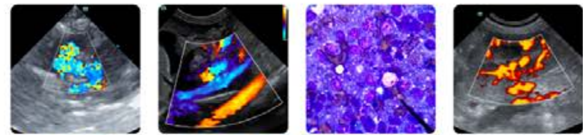


PATIENT

Portia Wolven

SPECIES

Canine

BREED

Italian Greyhound

SEX

Spayed Female

AGE

13 Years

WEIGHT

5 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Grand River Veterinary Hospital

REFERRING VET

Dr. Kenny-Foeldessy

INVOICE

72416

DATE

12/9/25

PRESENTING CLINICAL SIGNS

Presented for vomiting and inappetance that began on Dec 3, 25. O reports that P vomited food yesterday morning, followed by three episodes of vomiting bile. Has had soft, dark, mucoid and liquid stools and her appetite has been poor since yesterday. O concerned that P may have eaten some small pieces of plastic from a toy but did not witness this. P has a history of intermittent GI upset which always responded to Metronidazole but never formally diagnosed with IBD at previous reg DVM. T 38.4C, HR 136, MM pink, mildly dehydrated. Has been on Cerenia, Metronidazole, Famotidine whenever GI upsets occur.

Abnormal PE/Chem/CBC/UA Results: Please see attached lab results and radiographs

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 is small (3.15 cm), irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted. Small, non-visibly obstructive nephroliths are noted.

The right kidney is normal in size (3.64 cm) but irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted. Pinpoint non-obstructive nephroliths are noted.

Adrenal Glands

The right adrenal gland is plump/swollen in size, measuring 1.0 cm at the cranial pole and 1.2 cm at the caudal pole. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.47 cm at cranial pole and 0.45 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

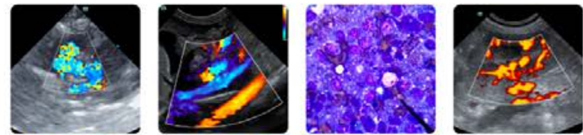
Spleen

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.

The gallbladder is unable to be visualized in these images.



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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 intestine demonstrates areas of moderately thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). This change is most significant in the ileum. Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

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.

There is no apparent pathologic lymphadenopathy noted in these images.

PRIMARY FINDINGS

- Moderate inflammatory bowel disease (IBD) pattern (most significant in the ileum) – Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No loss of layering, etc. is noted to make lymphoma more probable, but lymphoma cannot be definitively ruled out without tissue sampling.

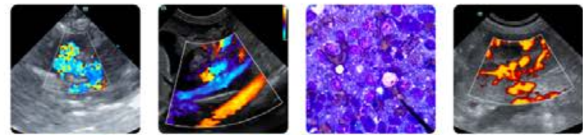
- Mild to moderate chronic kidney disease changes, primarily appreciated in the left kidney, with pinpoint/small non-obstructive nephroliths noted bilaterally.

SECONDARY FINDINGS

- The mild right adrenomegaly in the face of a relatively normal appearing left adrenal gland should be interpreted in combination with any clinical history of suspected emerging adrenal disease, as normal patient variant, chronic stress, etc. can't be ruled out, and this finding in my opinion is likely unrelated to patient's presenting gastrointestinal complaints.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated, especially given patient's reportedly increased BUN and the appearance of the kidneys, a urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ratio is recommended.



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A blood pressure is also recommended if not recently evaluated.

Beyond that, given clinical history, further gastrointestinal workup recommendations include a routine fecal/giardia exam if not recently evaluated.

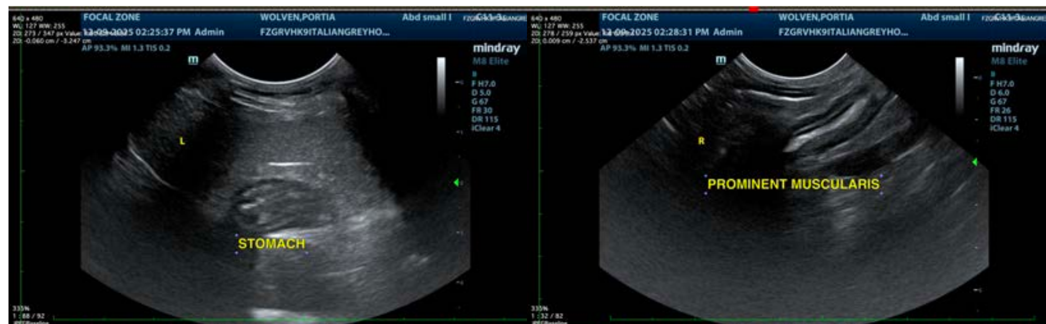
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

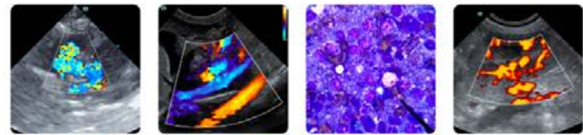
A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

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.

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.
- A full course of empirical Helicobacter triple therapy could be considerd.
- A probiotic, such a visbiome or proviable, may be helpful.
- 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.
- Fecal microbe transplant therapy may also be helpful.





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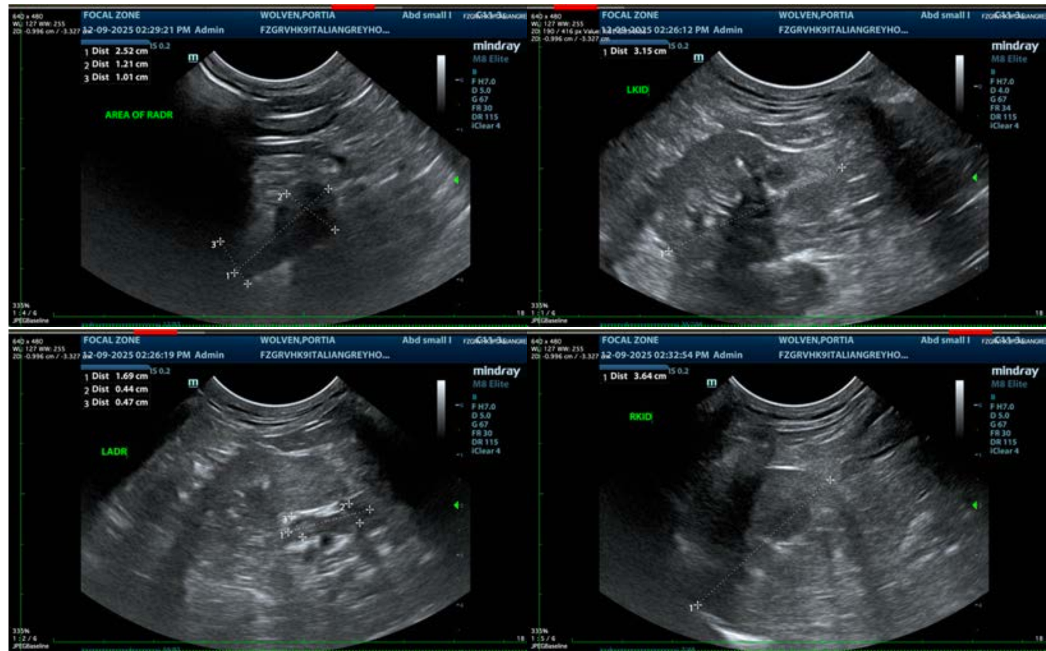

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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