PATIENT

Mickie Smith

SPECIES

Canine

BREED

Mini Pinscher Mix

SEX

MN

AGE

13 years

WEIGHT

13 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Peavine Animal Hospital

REFERRING VET

Dr. Baggett

INVOICE

11198

DATE

1/29/2026

PRESENTING CLINICAL SIGNS

- Presenting Complaint on 1/26/2026-: Mickie presents for vomiting, hematochezia, and syncope starting yesterday.
- Patient History: Vomiting, hematochezia, and syncope started yesterday, has not happened before. Not eating or drinking. Not urinating or defecating normally. Vocalizing frequently and appears to be in pain. History of diabetes mellitus. Liver condition. Blind in right eye. Back issues, sees chiropractor. Currently receiving insulin injections (Novolin and insulin, prescribed at 6 units sub-Q BID, though owner unable to confirm actual home dosing.) No recent surgeries. Up to date on vaccines. No unusual food or toxin exposure initially reported. Owner later reported patient tends to eat inappropriate items and has been eating blankets.
- Assessment Problem List: Acute vomiting and hematochezia - r/o foreign body obstruction, dietary indiscretion, gastroenteritis, Syncope, Diabetes mellitus, Blindness right eye.
- 1/27/2026 and today - She states he is no longer whining, eating small amounts, and has not vomited. He seems to be improving significantly. She is having trouble getting him to take his medications due to lack of appetite. still not eating well but no vomiting.

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 (4.75 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. A 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 (4.16 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. A 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 (0.58 cm at cranial pole and 0.71 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 0.58 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively normal in size (1.2 cm thick at the hilus) 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. Multifocal mineral foci are noted. Splenic vasculature appears normal. Additionally, several discrete, homogenous, hyperechoic nodules consistent with possible myelolipomas are noted throughout the parenchyma.

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Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is moderately heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

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 is diffusely mildly distended with primarily echogenic non-shadowing luminal contents and some shadowing gas consistent with normal ingesta/chyme. There is one very subtle, focal area in the very distal jejunum that potentially demonstrates a slightly more curvilinear shadowing echogenic density that could represent the small non-obstructive foreign object seen radiographically. However, the pattern is also very likely just gas and there is no evidence of obstruction noted in these images at this time.

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.

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.

Assessment of heart base images is included when/if a splenic nodule/mass is present (as a complimentary add on). They are also assessed when a specific request is made for assessment of a limited second cavity (heart base and/or thorax) for an additional charge. Images of the heart (and/or) thorax were not assessed for this study. Please contact us if you would like a second cavity.

ULTRASONOGRAPHIC FINDINGS

- Moderately heterogenous liver – These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.

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- Moderate gallbladder debris - Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.
- 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.
- Spleen mineralization – This is a benign change but can be associated with endocrinopathies, especially hyperadrenocorticism. With concurrent hyperechoic splenic nodules – most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.
- Moderately reactive mesenteric and medial iliac lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

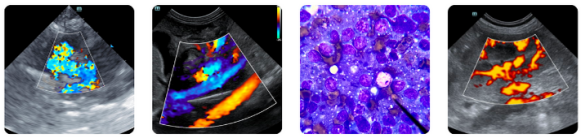
As stated above, there's not a definitive ultrasonographically visible intraabdominal explanation for patient's reported gastrointestinal signs and no signs of an obstruction noted in these images at this time. If the subtle shadowing in the distal jejunum is indicative of the foreign object it appears to be non-obstructive and likely passing. Given patient's clinical resolution, additional gastrointestinal workup/follow up may not be indicated.

Having said that, further workup could include:

- If not recently evaluated, a general metabolic health screen (CBC, chemistry panel with electrolytes and urinalysis) is recommended.
- 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.

Imaging performed by

pawsonography@gmail.com
530-786-8340



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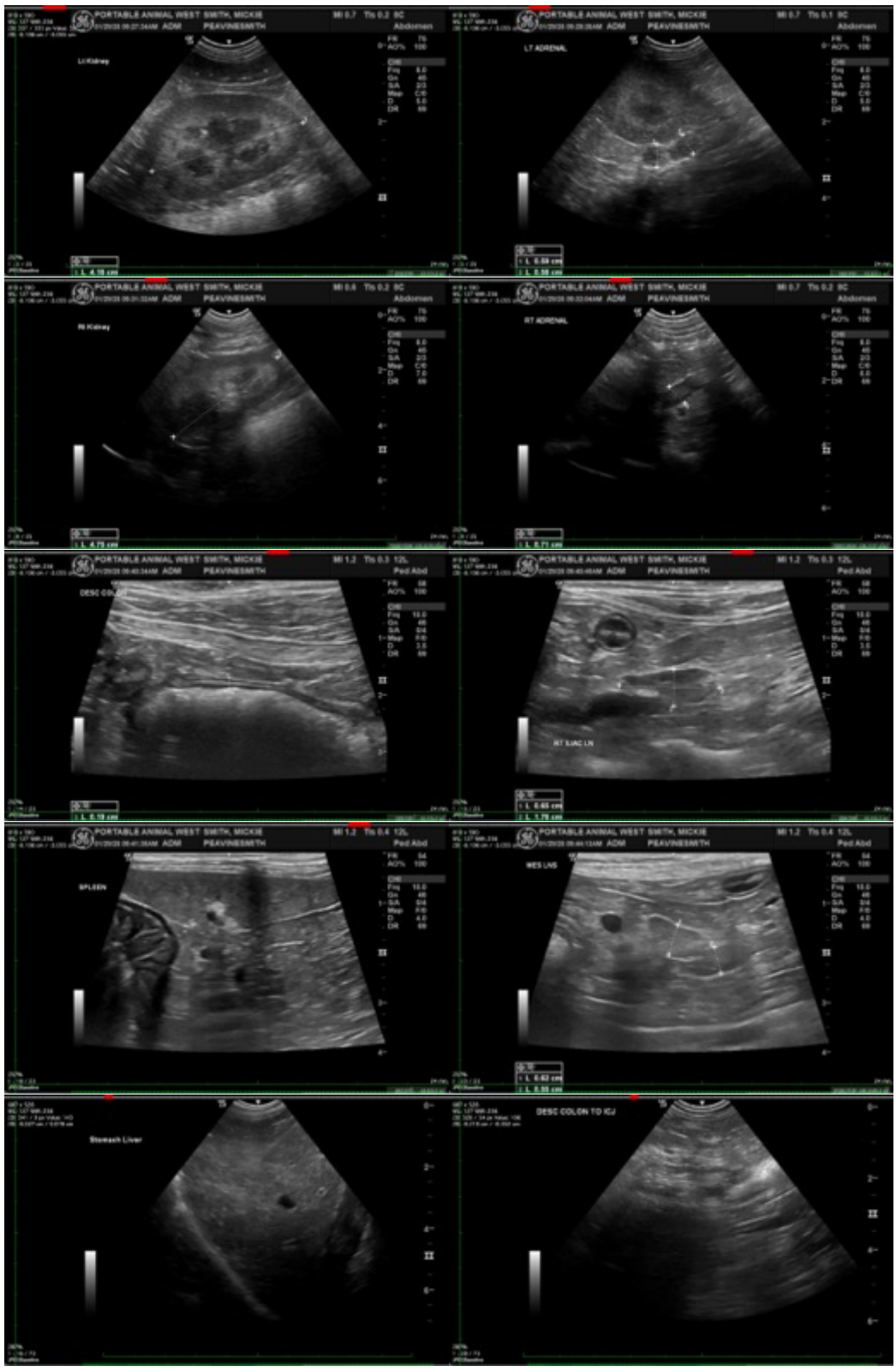

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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