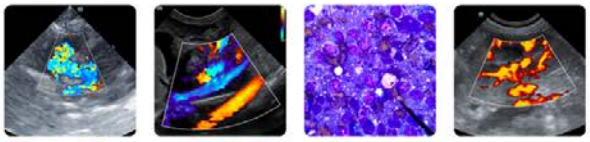




**PATIENT**

Benny Buckley

**SPECIES**

Canine

**BREED**

Pit x

**SEX**

Intact Male

**AGE**

1 Year

**WEIGHT**

31 kg

**INTERPRETED BY**

Beth Johnson, DVM DACVIM

**IMAGING PERFORMED BY**

Erin Wicks

**HOSPITAL NAME**

Shores Veterinary Emergency Center

**REFERRING VET**

Dr. Law

**INVOICE**

72559

**DATE**

1/29/26

## PRESENTING CLINICAL SIGNS

Patient History: Normal until 5:30 AM today when client noticed hind limb weakness, ataxia, and reluctance to walk or go upstairs. Patient was vocalizing, panting, and would fall down when attempting to walk. Client had to carry patient. Developed diarrhea twice (no blood noted). Known to eat pieces of toys and sticks. Fed dry food with occasional cooked egg weekly. Up to date on vaccines, heartworm, flea, and tick prevention. No current medications or previous health issues.

Abnormal PE/Chem/CBC/UA Results: Reactive to abdominal palpation, increased borborygmi Leukocytosis Neutrophilia Hyperkalemia Hypocalcemia Hyperglobulinemia Na:K 24 Resting cortisol 2.61 Radiographs Stoamch distended with normal ingesta vs foreign material, large gas distended colon obscuring bladder and caudal abdomen, no clear evidence of urolithiasis, one view suspicious for foreign clothlike material

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

The urinary bladder is subjectively over 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 appears largely normal for a young intact dog.

The right kidney is normal is size (8.7 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 (7.3 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 (0.64 cm at cranial pole and 0.72 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

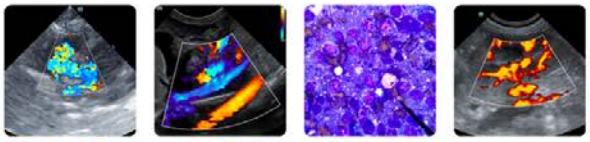
The left adrenal gland is small (flattened contour), measuring 0.38 cm at the cranial pole and 0.47 cm at the caudal pole. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

### *Spleen*

Spleen is subjectively large in size with normal smooth margins. Parenchyma is normal in echogenicity with a diffusely coarse/heterogenous echotexture. No discrete sizable 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.





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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 markedly overdistended with a large amount of fluid, some echogenic non-shadowing densities consistent with normal ingesta/chyme, and a large amount of reverberation artifact from gas. The pylorus is difficult to fully visualize due to the gas artifact but 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 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.

Medial iliac and mid abdominal/medial to the spleen 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

- Flat left adrenal gland– This can be a normal patient variant and/or a sign of exogenous cortisol administration. If exogenous steroids are not being administered, hypoadrenocorticism (either relative or absolute) should be considered.
- Coarse splenomegaly – can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.
- Mildly to moderately reactive medial iliac and mid abdominal (medial to the spleen) lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- The subjectively overdistended urinary bladder should be interpreted in combination with patient's last urination, ability to urinate, any straining to urinate, etc., as there is not a definitive ultrasonographically visible explanation in these images at this time.
- Similarly, the fluid and gas distended stomach should be interpreted in combination with clinical signs, other underlying metabolic, potentially neurologic disease that may be diagnosed,

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etc., as a partial obstruction can't be definitively ruled out, but there is no definitive ultrasonographically visible explanation of one in these images at this time. Therefore, delayed gastric emptying secondary to gastric ileus likely related to underlying metabolic or neurologic disease is considered most likely.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

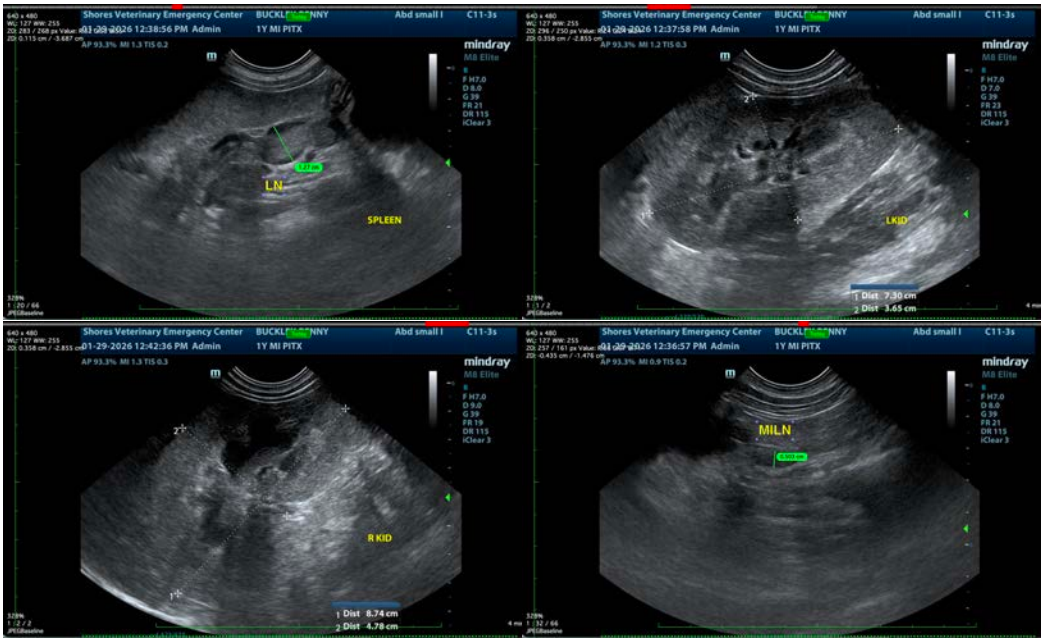
It is difficult to link patient's reported neurologic signs, laboratory changes, and these ultrasound findings all together unless there is a diffuse metabolic or neurologic condition resulting in potentially lack of urinary bladder contraction, potentially some gastrointestinal ileus, and the ataxia, etc. Therefore, further neurologic evaluation, potentially consultation with a veterinary neurologist, advanced imaging, etc. could be considered. Having said that, there are some subtle changes that warrant further investigation potentially prior to or simultaneous to that, including:

A full ACTH stimulation test could be considered, given the low-normal baseline cortisol.

Fine needle aspirates of the spleen +/- enlarged lymph nodes could be considered if patient's coagulation status is appropriate.

Given patient's young age, hyperglobulinemia, etc., comprehensive infectious disease evaluation could also be considered.

Other than supportive/symptomatic medical management of clinical signs, further diagnostic and treatment recommendations are largely dependent on results of the above.



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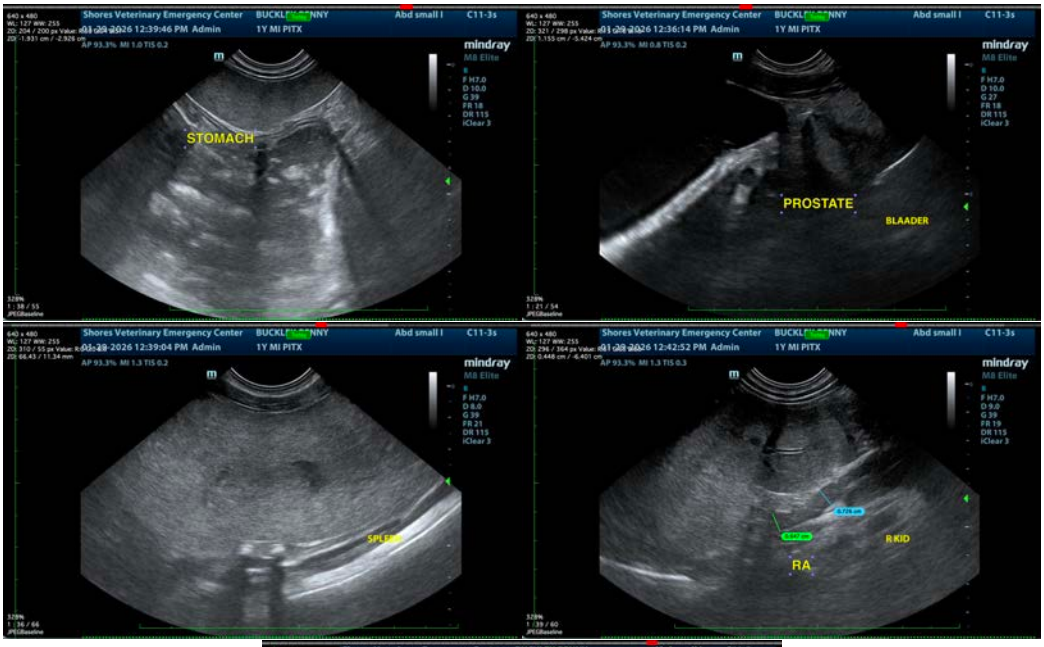


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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