



PATIENT

Junior McCormick

SPECIES

Canine

BREED

Boxer

SEX

Neutered Male

AGE

3 Years

WEIGHT

52 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. James Hornbuckle

HOSPITAL NAME

Golden Isles AH

REFERRING VET

Dr. James Hornbuckle

INVOICE

43940

DATE

1/5/23

PRESENTING CLINICAL SIGNS

Owner is visiting the area, px presented with diarrhea initially on Monday, has been intermittent but consistent. Px developed vomiting 1 day ago and continues to vomit with attempts to feed. UTD on vaccines, on Simparica Trio for hw/fl/tck. Presented with a fever of 104.1

Abnormal PE/Chem/CBC/UA Results: WBC $5.3 \times 10^9/L$ Lym $0.53 \times 10^9/L$ Mono $0.08 \times 10^9/L$ Platelet $126 \times 10^9/L$ (abaxis HMvet) Chem is wnl (Abaxis)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately 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 in size 5.7 (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. A hyperechoic band parallel to the corticomedullary border is present.

The left kidney is normal in size (6.2 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 caudal pole of the right adrenal gland is normal in size (0.64 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. The cranial pole is not well visualized in these images.

The left adrenal gland is normal in size (0.42 cm at the cranial pole and 0.45 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. 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



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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 (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). 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.

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

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Pancreas

The pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

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Free Abdomen

There is no evidence of free peritoneal effusion noted in these images.

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The 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.

ULTRASONOGRAPHIC FINDINGS

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- **Medullary rim sign bilaterally** - 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 FIP, 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.

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- **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.

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- **Reactive medial iliac lymph nodes** - infiltrative neoplastic disease cannot be ruled out but is considered less likely.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given this patient's reportedly mild leukopenia, further investigation of possible infectious disease including potentially a viral infection is recommended as the potential underlying cause for the gastrointestinal signs. In the meantime, supportive/symptomatic medical management of gastritis with antiemetics, gastroprotectants, a probiotic such as Visbiome or Provable, empirical deworming with a 5-day course of Panacur, and a bland easy to digest diet is recommended in addition to broad-spectrum antibiotics. If clinical signs persist, recheck imaging may be warranted, and/or, if leukopenia progresses, bone marrow cytology may be indicated.

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Other diagnostic considerations could include a baseline cortisol. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

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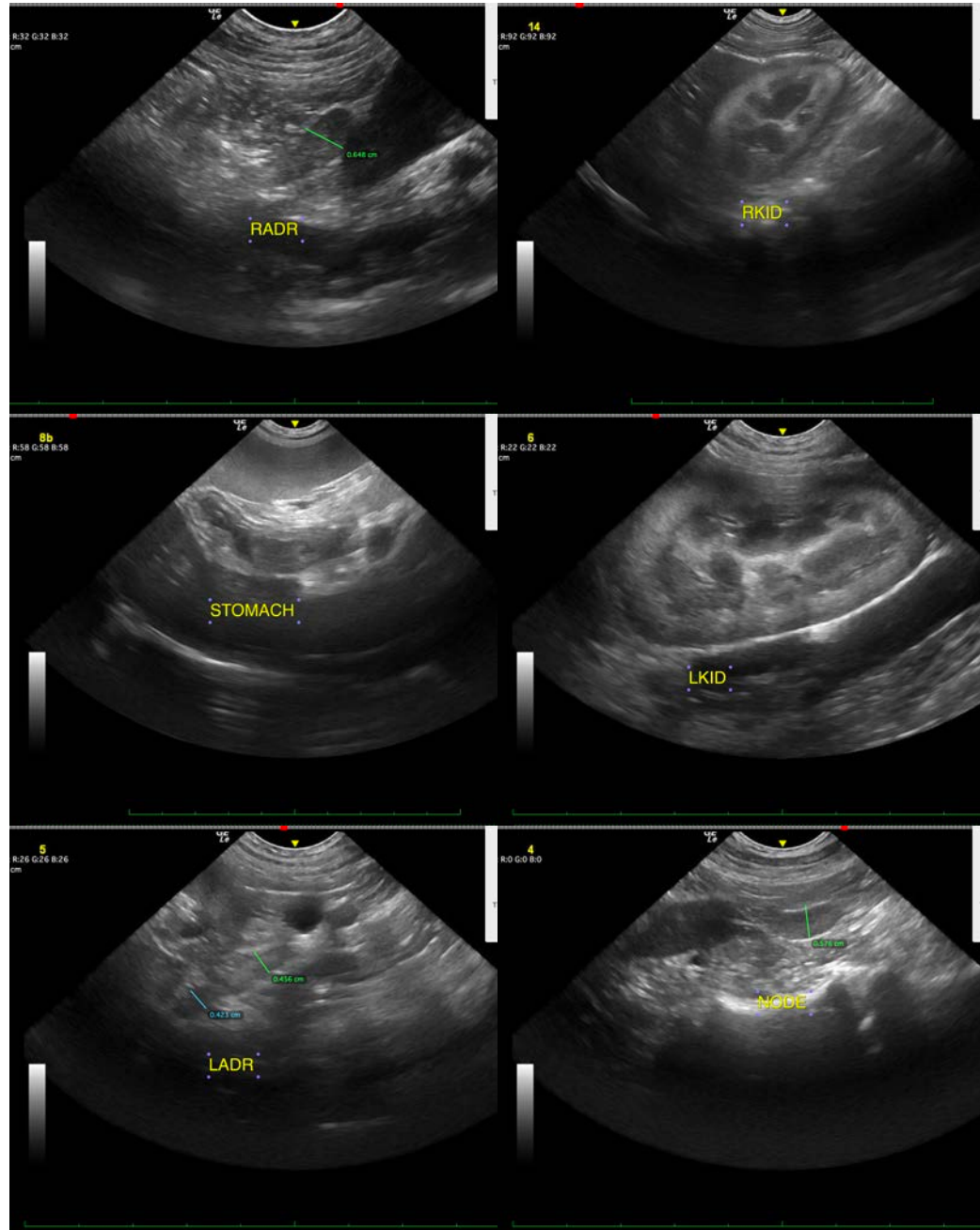
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
Beth.Johnson@sonopath.com



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