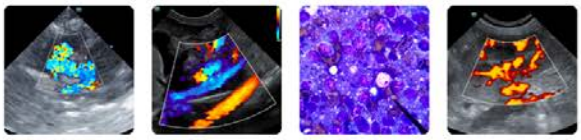


DATE

1/29/26

PATIENT

Kate Horsey

SPECIES

Canine

BREED

Havanese

SEX

Spayed Female

AGE

10/9/17

WEIGHT

11 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Northwind Animal Hospital

REFERRING VET

Dr. Repsher

INVOICE

72600

PRESENTING CLINICAL SIGNS

Patient History: Kate presents for a one-day history of lethargy, anorexia, shivering, and hiding behind a chair, which is abnormal behavior for her. She has not eaten in approximately a day and a half and is disinterested in food, including treats. She will drink small amounts of water. The owner notes her tongue appears very red and her breath has a bad odor. There has been no coughing, sneezing, vomiting, or diarrhea. Her last bowel movement was two days ago and was normal. Her diet was changed to a new food (Blue Buffalo) about three weeks ago. She is an indoor-only dog and lives with another dog who is currently healthy. She has a history of ear infections.

Current Medications: SQF, Gabapentin.
Labwork Results: Labwork attached, reported as: Bloodwork (CBC/Chemistry) results are within normal limits, ruling out significant kidney, liver, or pancreatic disease. Amylase is slightly low, which is considered clinically insignificant. No evidence of a systemic infection was noted on the CBC.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed by: Rachel Brilhart, RDMS.

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 right kidney is normal is size (4.17 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. A hyperechoic band parallel to the corticomedullary border is present.

The left kidney is normal is size (3.79 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. A hyperechoic band parallel to the corticomedullary border is present.

Adrenal Glands

The right adrenal gland is normal in size (0.66 cm at cranial pole and 0.48 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.54 cm at cranial pole and 0.62 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. Very subtle 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.

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

Pancreas

Pancreas is prominent (enlarged) in size and mildly irregular in shape with a slightly undulating contour. Parenchyma is coarse in echotexture and heterogenous to hypoechoic in echogenicity.

Free Abdomen

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

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- The pancreatic changes are mild/subtle, but chronic low-grade smoldering pancreatitis or potentially resolving pancreatitis can't be ruled out as a contributing factor to patient's reported anorexia.

- Very subtle 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.

- Bilateral medullary rim sign (canine) - 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

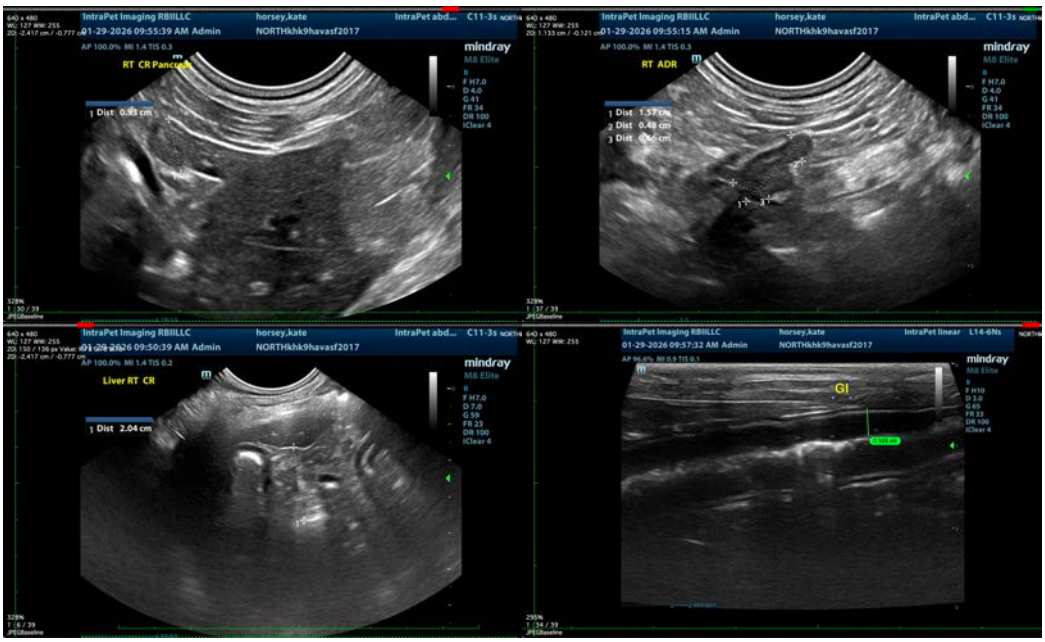
Further workup recommendations for the anorexia could include a routine fecal/giardia exam if not recently evaluated.

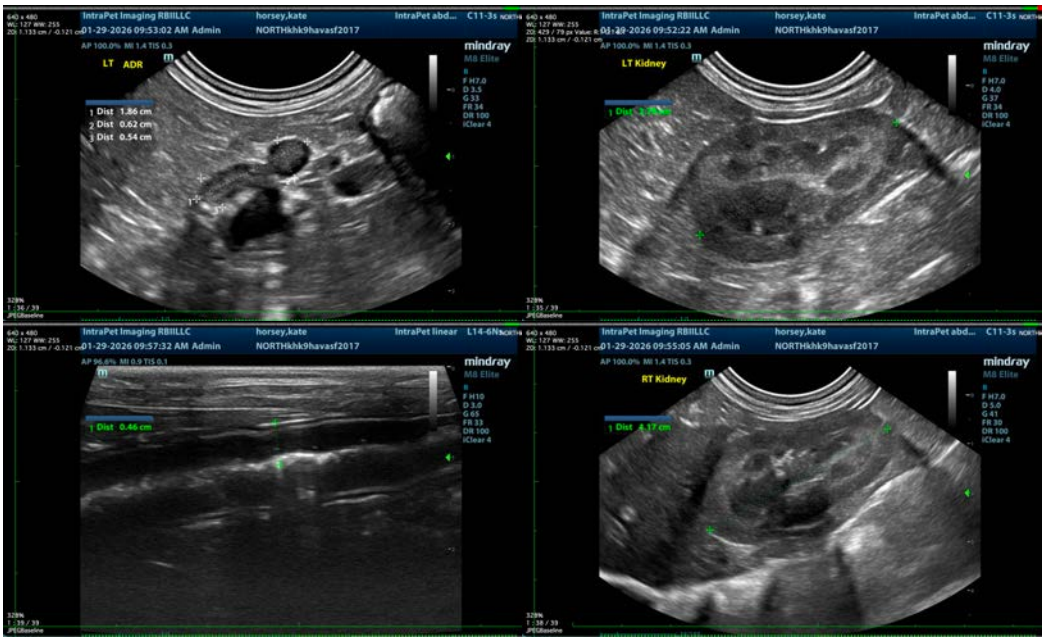
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

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

Additionally, pending results of above, further evaluation for possible pain (dental, orthopedic, other), upper respiratory disease or oropharyngeal disease, cardiac disease and/or neurologic disease vs other as possible causes for decreased appetite is also recommended.

While continuing workup, supportive/symptomatic medical management of clinical signs, including management of possible subclinical nausea, could be considered in the form of antiemetics, gastroprotectants, an appetite stimulant, fluid therapy if clinically indicated, empirical deworming with a 5-day course of Panacur, etc.





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