



**PATIENT**

Charlie Moffatt

**SPECIES**

Canine

**BREED**

Collie x

**SEX**

Neutered Male

**AGE**

11 Years

**WEIGHT**

20.2 kg

**INTERPRETED BY**

Beth Johnson, DVM  
 DACVIM

**IMAGING PERFORMED BY**

Kelly Reschny

**HOSPITAL NAME**

Grand River Veterinary  
 Hospital

**REFERRING VET**

Dr. Kenny-Foeldessy

**INVOICE**

72528

**DATE**

1/28/26

**PRESENTING CLINICAL SIGNS**

Charlie presents for an acute onset of vomiting and diarrhea that began on Sunday, January 25th. The owners note that new peanut butter-flavored treats were introduced on Saturday, January 24th. He has vomited multiple times today, both at work and at home. He did not eat his dinner last night and has not eaten his regular food today. Stools have been soft to diarrheic, and he has had increased frequency of defecation (4-5 times per day). For the past two weeks, the owners have also noticed an increase in his water consumption. He has been waking the owners up in the middle of the night to be let out, which is abnormal behavior for him.

Diet: A commercial food, to which red meat is sometimes added.

TPR wnl, Grade 2/6 left sided murmur, cranial abdominal pain and mild dehydration.

Current Medications: Emavert, metronidazole

Abnormal PE/Chem/CBC/UA Results: Bloodwork reveals lymphopenia, hypokalemia, and hypochloremia. Canine pancreatic lipase is within normal limits. Lymphocytes 0.31 1.05 - 5.10 x10<sup>9</sup>/L Potassium 2.8 3.5 - 5.8 mmol/L Chloride 106 109 - 122 mmol/L

**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.

The prostate is unable to be well visualized in these images.

The right kidney is normal in size (5.53 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 in size (5.87 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 (1.3 cm at cranial pole and 0.68 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.60 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.



**PATIENT**

Charlie Moffatt

**SPECIES**

Canine

**BREED**

Collie x

**SEX**

Neutered Male

**AGE**

11 Years

**WEIGHT**

20.2 kg

**INTERPRETED BY**

Beth Johnson, DVM  
 DACVIM

**IMAGING PERFORMED BY**

Kelly Reschny

**HOSPITAL NAME**

Grand River Veterinary  
 Hospital

**REFERRING VET**

Dr. Kenny-Foeldessy

**INVOICE**

72528

**DATE**

1/28/26

**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, except for a discrete homogeneous hyperechoic nodule in the left caudal liver measuring 0.60 cm in diameter. 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. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine contains fluid.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. The colon is diffusely significantly fluid distended.

There are pockets of enhanced hyperechoic mesentery and fat throughout the mid abdomen, surrounding fluid dilated bowel loops, especially the dilated colon.

**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.

There is no apparent pathologic lymphadenopathy noted in these images.

**PRIMARY FINDINGS**

- 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.
- Concurrent colitis is suspected.
- The enhanced mesenteric fat is consistent with diffuse gastrointestinal inflammation. Having said that, given the diffuse enhancement, while not ultrasonographically visible, concurrent mild acute pancreatitis can't be definitively ruled out.



**PATIENT**

Charlie Moffatt

**SPECIES**

Canine

**BREED**

Collie x

**SEX**

Neutered Male

**AGE**

11 Years

**WEIGHT**

20.2 kg

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**IMAGING PERFORMED BY**

Kelly Reschny

**HOSPITAL NAME**

Grand River Veterinary  
Hospital

**REFERRING VET**

Dr. Kenny-Foeldessy

**INVOICE**

72528

**DATE**

1/28/26

**SECONDARY FINDINGS**

- Liver nodule – Differentials for a discrete hyperechoic liver nodule(s) include primarily benign changes such as nodular hyperplasia, fibrosis of an old hematoma, granuloma, myelolipomas, etc.; however, while considered less likely, primary hepatic neoplasia, infiltrative round cell neoplasia and metastatic disease can mimic benign lesions and cannot be definitively ruled out.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

A routine fecal/giardia exam is recommended if not recently evaluated.

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.

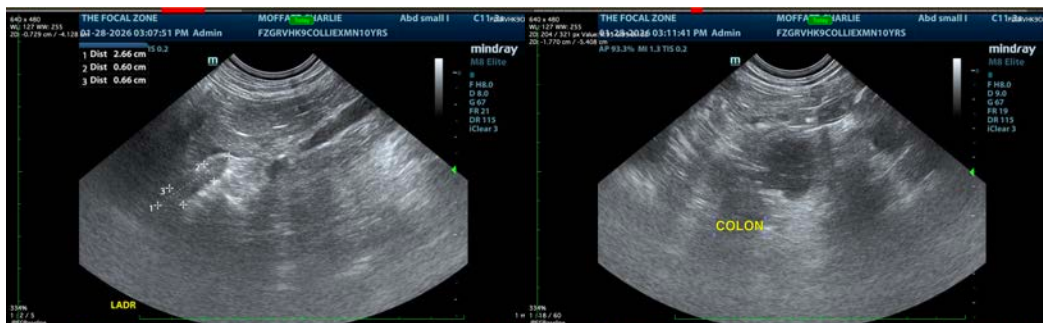
A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

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

In the meantime:

- Supportive/symptomatic medical management of clinical signs is recommended, including anti-emetics, gastroprotectants (+/- sucralfate, especially with any history of hematemesis), an appetite stimulant and fluid therapy if indicated, etc.
- Additionally, empirical deworming with a 5-day course of Panacur is recommended.
- A full course of empirical Helicobacter triple therapy could be considered.
- A probiotic, such a visbiome or proviable, may be helpful.
- Finally, if tolerated, a transition in diet could be considered, based on trial-and-error response with some options to consider including a gastrointestinal biome diet vs a hydrolyzed protein diet (sometimes several trials with different brands are necessary) vs an easy to digest, bland or low-fat diet vs other.

While there is not a definitive obstructive pattern or evidence of foreign material present in these images at this time, given the fluid distention, etc., if a diagnosis is not made and clinical signs persist, recheck imaging to further investigate a possible early or partial obstruction could be considered. Alternatively, alternative imaging such as contrast radiography, CT scan, etc. may be an option.





**PATIENT**

Charlie Moffatt

**SPECIES**

Canine

**BREED**

Collie x

**SEX**

Neutered Male

**AGE**

11 Years

**WEIGHT**

20.2 kg

**INTERPRETED BY**

Beth Johnson, DVM  
 DACVIM

**IMAGING PERFORMED BY**

Kelly Reschny

**HOSPITAL NAME**

Grand River Veterinary  
 Hospital

**REFERRING VET**

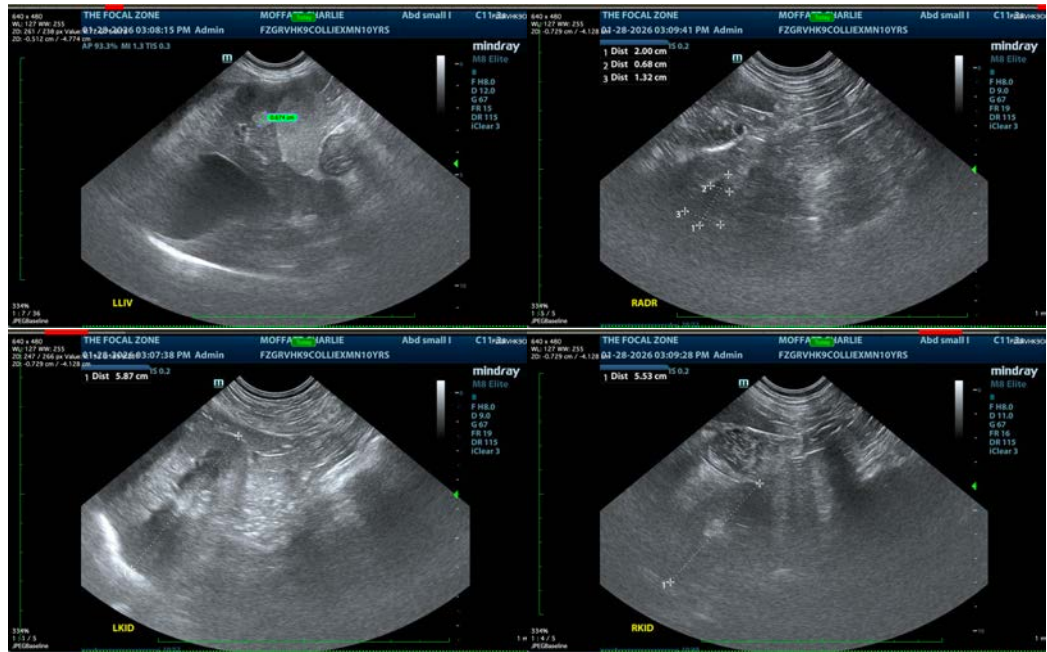
Dr. Kenny-Foeldessy

**INVOICE**

72528

**DATE**

1/28/26



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