

**PATIENT**

Lucky Maus

**SPECIES**

Canine

**BREED**

Border Collie Mix

**SEX**

MN

**AGE**

11 years 8 months

**WEIGHT**

18.5 kg

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**IMAGING  
PERFORMED BY**

Loetitia Saint-Jacques,  
LVT

**HOSPITAL NAME**

Penn Valley veterinary  
Associates

**REFERRING VET**

Dr. Nancy Reese

**INVOICE**

11119

**DATE**

1/14/2026

**PRESENTING CLINICAL SIGNS**

Presumed IBD based on symptoms for years from previous clinic- on metronidazole chronically 250 mg 1-2/day depending on stool. In the past they tried to d/c and diarrhea got bad again so resorted to daily. Diarrhea is main symptom often bloody, but sometimes has vomiting as well; concern for some neurotoxicity with the chronic use and he recently did have some behavioral changes- wandering at night and acting somewhat confused so owners did d/c the metronidazole for about a week now. Working diagnosis GI: IBD, neoplasia, food allergy/maldigestion; platelets decrease- neoplasia, immune, spurious; metronidazole toxicity vs CCD vs primary brain recently discontinued but metronidazole 250 1-2x/day.

Abnormal PE/Chem/CBC/UA Results: Panel 1/9/2026 chems all WNL, fecal neg for parasites and giardia, UA NSF; Platelets decreased with large platelets present- 72,000 (170,000-400,000); recheck 1/12/26 days later- 78,000. In house 11/2026 positive elisa for lyme and anaplasma- no symptoms; Antech panel 1/9/2026 negative for both.

**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 (5.67 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. A subtle hyperechoic band parallel to the corticomedullary border is present. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal is size (5.32 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. A subtle hyperechoic band parallel to the corticomedullary border is present. There is no evidence of pyelectasia, mineral or infarcts observed.

**Adrenal Glands**

The right adrenal gland is normal in size (cranial pole is unable to be well visualized 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 (0.59 cm at cranial pole and 0.55 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**



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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 diffusely at the upper ends of normal limits for thickness, with the duodenum measuring 0.47 cm thick, and the jejunum measuring 0.49 cm thick. No loss of layering is appreciated. Normal layering remains intact. The lumen is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

**Pancreas**

The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

**Free Abdomen**

There is no visible free peritoneal effusion noted in these images.

Reactive mesenteric and medial iliac 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.

**ULTRASONOGRAPHIC FINDINGS**

- Diffusely, very mildly thick bowel. Could be a normal patient variant or given patient's history, could suggest infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. Again, there are no characteristics of malignancy present in these images, at this time.
- Very mildly reactive mesenteric and medial iliac lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Subtle bilateral medullary rim sign - This finding is of unknown clinical significance and can be a normal variant, often idiopathic. Medullary rim sign can be present with renal disease including lymphoma, hypercalcemic nephropathy, Leptospirosis, tubular disease, other and should be interpreted in combination with other more specific indications of kidney disease such as isosthenuria, proteinuria, azotemia, etc. This is a common incidental finding in patients with diabetes mellitus.



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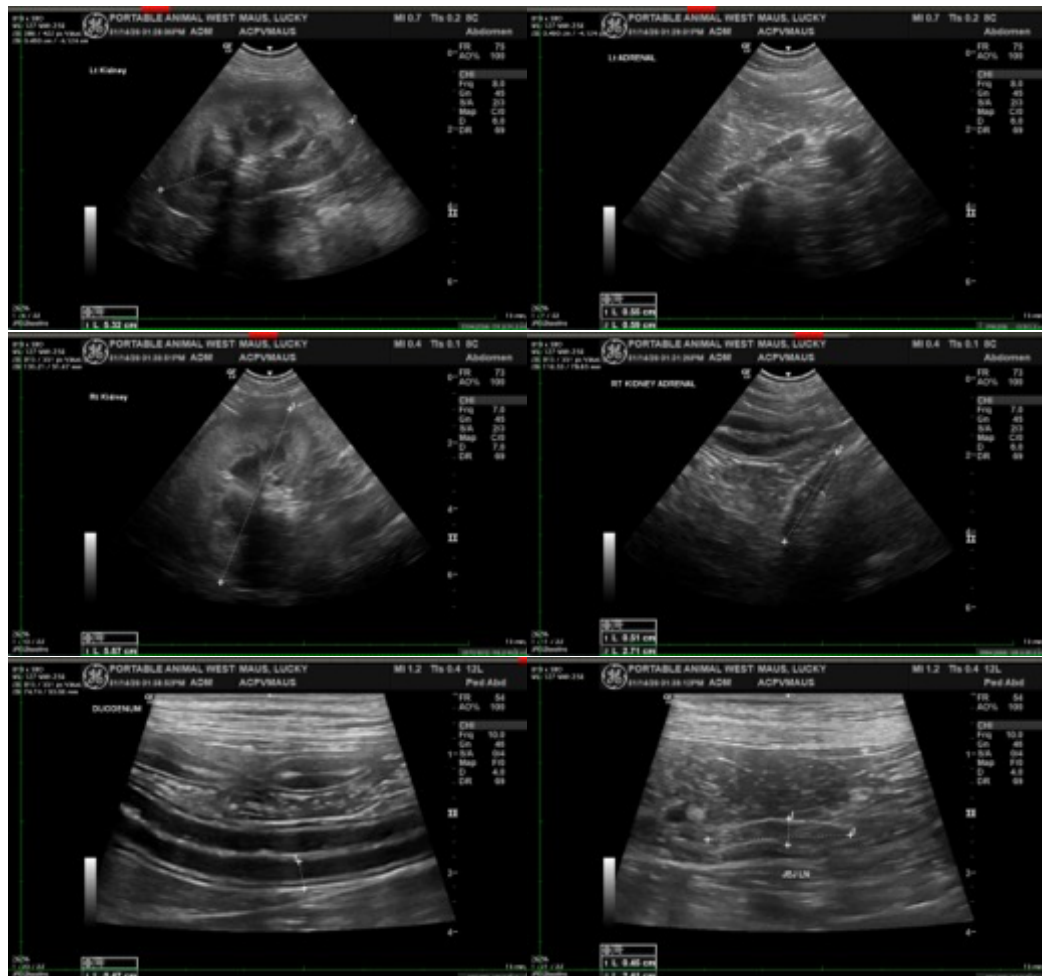
1/14/2026

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

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.

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. If a biome diet, empirical deworming, etc., is not helpful, then additionally, especially given chronic antibiotic use, fecal microbe transplant therapy could be considered. Ultimately, if antibiotic therapy has to be continued, a transition to Tylosin may be helpful given the concern for possible Metronidazole neurotoxicity.



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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**  
info@sonopath.com