



**PATIENT**

Kincaid Waldron

**PRESENTING CLINICAL SIGNS**

History: Vomiting for days and bloody diarrhea. Current meds: Fluconazole and Atopica.

**SPECIES**

Canine

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

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.

**BREED**

Yorkshire Terrier

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

**SEX**

Neutered Male

Left kidney is normal is size (4.01 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.

**AGE**

6 Years

Right kidney is normal is size (4.29 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**

**WEIGHT**

13.1 Pounds

Left adrenal gland is normal in size (1.95 cm long x 0.57 cm at cranial pole and 0.61 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (1.46 cm long x 0.71 cm at cranial pole and 0.77 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**Spleen**

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.

**IMAGING PERFORMED BY**

Kelly Vazquez

**Liver**

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.

**HOSPITAL NAME**

New Bridge VP

**REFERRING VET**

Dr. Abina Glennon

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.

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**Gastrointestinal**

Fundic mucosal hypertrophy with hyperechoic mucosa and some mucosal remodeling is noted. There is no loss of mural detail. Layering is normal. There is mild luminal fluid accumulation. No evidence of masses/nodules or foreign material present.

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The visible small intestines are normal in wall thickness and layering. Bowel is diffusely mildly fluid distended without evidence of an obstructive pattern, plication and/or visible foreign material. Small intestinal hyperperistalsis is noted.

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The visible colon is normal in wall thickness and layering. Contents are consistent with normal formed feces and gas.

**Pancreas**

**BREED**

Yorkshire Terrier

The observed pancreas 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**

**SEX**

Neutered Male

There is no evidence of peritoneal effusion. There is no apparent lymphadenopathy.

**ULTRASONOGRAPHIC FINDINGS**

**AGE**

6 Years

- Gastritis – Consistent with irritation secondary to dietary indiscretion or intolerance, infection (bacterial, viral, other), parasitic or protozoal disease, toxin, other metabolic disease such as pancreatitis, other. Microulceration cannot be ruled out.

**WEIGHT**

13.1 Pounds

- Gastroenteritis – Consistent with irritation secondary to dietary indiscretion or intolerance, infection (bacterial, viral, other), parasitic or protozoal disease, toxin, other metabolic disease such as pancreatitis, other.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

As is reportedly already pending, a general metabolic health screen is recommended, beginning with CBC/chemistry panel, electrolytes and 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. If not recently evaluated, a fecal exam is recommended. Additionally, a baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism. 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.

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In the meantime, pending results, supportive/symptomatic medical management of gastritis/gastroenteritis is recommended with antiemetics, gastroprotectants, including sucralfate, a probiotic such as Visbiome or Provable, empirical deworming with a 5-day course of Panacur, a bland easy-to-digest, or potentially even low-fat diet (if tolerated), and given the reported hematochezia, an antibiotic such as Metronidazole or Tylosin.

**REFERRING VET**

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If clinical signs persist and a diagnosis is not obtained from the above recommended diagnostics, further evaluation of the gastrointestinal tract via upper and lower GI endoscopy/colonoscopy may be warranted for further visual evaluation and biopsies.

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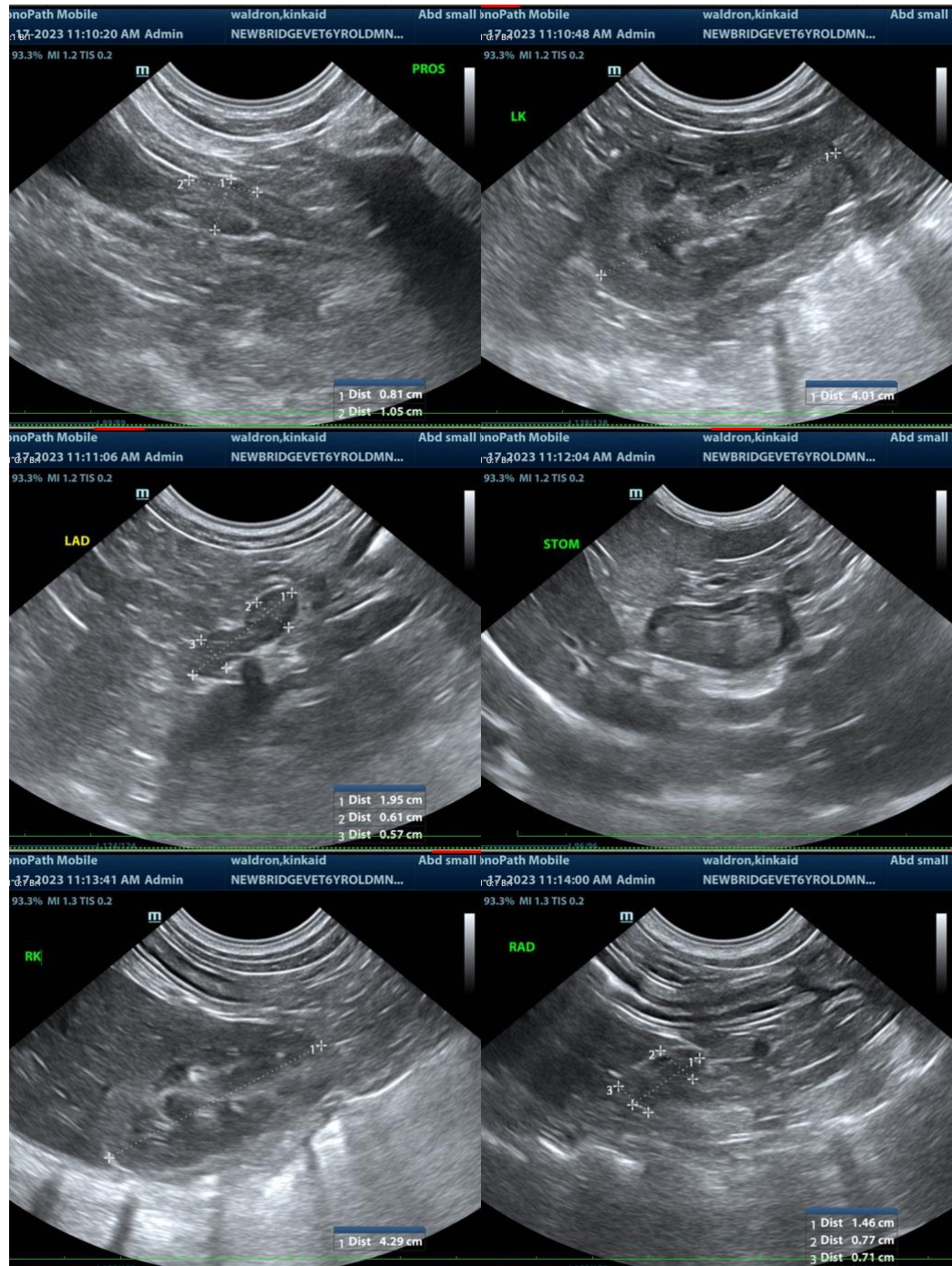
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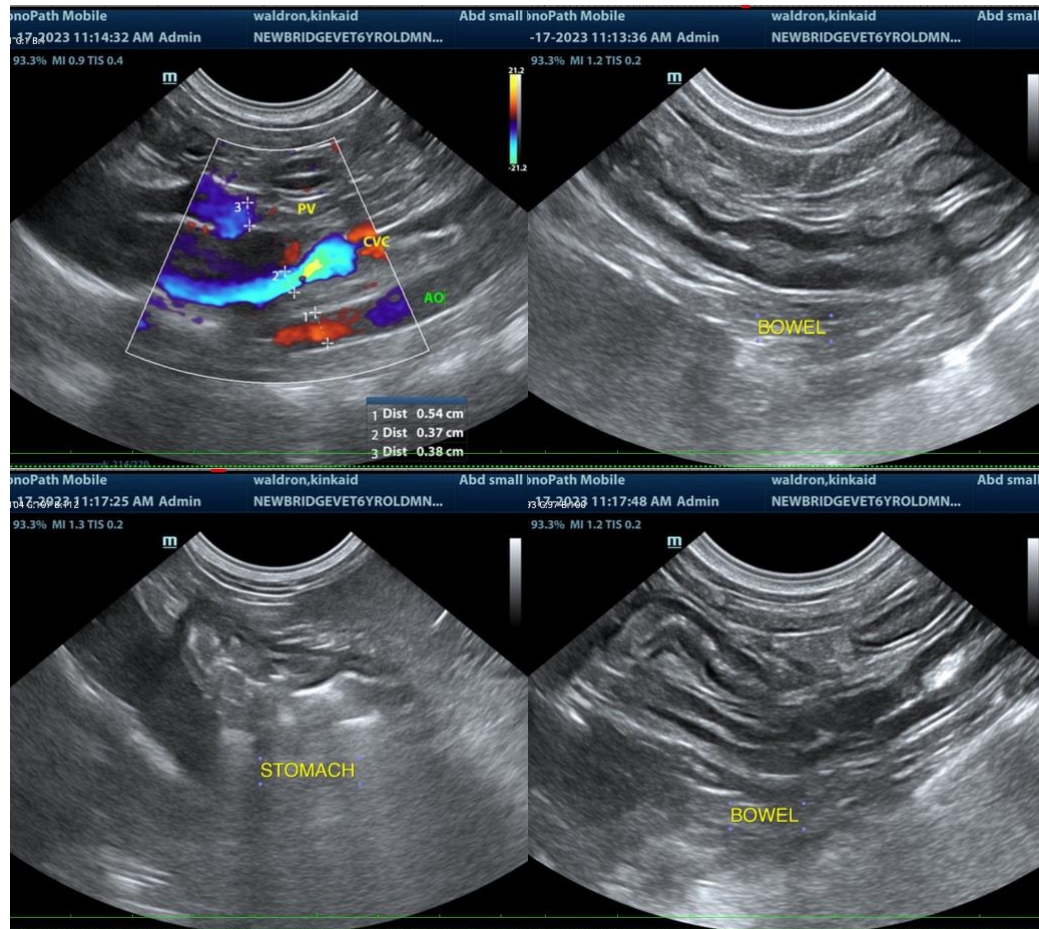
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**The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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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