

## PATIENT

Tucker Tell

## SPECIES

Canine

## BREED

Jack Russell

## SEX

Neutered Male

## AGE

10 Years

## WEIGHT

6.6 kg

## INTERPRETED BY

Beth Johnson, DVM  
DACVIM

## IMAGING PERFORMED BY

Dr. Gira

## HOSPITAL NAME

Chaparrall VC

## REFERRING VET

Dr. Fayyhad

## INVOICE

72192

## DATE

1/13/26

## PRESENTING CLINICAL SIGNS

Chronic diarrhea not responding to medical therapy .

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Prostate is normal in size, echotexture and echogenicity for a neutered male.

The right kidney is normal is size (4.4 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal is size (4.87 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

### *Adrenal Glands*

The right adrenal gland is normal in size (0.46 cm at cranial pole and 0.51 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.36 cm at cranial pole and 0.60 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

### *Spleen*

The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

### *Liver*

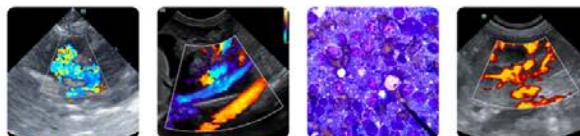
The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

### *Gastrointestinal*

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Hyperechoic mucosal fogging or speckling is noted. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction or foreign material.



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The visible colon is normal in wall thickness (< 0.2 cm) and layering. The lumen is diffusely mildly to moderately distended with soft stool.

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### **Pancreas**

The area of the pancreas contains irregular hyperechoic pancreatic remodeling.

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### **Free Abdomen**

There is a trace amount of anechoic free fluid in these images.

## SEX

Neutered Male

Mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

Additionally, subtly diffusely enhanced hyperechoic mesenteric fat is noted.

## AGE

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## ULTRASONOGRAPHIC FINDINGS

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- Mucosal speckling – Mucosal speckling is often present with inflammatory bowel disease (IBD). It is not specific for type or severity of disease. Mild speckling change can occur as a normal patient variant in the post-prandial state.
- Hyperechoic pancreas – This finding is suggestive of pancreatic fibrosis, possibly secondary to chronic pancreatitis. A TLI is recommended to rule out exocrine pancreatic insufficiency (EPI), especially if clinical signs (weight loss, diarrhea, etc.) are present.
- The scant free fluid is of unknown origin. Differentials (unless already ruled out) could include increased hydrostatic pressure (cardiac disease and/or vascular or lymph blockage), decreased oncotic pressure (low albumin), vasculitis, paraneoplastic fluid, rupture/leakage of/from an organ (GI, GB, UB, other), blood (hemoabdomen), other.
- Reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

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## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

## HOSPITAL NAME

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Given patient's reported history and ultrasound findings, malabsorptive and/or maldigestive disease are top differentials. Having said that, ruling out other causes of hypoalbuminemia is also recommended, including (given the concurrent hypoglycemia) assessing possible liver function. Therefore, recommendations include:

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Urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

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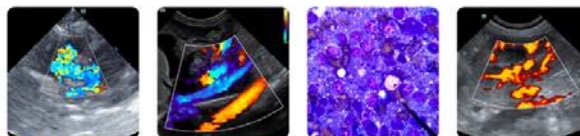
A routine fecal/giardia exam is recommended.

## DATE

1/13/26

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.



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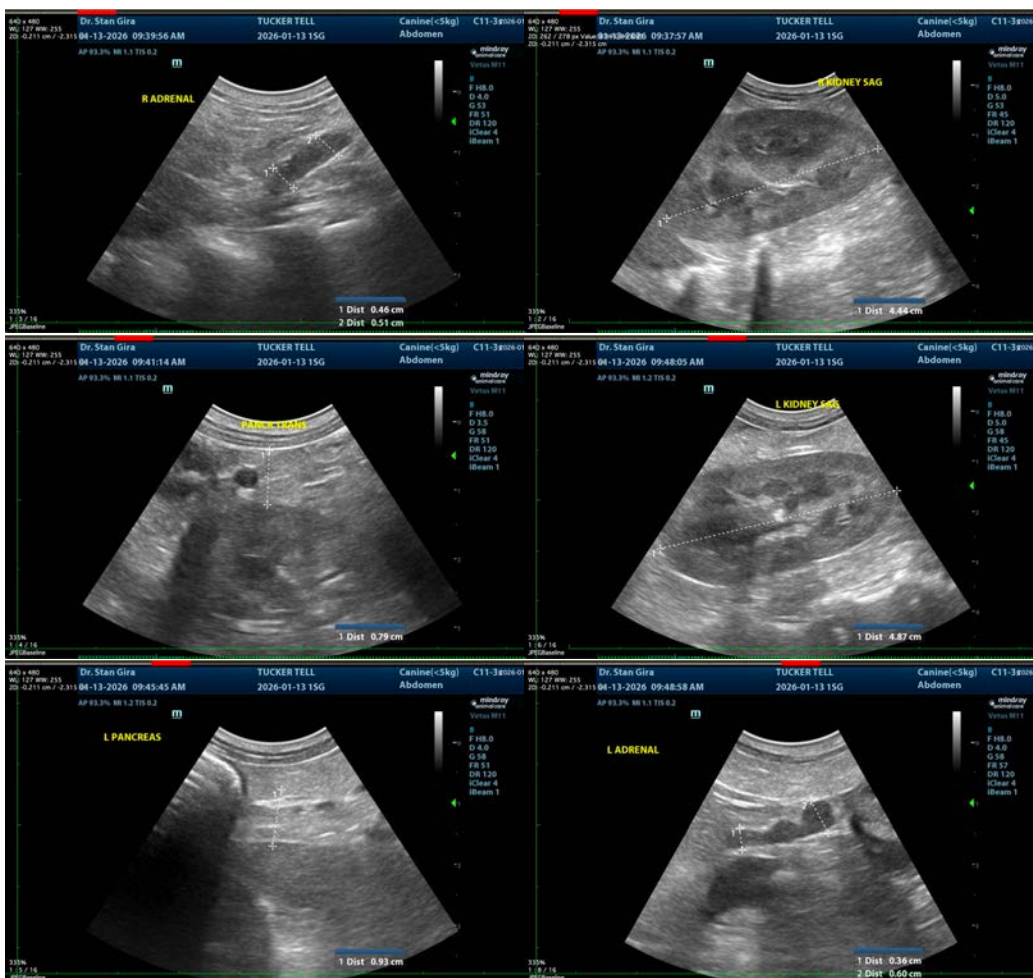
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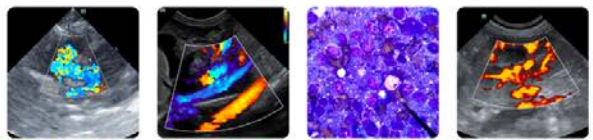
A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

Pending results of above, +/- bile acids if patient's total bilirubin is not increased.

Ultimately, biopsies of the GI tract may be necessary for a definitive diagnosis.

In the meantime, supportive/symptomatic medical management of clinical signs is recommended, including a probiotic (such as visbiome or proviable), empirical deworming with a 5-day course of Panacur and, if tolerated, a transition in diet, based on trial-and-error response, beginning possibly with a gastrointestinal biome diet vs a hydrolyzed protein diet vs other. Some patients respond to one brand/version of a hydrolyzed protein diet better than another brand, so several brand attempts may be required.





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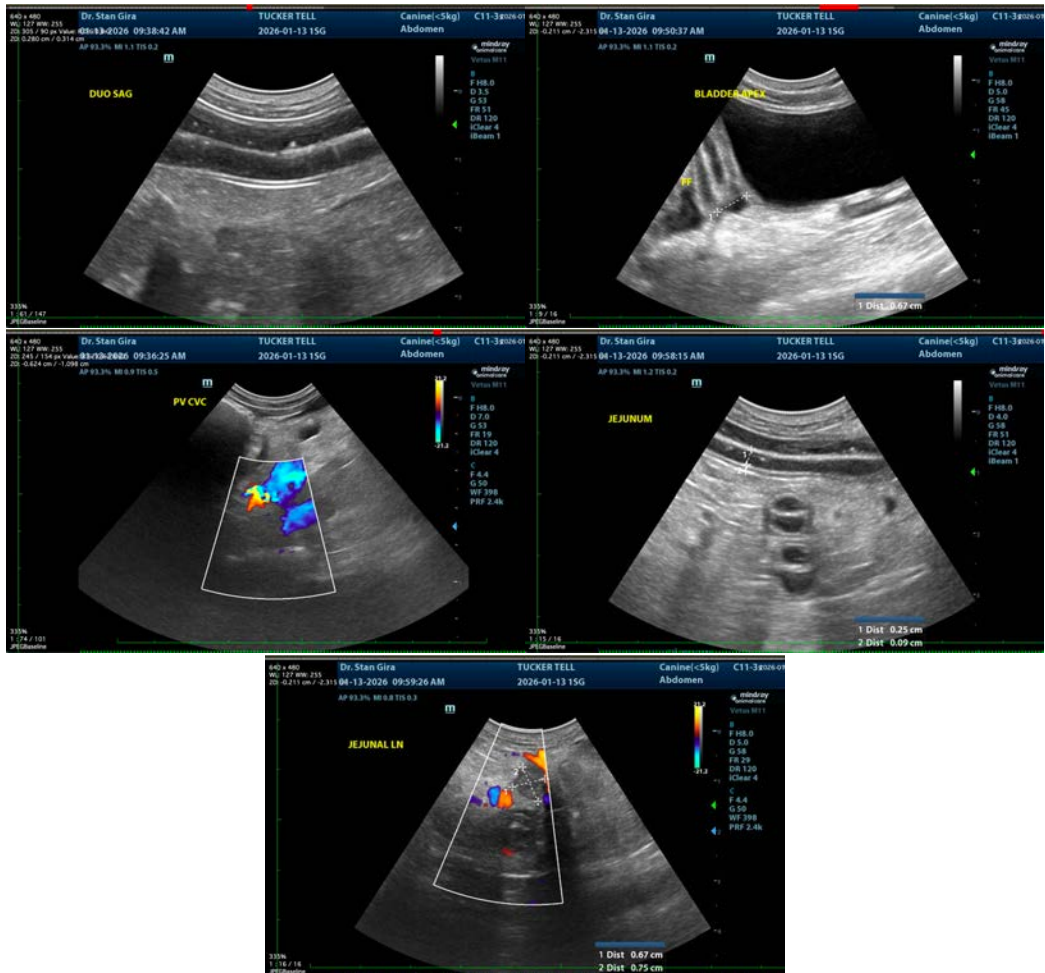
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

**Beth Johnson, DVM, DACVIM**  
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