



## PATIENT

Bailey Rennie

## SPECIES

Canine

## BREED

Fox Terrier

## SEX

Spayed Female

## AGE

11 years 9 months

## WEIGHT

9.9 kg

## INTERPRETED BY

Beth Johnson, DVM  
DACVIM

## IMAGING PERFORMED BY

Dr. Jill Rankin

## HOSPITAL NAME

Bridgeland Vet Clinic

## REFERRING VET

Dr. Kaylan Elock

## INVOICE

10946

## DATE

12/16/2025

## PRESENTING CLINICAL SIGNS

Presented for vomiting and appearing uncomfortable History of intermittent vomiting episodes ("barfing jags") that typically last 12-24 hours. History of elevated alkaline phosphatase. The patient has been tested for Cushing's disease with a low-dose dexamethasone suppression test that was negative. History of urinary stones, urinary tract infections, and urinary incontinence. History of perivulvar dermatitis. Point of Care Diagnostics: Radiographs: Radiographs of the abdomen revealed a loss of serosal detail and a soft tissue opacity creating a mass effect in the left cranial abdomen. This has caused displacement of the intestines. The mass is suspected to be associated with the stomach, liver, or spleen based on radiographic location. Brief Abdominal Ultrasound: A brief, non-specialist ultrasound examination of the cranial abdomen was performed. Findings suggest stomach wall thickening with a mass effect and loss of normal mural detail. The mass is suspected to be of gastric origin. Incidental sludge was noted in the gallbladder.

## 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.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. Non-obstructive linear multifocal hyperechoic diverticular foci with acoustic shadowing are noted bilaterally. There is no evidence of pyelectasia or infarcts observed. Left kidney measures 5.3 cm, and the right kidney measures 4.8 cm.

### Adrenal Glands

The right adrenal gland is normal in size (1.1 cm at cranial pole and 0.52 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.6 cm at cranial pole and 0.54 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

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.



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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.

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### Gastrointestinal

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.

## BREED

Fox Terrier

The visible small intestines are normal in wall thickness and layering. 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.

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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 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. **\*See Free Abdomen\***

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### Free Abdomen

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

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There are several discrete, homogenous, hypoechoic densities noted adjacent to the stomach around the pancreas, measuring between 0.5 cm and 0.7 cm in diameter. That I believe represent lymph nodes. Pancreatic nodules can't be ruled out but are thought less likely.

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### PRIMARY FINDINGS

- 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.
- Subtly/mildly 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.
- Suspect moderately reactive gastric/pancreaticoduodenal lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely. As described above, however, pancreatic nodules versus lymph nodes can't be ruled out.

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### SECONDARY FINDINGS

- Hyperechoic hepatomegaly – This appearance is non-specific and most consistent with a benign steroid (endocrine) or vacuolar hepatopathy or reactive or idiopathic hepatopathy. Inflammatory and/or infiltrative disease (such as round cell neoplasia) are also possible, but considered less likely.



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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.
- Age related kidney changes with non-obstructive dystrophic mineralization bilaterally.

**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.

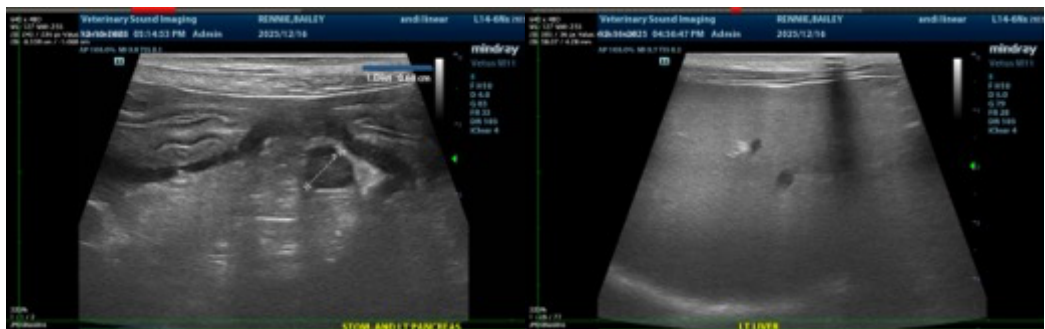
A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

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 as is a full course of empirical Helicobacter triple therapy.

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.

If clinical persist, however, and a diagnosis is not obtained, ultimately, upper GI gastroscopy/endoscopy could be considered for further visual evaluation and biopsies of the stomach and proximal small bowel.





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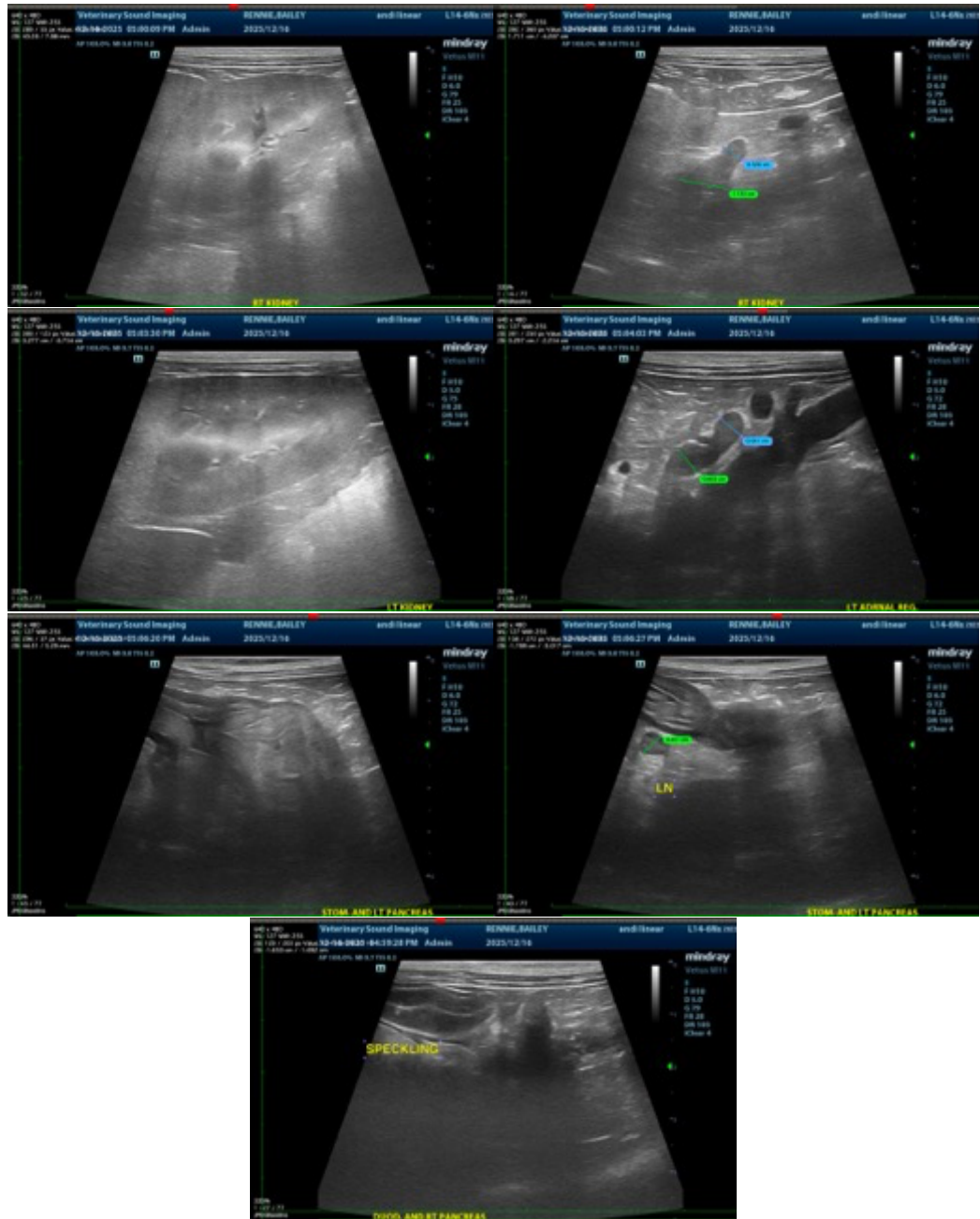
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

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