations regarding any clinical significance to this presentation. The hepatic lymph nodes were unremarkable.

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.

ULTRASONOGRAPHIC FINDINGS

- Enlarged right adrenal gland
- Measurably normal left adrenal gland
- Bilateral adrenal nodular changes and remodeling
- Slightly enlarged and slightly heterogenous spleen
- Largely geriatric abdomen with nonspecific changes

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

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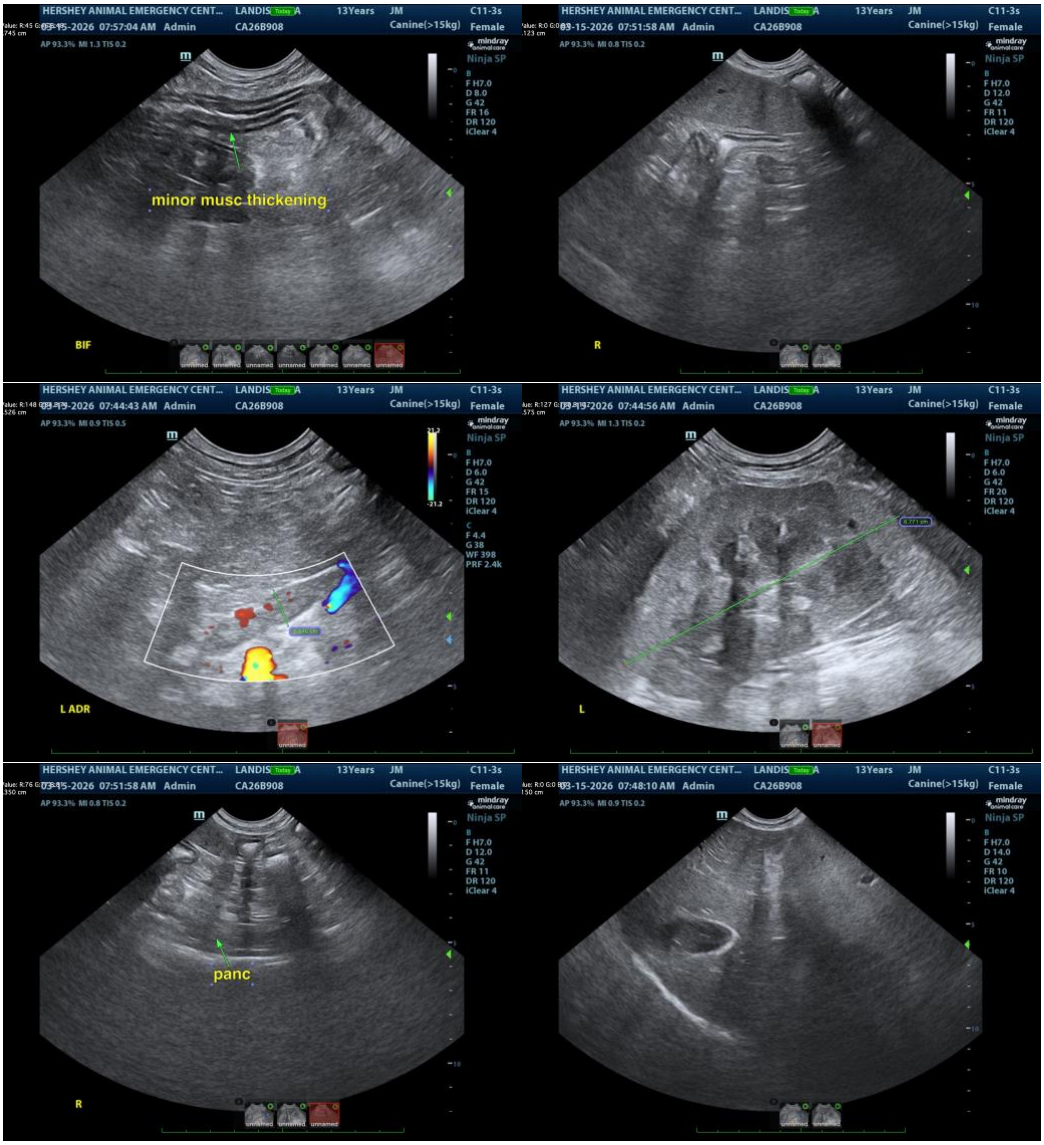
24-hour NPO and reintroduction of bland diet indicated. I recommend a baseline cortisol or ACTH stimulation test, a fresh fecal smear and fecal floatation analysis if not already performed. Note that recent research has shown that indiscriminate use of antibiotics may actually cause harm. Most acute cases of diarrhea will respond to probiotic therapy, fiber, and gastrointestinal diets over the next 3-5 days.



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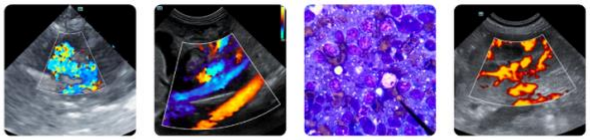

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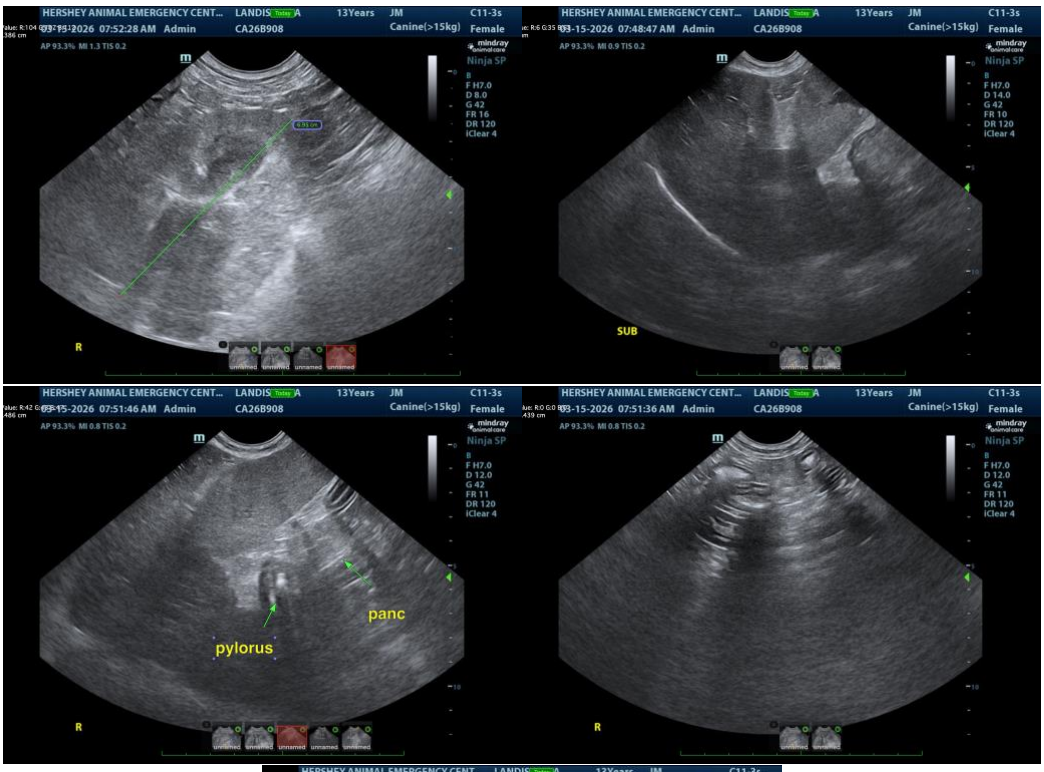

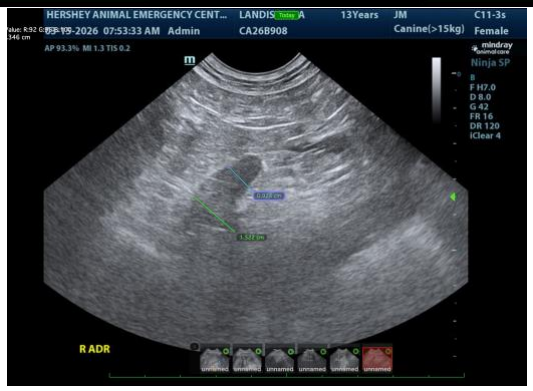

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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(CFM), Cert. IVUSS,
CEO, Owner, Founder -- SonoPath.com
info@SonoPath.com