


DATE PRESENTING CLINICAL SIGNS

12/2/25 **Patient History:** Owner notes emesis 2x/week, unexplained slight weight loss, probable carnassial tooth abscess L side, Afebrile

PATIENT

Angel King

SPECIES

Canine

BREED

Chihuahua x

SEX

Spayed Female

AGE

2/3/13

WEIGHT

5.15 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

HOSPITAL NAME

Edgewood Veterinary
Hospital

REFERRING VET

Dr. Moffa

INVOICE

72261

PRESENTING CLINICAL SIGNS

Patient History: Owner notes emesis 2x/week, unexplained slight weight loss, probable carnassial tooth abscess L side, Afebrile

Current Medications: Clindamycin 25mg BID-- started 12/1, Meloxicam .6mg SID -- started 12/1

Labwork Results: Labwork attached, reported as: Chem/CBC unremarkable, severe caudal cervical spondylosis note abdominal mass displacing GI contents

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not approved.

Imaging Performed by: Rachel Brillhart, 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 left kidney contains an approximately 3.6 cm x 5.1 cm anechoic density replacing the entire cranial pole. The density is filled with visibly swirling/mobile echogenic fluid. The caudal pole of the left kidney has the more normal appearance of a senior kidney. The left kidney measures 5.95 cm in length and demonstrates mild pyelectasia measuring 0.29 cm in the transverse view.

The right kidney is overall normal in size (3.32 cm) 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. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

The right adrenal gland is normal in size (0.40 cm at cranial pole and 0.50 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.40 cm at cranial pole and 0.50 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.

Gallbladder is mildly overdistended with a moderate amount of non-dependent, mildly aggregated/inspissated sludge. Hypo to anechoic cystic areas are noted between the gallbladder sludge and luminal wall. The wall is otherwise smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with a small to moderate amount of echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is 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 is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta/chyme. There is 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

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.

The visible heart base (RA) and pericardium are unremarkable without obvious pathology noted in these images at this time. If cardiac function evaluation is desired, a full echocardiogram is recommended.

ULTRASONOGRAPHIC FINDINGS

- The large anechoic density involving the cranial pole of the left kidney could represent a benign cyst or complicated cyst, hematoma, abscess, other, although an infiltrative neoplastic process can't be definitively ruled out without tissue sampling.
- Emerging mucocele – 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. The non-dependent nature of this sludge combined with the cystic areas are suggestive, however, of possible emerging cystic mucosal hyperplasia or early gallbladder mucocele.
- Chronic low-grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

Sampling of the left kidney density is recommended if patient's coagulation status is appropriate, for cytology, culture and sensitivity, etc.

Having said that, the density is of unknown contribution to patient's reported gastrointestinal history. Therefore, additional gastrointestinal workup recommendations include a routine fecal/giardia exam.

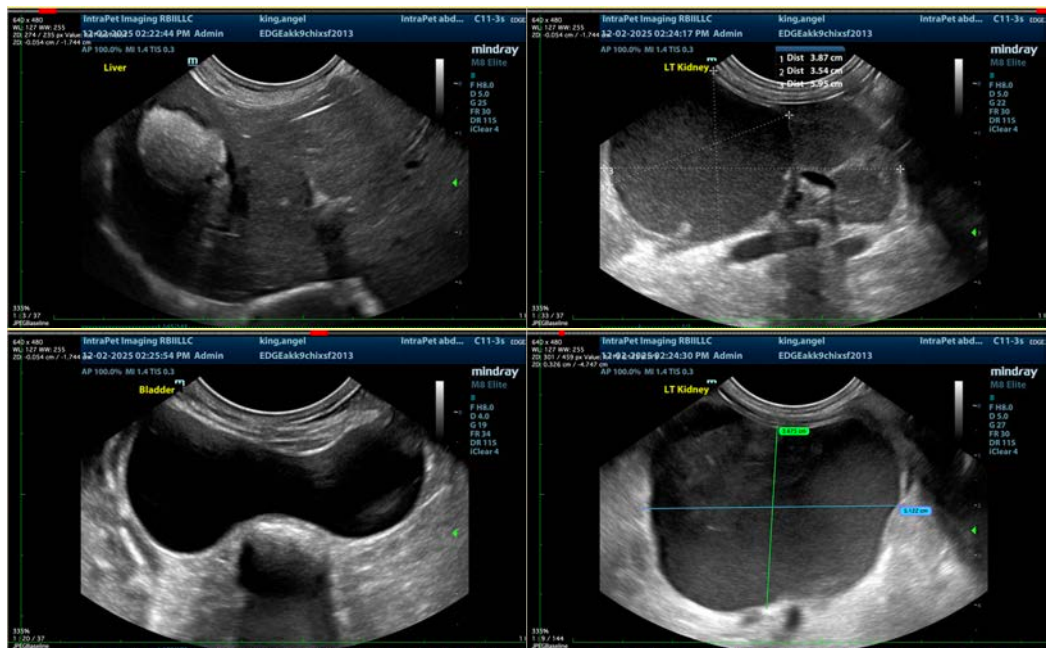
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

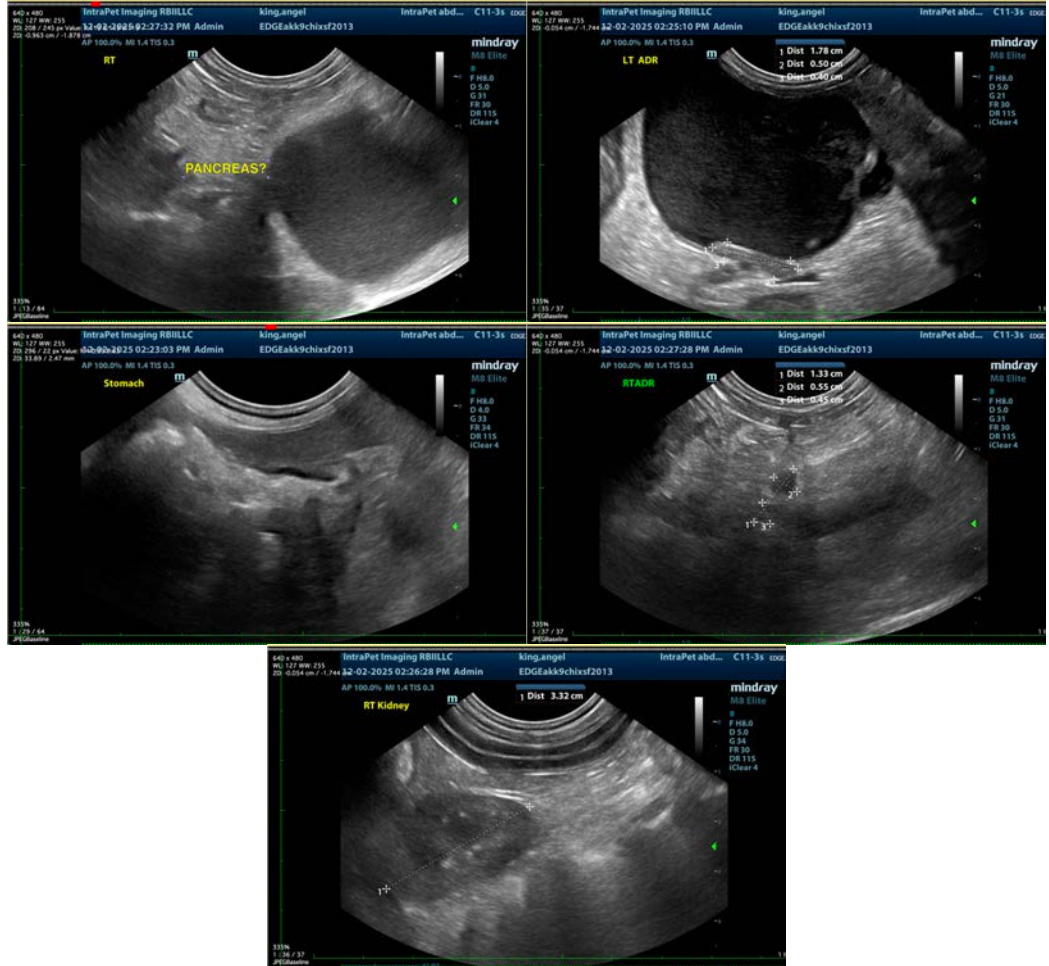
A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

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.





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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