



PATIENT

Snickers Jacobson

SPECIES

Canine

BREED

Doodle

SEX

Spayed female

AGE

11 years

WEIGHT

70 lbs

INTERPRETED BY

Remo Lobetti, BVSc,
MMedVet (Med),
PhD, Dipl. ECVIM

IMAGING PERFORMED BY

Brian Klug

HOSPITAL NAME

Sondel Family VC

REFERRING VET

Dr. Sondel

INVOICE

71735

DATE

2/19/26

PRESENTING CLINICAL SIGNS

- History of on and off vomiting/diarrhea with ADR.
- ALT 243 ALKP 383 mild neutrophilia Amylase 1357 PE - NSF

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is small with a normal thickness and smooth appearance of the wall. Normal anechoic urine with no sediment or uroliths evident.

Normal appearance of the trigone area, proximal urethra, and iliac blood vessels.

Normal appearance and size of the iliac lymph nodes. Ureters not visualized, which can be considered a normal finding.

Normal renal size (left measured 6.8 cm, right measured 7.3 cm), architecture, echogenic appearance, cortico-medullary differentiation, which maintains a 1:3 cortex to medulla ratio, pelvis, and capsule. No infarcts, mineralization or renoliths evident.

Adrenal Glands

Normal shape, echogenic appearance, size, position, and appearance of the visible peri-adrenal vasculature. Left adrenal gland measured 0.82 cm and 0.76 cm in width. The right adrenal gland measured 0.59 cm in width.

Spleen

Normal size and echogenic appearance. Smooth homogenous parenchyma and regular curvilinear capsule. Normal volume of the splenic vasculature without any overt congestion or thrombosis evident. Focal, hypoechogenic parenchymal nodule in the body of the spleen measuring 0.9 x 1.2 cm in size. Multiple, myelolipomas are present. The spleen measures 2.4 cm in width.

Liver

Normal size, echogenic appearance, portal markings, and regular curvilinear capsule. No nodules or masses evident. Normal appearance of the hepatic and portal vasculature.

Gallbladder

The gallbladder is full containing a moderate amount of non-adhered, hyperechogenic sediment. Normal thickness and echogenic appearance of the wall. Normal size and appearance of the cystic and common bile duct.



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Gastrointestinal

Normal appearance of the stomach, ileo-cecal junction, and colon with no loss of layering, 1:3 muscularis to mucosa ratio, normal wall thickness and peristaltic activity, and no distension of the lumen. Normal thickness of the duodenum (0.37 cm) and small intestine (0.44 cm) with no loss of layering, but with an increase in the muscularis to mucosa ratio, normal peristaltic activity and no distension of the lumen. Fecal material is present in the colon.

Pancreas

The visible sections of the pancreas are of normal size and echogenic appearance with a regular capsule. Normal echogenic appearance of the mesentery and fat surrounding the pancreas.

Free Abdomen

Normal mesenteric lymph nodes.

No ascites evident.

ULTRASONOGRAPHIC FINDINGS

- Enteropathy.
- Splenic nodule.
- Gallbladder sediment.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Etiologies for the enteropathy would be parasitic enteritis, dietary hypersensitivity and inflammatory bowel disease with emerging lymphoma a less likely differential diagnosis.

Etiologies for the splenic nodule would be reactive hyperplasia/extramedullary hemopoiesis, hematoma and granuloma with emerging neoplasia a less likely differential diagnosis.

The gallbladder sediment and multiple splenic myelolipomas can be considered incidental findings.

Further assessment would be fecal analysis, cobalamin and folate assay and endoscopy of the upper GI tract with biopsies.

Ultrasound monitoring of the splenic nodule would be recommended and if there is any progressive enlargement or bulging of the overlying capsule noted then a splenectomy would be indicated.

Specific therapy for the enteropathy would be dependent on an etiological diagnosis. Symptomatic management that can be considered would be feeding small frequent meals of a novel protein/hypoallergenic diet, course of Fenbendazole, cobalamin supplementation and if there is still not a satisfactory improvement then a course of Prednisolone would then be indicated.



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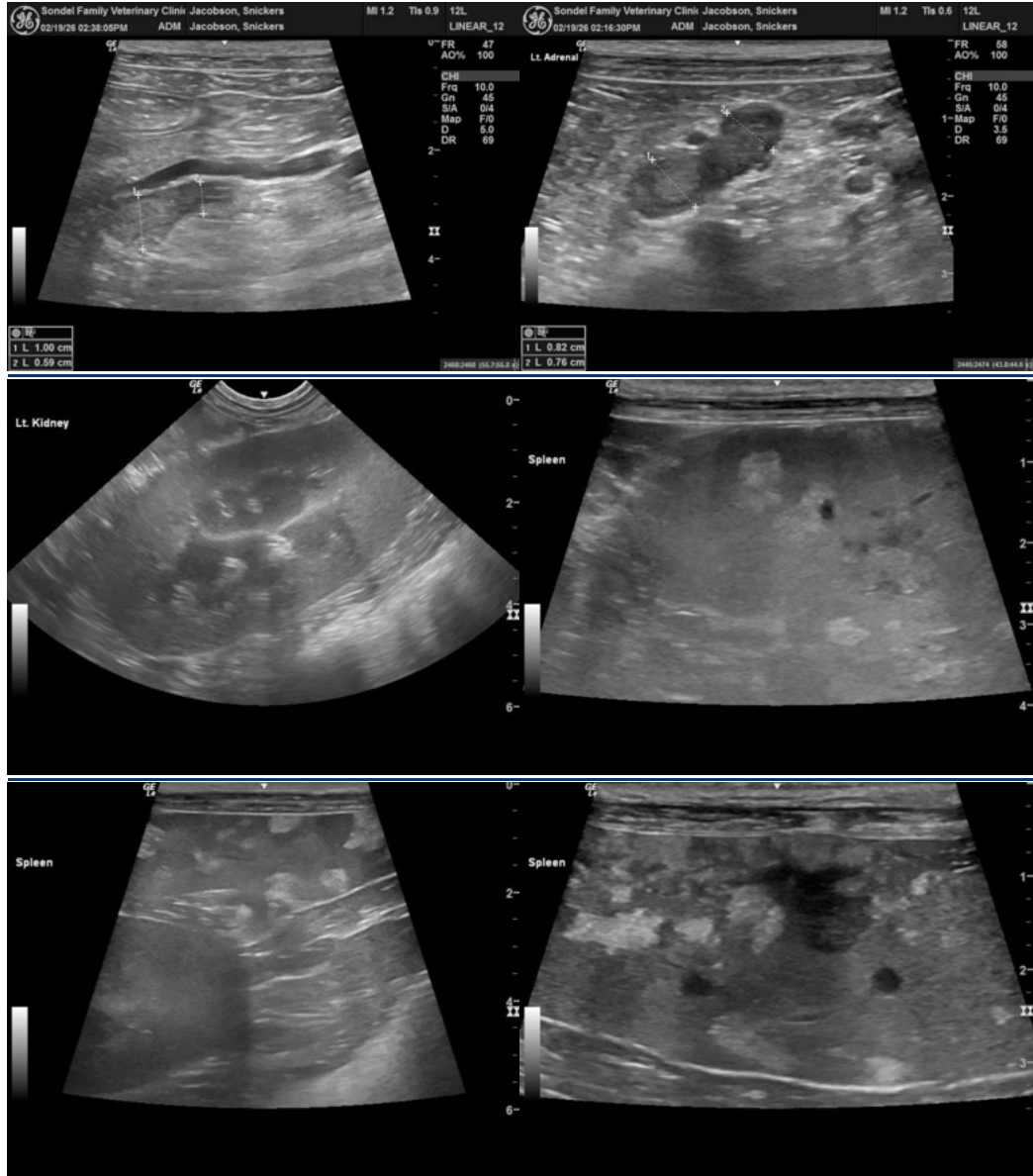
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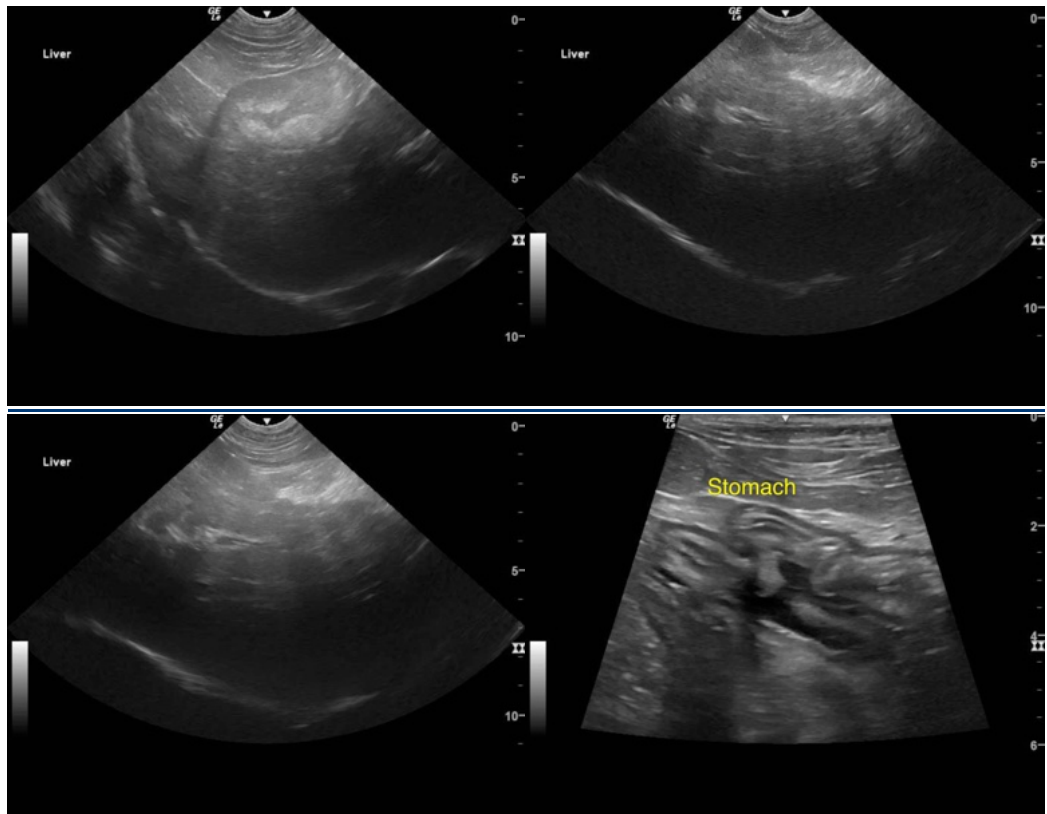
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Remo Lobetti, BVSc, MMedVet (Med), PhD, Dipl. ECVIM (Internal Medicine)

info@sonopath.com