



PATIENT

Burban Cruickshanks

SPECIES

Canine

BREED

Rottweiler

SEX

Neutered Male

AGE

10 Years

WEIGHT

39.2 kg

INTERPRETED BY

Beth Johnson, DVM
 DACVIM

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Grand River Veterinary
 Hospital

REFERRING VET

Dr. Robinson/Day

INVOICE

72240

DATE

12/2/25

PRESENTING CLINICAL SIGNS

Decreased appetite for about 1 week, no vomiting or diarrhea, history of chronic right hind lameness with muscle atrophy. Has had diarrhea in past as well as panhypoproteinemia with low T4. Vet visit related anxiety. Abdomen comfortable on palpation, no obvious mass effect, no fluid wave. Progressive muscle atrophy and historical low protein levels concerning for systemic disease.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is only mildly distended. Visible contents are anechoic. Urinary bladder wall is unable to be fully assessed for pathology without further distension. No visible masses or definitive cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface. In the face of urinary signs and/or suspected urinary bladder pathology, reassessment after complete filling is recommended.

The prostate is unable to be visualized in these images.

The right kidney is normal is size (6.6 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.

The left kidney is normal is size (6.43 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. Mild pyelectasia is noted. There is no evidence of mineral or infarcts observed.

Adrenal Glands

The right adrenal gland is normal in size (1.0 cm at cranial pole and 0.40 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.90 cm at cranial pole and 0.80 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large in size with a mildly swollen but smooth capsule. Parenchyma is normal and homogenous in echogenicity and echotexture. 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.



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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The stomach is moderately distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. If patient was appropriately fasted, delayed gastric emptying could be considered. Non-shadowing foreign material is considered less likely but cannot be definitively ruled out.

If clinical signs are consistent (vomiting, etc.), recommendations include supportive medical care, 24 hours fasting and re-image.

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 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. In one clip that I believe is in the caudal abdomen, there is a focal fluid distended loop of small bowel that I can't trace beyond the loop imaged.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. It is diffusely mildly distended with soft stool. In several clips there is hard shadowing coming from the bowel. This may represent colon but I can't determine which bowel loops I'm seeing. Therefore, normal colonic contents versus gas versus foreign material is difficult to differentiate.

**This study was a challenge due to dark images and a very full GI tract, with evaluation of the GI tract especially limited, and foreign material unable to be ruled out.*

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.

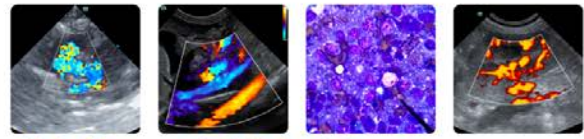
Free Abdomen

There is a very scant/trace amount of anechoic free fluid noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Splenomegaly- can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.
- 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.



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- As described above, I believe this is a post-prandial GI tract with gas and ingesta, making evaluation difficult. Having said that, given the focally fluid distended loop of small bowel as well as the shadowing in some views, I'm unable to rule out foreign material including a partial or even full obstruction. Having said that, a full obstruction is considered less likely in a patient who is not vomiting.
- The trace free fluid is of unknown origin. Differentials (unless already ruled out) could include increased hydrostatic pressure (cardiac disease and/or vascular or lymph blockage), decreased oncotic pressure (low albumin), vasculitis, paraneoplastic fluid, rupture/leakage of/from an organ (GI, GB, UB, other), blood (hemoabdomen), other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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

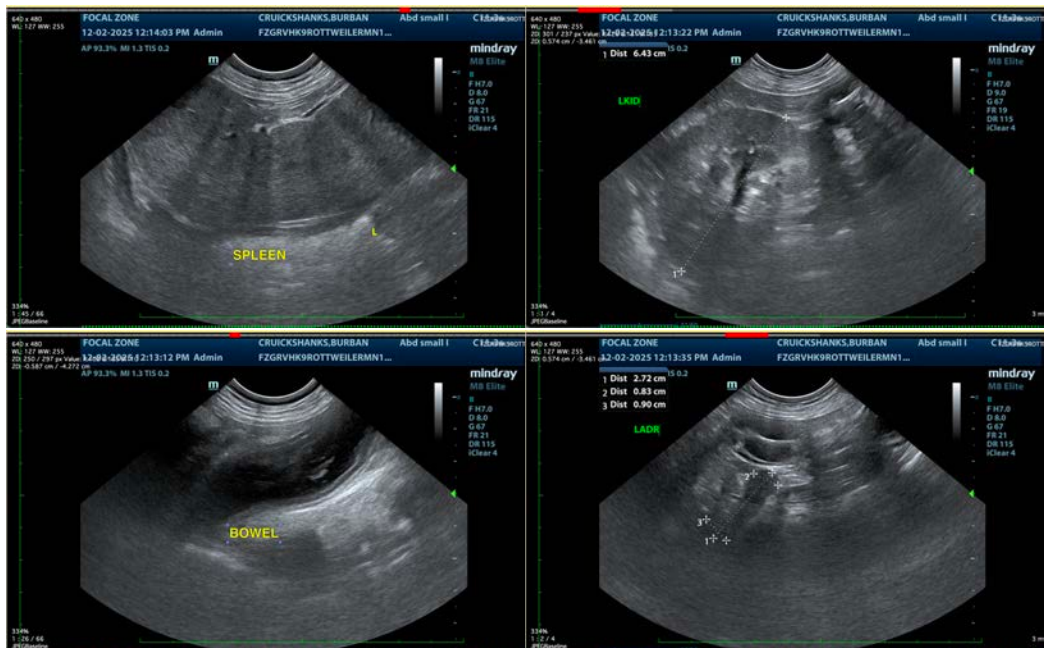
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

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, an additional 12-24 hours of fasting followed by recheck imaging of the GI tract, and/or alternative imaging such as contrast radiography versus other could be considered.

Fine needle aspirates of the spleen could be considered if patient's coagulation status is appropriate.

Other than supportive/symptomatic medical management of clinical signs, further diagnostic and treatment recommendations are largely dependent on results of the above.





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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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