



PATIENT

Misty Ferguson

SPECIES

Canine

BREED

Wheaton Terrier

SEX

Spayed female

AGE

4 years

WEIGHT

12.9 kg

INTERPRETED BY

Alicia Angosto
Guerrero, DMV,
PgDip, MSc.

IMAGING PERFORMED BY

Dr. Louise Corbeil

HOSPITAL NAME

Cochrane AC

REFERRING VET

Dr. Corbeil

INVOICE

78113

DATE

5/29/26

PRESENTING CLINICAL SIGNS

History: Chronic vomiting and poor body condition.
Not eating well the past 4 days, eating grass and woodchips.

NOT FASTED - the owner did feed her this morning.

History: On 06/May/2026, Misty presented for chronic, intermittent vomiting, inability to gain weight, and a recent episode of vomiting undigested food more than 9 hours after eating. Diagnostics declined, empirical tx Omeprazole and Cerenia. Hydrolyzed or gastro diet trial declined at the time. Continued significant vomiting and weight loss.

Diet consists of a freeze-dried beef kibble ("Ultra") and a scoop of beef organs. Fresh Pet chicken-based food. Misty has a history of significant anxiety (potential contributing factor to her gastrointestinal signs). She is a rescue from a puppy mill and was previously on Prozac for approximately two years, which was discontinued a few months prior to May 2026. Her anxiety has been managed with various medications, including Gabapentin (prescribed starting 10/2024), Trazodone (prescribed 01/2025), and currently Therabite's Mellows. 2024 - Grade 2-3 periodontal disease, COHAT with extractions, bloodwork declined at the time.

CBC chem T4 WNL UA (free catch) Specific Gravity 1.009, no protein/WBC/RBC or crystals Urinating spontaneously while sedated for ultrasound

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is normally distended, and the wall of the urinary bladder appears thin and smooth. The urine is anechoic. Normal appearance of the bladder neck and proximal urethra. There are no calculi, and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size: 5.11x2.65 cm, and the thickness of the cortex is 0.44 cm, in the sagittal plane. The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is normal and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

The right kidney is normal in shape and size: 4.90x2.31 cm, and the thickness of the cortex is 0.41 cm, in the sagittal plane. The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is normal and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane: The left adrenal gland measures 0.41 cm at the cranial pole and 0.56 cm at the caudal pole. The right adrenal gland measures 0.38 cm at the cranial pole and 0.46cm at the caudal pole.

Spleen

Splenic thickness is 1.69 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.



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Liver

The liver is subjectively normal in size, with sharp edges and a regular contour. The liver parenchyma looks uniform and isoechoic compared to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder lumen is normally distended. The wall is thin and the contents are primarily anechoic. No evident dilation of the cystic duct or common bile duct is observed.

Gastrointestinal tract

The stomach is distended with ingesta, with mural thickness (2.66 mm) and preserved wall layering. The pylorus (4.94 mm). Duodenum: 4.79 mm. Jejunum: 3.83 mm. Mucosa: mm. Submucosa: mm. Muscularis propria: mm. Ileum: 2.19 mm. Mucosa: mm. Submucosa: mm. Muscularis propria: 0. mm. Normal wall layering. The ileocecal junction measures 2 mm and appears normal. No signs of inflammation, ileus, or foreign material are identified. Colon: Ascending colon: 1.20 mm, containing gas. Transverse colon: 1.52 mm, containing gas. At least two rounded hypoechoic intraluminal structures are identified, the largest measuring 0.62x0.93 cm, favored to represent partially undigested food material. Descending colon: 1.08 mm, containing heterogeneous fecal material with mild distal acoustic shadowing.

Pancreas

The pancreas measures 9.08 mm in thickness. The pancreatic parenchyma is isoechoic relative to the adjacent omental fat. No evidence of active peripancreatic fat inflammation is identified.

Free Abdomen

No sonographic evidence of abdominal effusion, peritonitis, or lymphadenomegaly is identified. The iliac trifurcation is normal.

PRIMARY FINDINGS

- Small rounded intraluminal hypoechoic structures within the colon, favored to represent incompletely digested ingesta.
- Isostenuria without sonographic evidence of structural urinary tract disease.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Despite the largely unremarkable abdominal ultrasound examination, the clinical history of chronic vomiting, poor body condition, progressive weight loss, and the presence of partially digested intraluminal material within the colon raises concern for an underlying chronic gastrointestinal disorder. Differential considerations include chronic inflammatory enteropathy, food-responsive enteropathy, maldigestive disorders such as exocrine pancreatic insufficiency, or intestinal dysbiosis. An infiltrative gastrointestinal disease below the resolution of ultrasound is considered unlikely.



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The reported episode of retention of recognizable food material within the stomach more than 9 hours after ingestion additionally raises concern for intermittent gastric dysmotility or delayed gastric emptying, although this could not be adequately assessed during the present examination because the patient was not fasted.

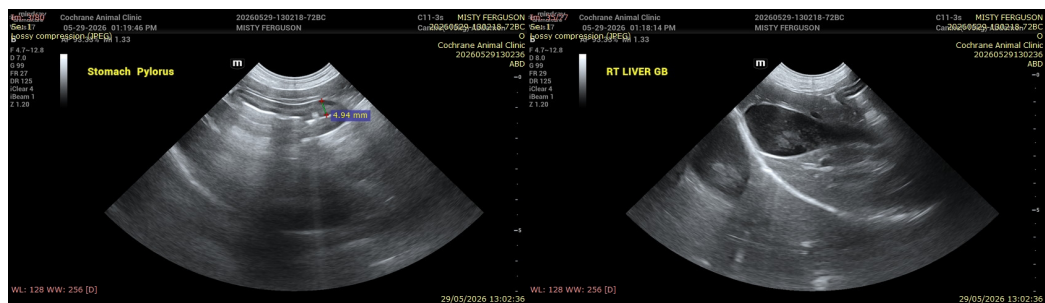
The documented isosthenuria is not explained by any structural renal abnormality identified during this examination. Increased water intake should be considered and correlation with the patient's drinking behavior is recommended. Given the breed predisposition to protein-losing nephropathy, early renal dysfunction cannot be completely excluded, although no sonographic evidence of renal disease is identified and the available urinalysis does not document significant proteinuria. A urine protein:creatinine ratio may be considered in the future if the isosthenuria persists on repeat urinalyses.

Although hypoadrenocorticism is considered less likely given the normal adrenal gland size, atypical hypoadrenocorticism cannot be entirely excluded in a relatively young dog with chronic gastrointestinal signs and weight loss. Resting cortisol screening may be considered if clinically warranted.

Additional recommendations:

- A strict dietary trial using a highly digestible or hydrolyzed protein diet is recommended if not previously performed.
- Assessment of serum cobalamin and folate concentrations is recommended. Cobalamin supplementation is advised if deficiency is identified.
- Serum canine trypsin-like immunoreactivity testing is recommended to exclude exocrine pancreatic insufficiency.
- Fecal PCR and/or comprehensive fecal testing may be considered to investigate infectious and dysbiosis-associated causes of chronic gastrointestinal disease.
- If clinical signs persist despite appropriate dietary and medical management, intestinal biopsy may be considered for definitive characterization of the underlying enteropathy.

Final diagnostic and therapeutic decisions should be made by the attending veterinarian, who can best integrate these findings with the patient's clinical status.





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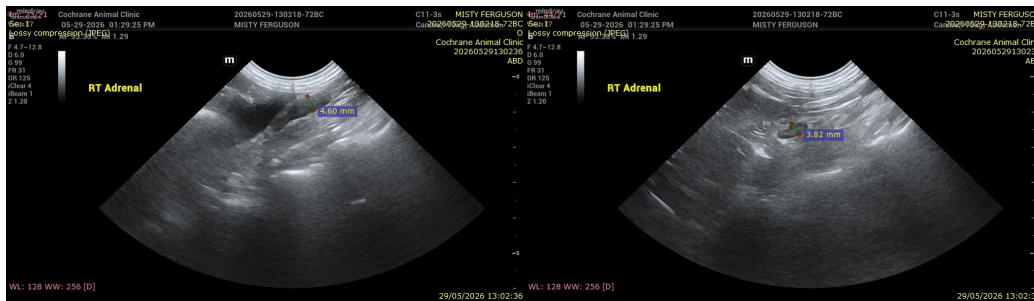
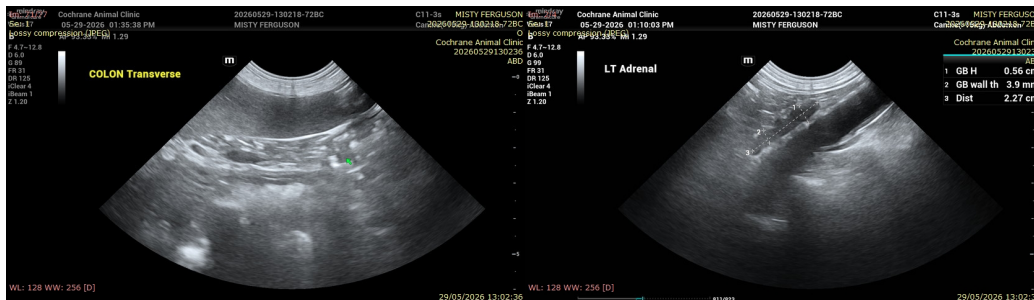
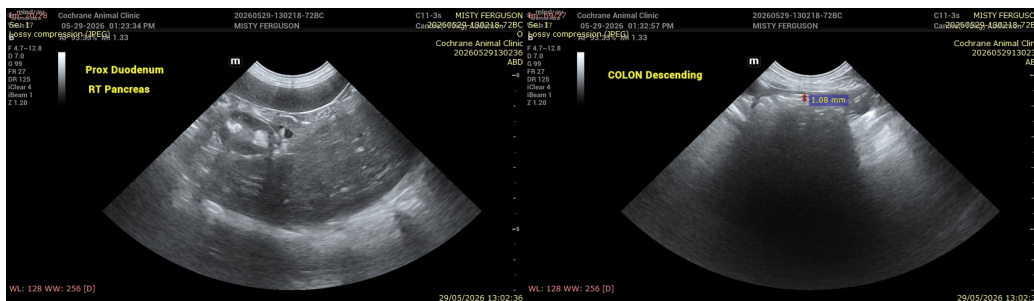
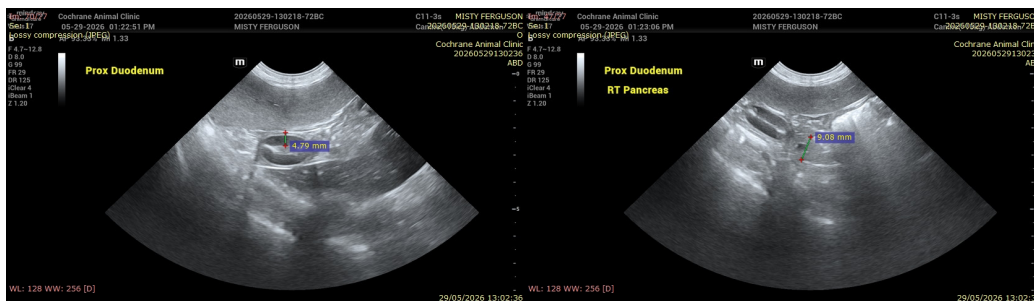
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

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