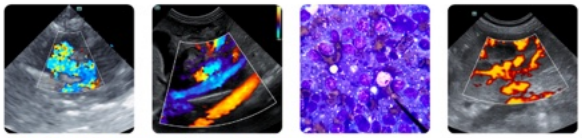


PATIENT

Bubba Dedoussis

SPECIES

Canine

BREED

Bulldog Mix

SEX

Neutered male

AGE

5 years

WEIGHT

44 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Ken Leal

HOSPITAL NAME

Black River VH

REFERRING VET

Dr. Zeliff

INVOICE

70162

DATE

1/15/26

PRESENTING CLINICAL SIGNS

History: Chronic diarrhea, vomiting. Persistent Horners (today had unilateral KCS (os) Medications: was previously on metronidazole 250 mg bid, Proviable DC Not currently on any medications.
Abnormal PE/Chem/CBC/UA Results: Cortisol = 3.3 SDMA = 15 (in November 2025)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is full 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 5.7 cm, right measured 5.8 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. Normal color flow pattern is evident in both kidneys.

The prostate is small and hypoechogenic measuring 1.0 cm in width.

Adrenal Glands

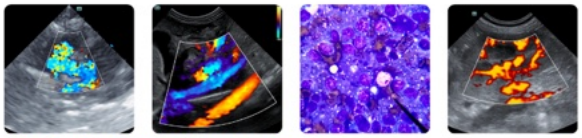
Normal shape, echogenic appearance, size, position, and appearance of the visible peri-adrenal vasculature. Left adrenal gland measured 2.3 cm in length x 0.61 cm and 0.64 cm in width. The right adrenal gland measured 2.36 cm in length x 1.06 cm and 1.15 cm in width.

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. No inflammatory, neoplastic, infarction, or infiltrative changes evident. The spleen measured 1.3 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.



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Gallbladder

The gallbladder is full containing a small 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.

Gastrointestinal

Thickening of the gastric pylorus (0.8 cm) with a hypoechogenic appearance with no loss of layering. The rest of the gastric wall is of normal thickness and appearance. Normal appearance of the duodenum, small intestine and ileo-cecal junction with no loss of layering, 1:3 muscularis to mucosa ratio, normal wall thickness and peristaltic activity, and no distension of the lumen. Normal appearance of the colon (0.21 cm) with no loss of layering, but with an increase in the muscularis to mucosa ratio. Fecal material was present in the colon.

Pancreas

Normal size (left pancreas 0.8 cm in width) with a mottled echogenic appearance and a mildly irregular capsule. Mild increased echogenic appearance of the mesentery and fat surrounding the pancreas.

Free Abdomen

Normal mesenteric lymph nodes.

No ascites evident.

ULTRASONOGRAPHIC FINDINGS

- Gastroenteropathy.
- Chronic pancreatitis versus emerging pancreatic fibrosis.
- Gallbladder sediment.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Etiologies for the gastroenteropathy would be parasitic disease, dietary hypersensitivity and inflammatory bowel disease.

Additional etiologies for the pyloric thickening would be ulcerative disease and Helicobacter gastritis.

The gallbladder sediment can be considered an incidental finding.

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

Specific therapy would be dependent on an etiological diagnosis.

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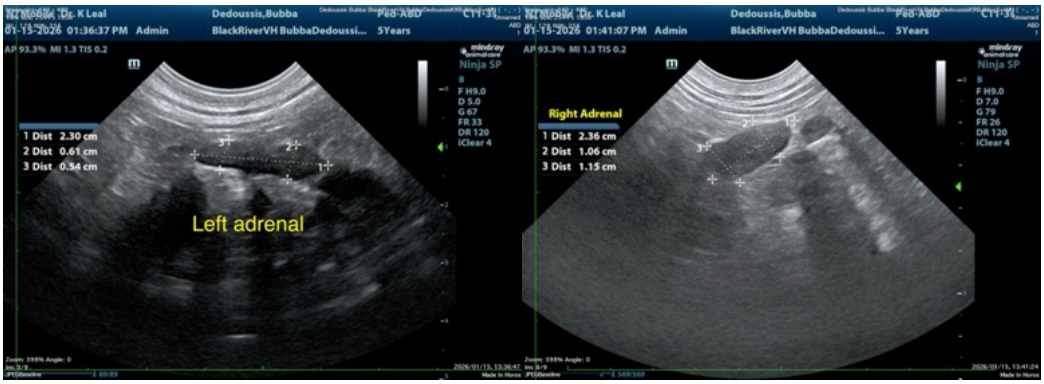
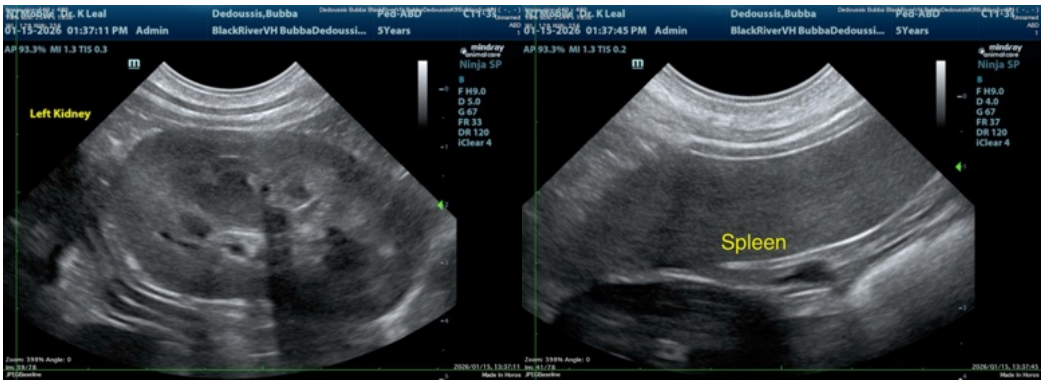
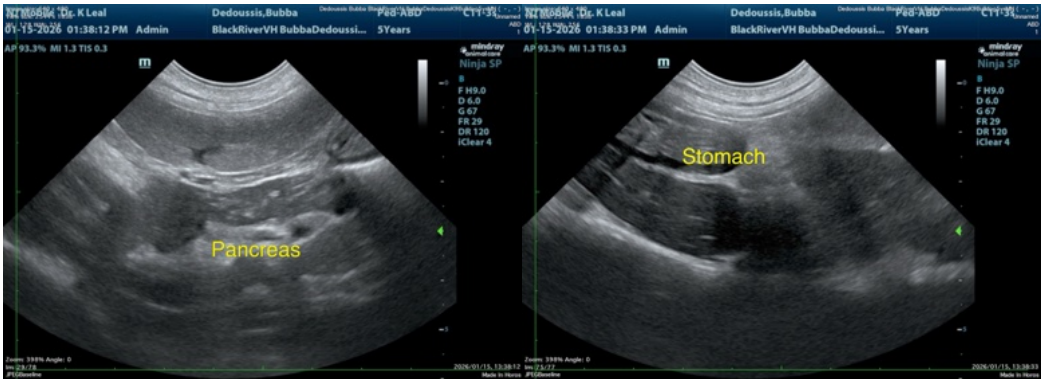
Symptomatic management that can be considered would be feeding small frequent meals of a novel protein/hypoallergenic diet, course of Fenbendazole, cobalamin supplementation and if there is not a satisfactory improvement then a course of Prednisolone would then be indicated.

Triple therapy for Helicobacter gastritis could also be considered.







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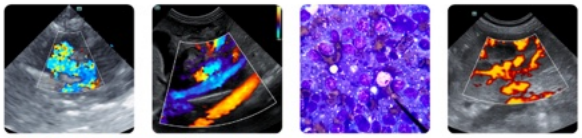

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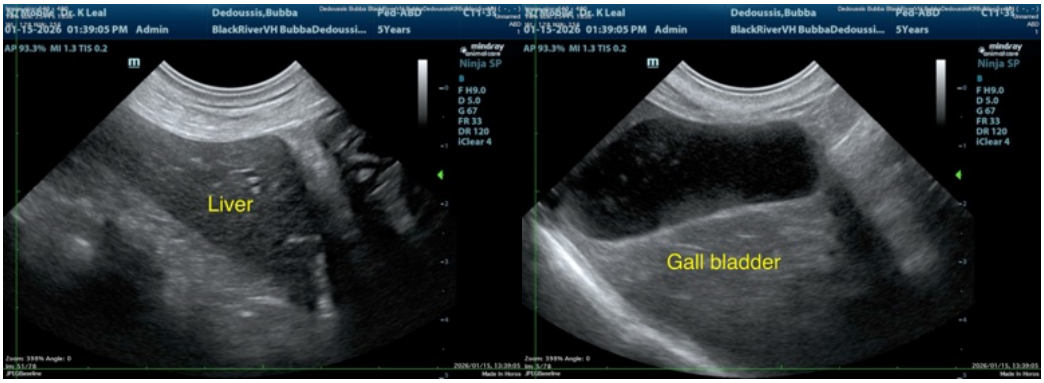

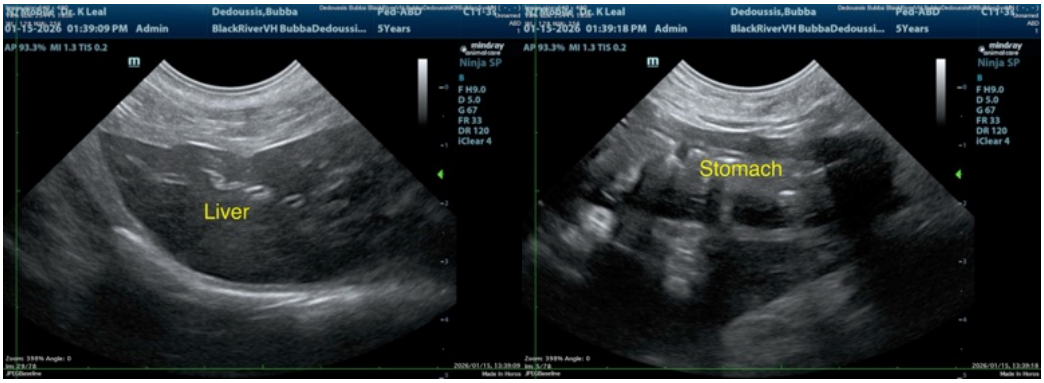

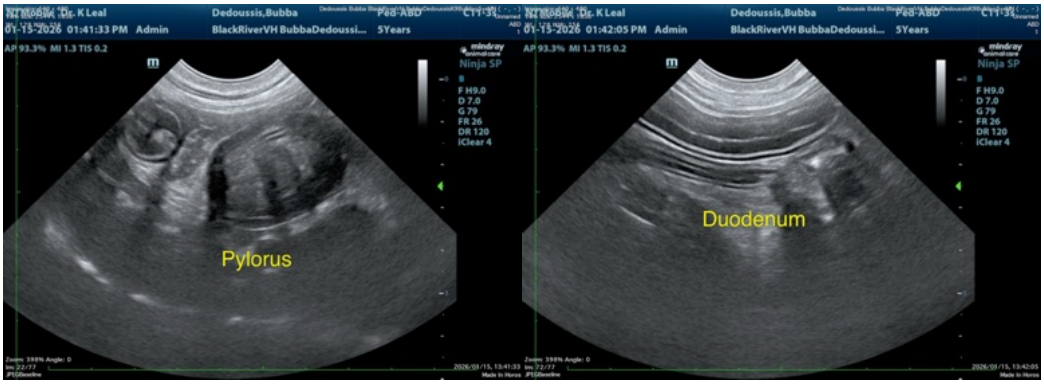

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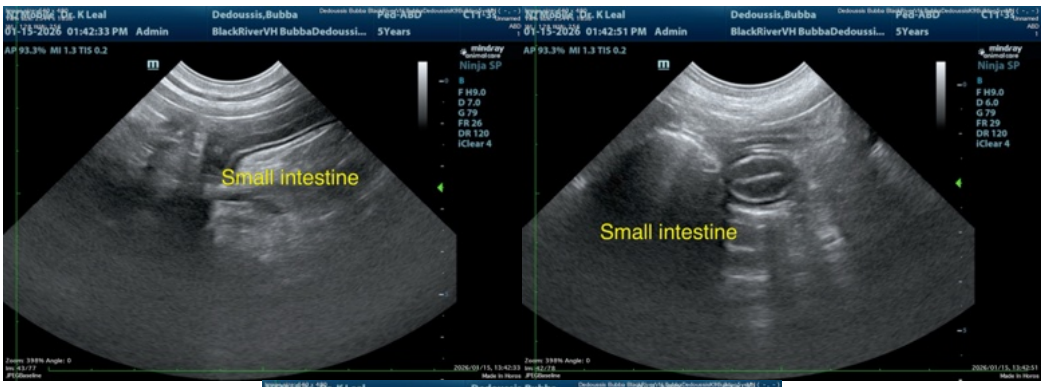

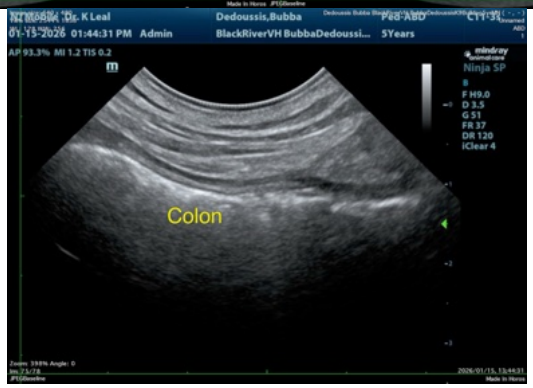

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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