



PATIENT

MaggieMae Davis

SPECIES

Canine

BREED

Yorkie

SEX

Spayed Female

AGE

15 Years 9 Months

WEIGHT

5.2 lbs

INTERPRETED BY

Beth Johnson, DVM
 DACVIM

IMAGING PERFORMED BY

Kathleen Byrnes

HOSPITAL NAME

Stoney Creek
 Veterinary Hospital

REFERRING VET

Dr. Eldred

INVOICE

73303

DATE

2/26/26

PRESENTING CLINICAL SIGNS

P presented for US due to vomiting, diarrhea with blood and food refusal. Treated supportively.

Abnormal PE/Chem/CBC/UA Results: CPL 494

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with a mild amount of echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or cystoliths are observed. The 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. There is no evidence of pyelectasia, mineral or infarcts observed. Left kidney measured 3.37 cm. Right kidney measured 3.23 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.70 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 (0.67 cm at cranial pole and 0.64 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), except for a subtle homogeneous hypoechoic, non-capsule disrupting nodule measuring 0.50 cm in size. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is moderately heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. Several suspect non-visibly obstructive mineral densities/cholecystoliths are noted, with a representative one measuring 0.66 cm in diameter. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

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,



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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. 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.

Medial to the right kidney in the right cranial abdomen, in what I believe is the area of the Ileoceocolic junction, is an intraluminal, approximately 0.70 cm x 0.70 cm, discrete homogeneous hypoechoic density that I can only appreciate in one view. The remaining colon is normal in wall thickness and appearance with normal stool cranially, and mildly fluid distended caudally.

Pancreas

The observed pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and irregular in shape with a swollen undulating contour. This change is very mild/subtle and largely appreciated in one focal spot caudal to the stomach. Enhanced hyperechoic ill-defined surrounding fat is noted.

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

- Possible tissue density within the Ileoceocolic junction as described above – This could represent a benign change such as a polyp versus other, although infiltrative neoplasia can't be ruled out without tissue sampling. Additionally, as mentioned above, I can only see the density in one view, so its existence isn't definitively pathologic.
- Suspect mild, potentially resolving versus emerging acute pancreatitis.
- Moderately heterogenous liver – These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.
- 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. Several non-visibly obstructive cholecystoliths are suspected.



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- Hypo to anechoic splenic nodule – likely represents a benign lesion such as a cyst, hematoma, nodular hyperplasia, extramedullary hematopoiesis, etc., however while considered less likely, infiltrative neoplasia can mimic benign lesions and cannot be ruled out.

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SECONDARY FINDINGS

- Age related kidney changes and a mild amount of echogenic urinary bladder debris.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Assessment of the gastrointestinal tract is partially limited by the very large amount of gastrointestinal contents/ingesta, gas, etc. Therefore, thorough reassessment of the ileocecolic junction and area medial to the right kidney following an additional 12-24 hours of fasting could be considered.

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Additionally, and/or alternatively, alternative imaging such as contrast radiography or even colonoscopy to assess the ileocecolic junction could be considered.

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In the meantime:

- If not recently evaluated, a general metabolic health screen (CBC, chemistry panel with electrolytes and urinalysis) is recommended.
- 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 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.
- +/- A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.
- 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.
- 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.

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- Additionally, empirical deworming with a 5-day course of Panacur is recommended.
- A full course of empirical Helicobacter triple therapy could be considered.
- A probiotic, such as 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.



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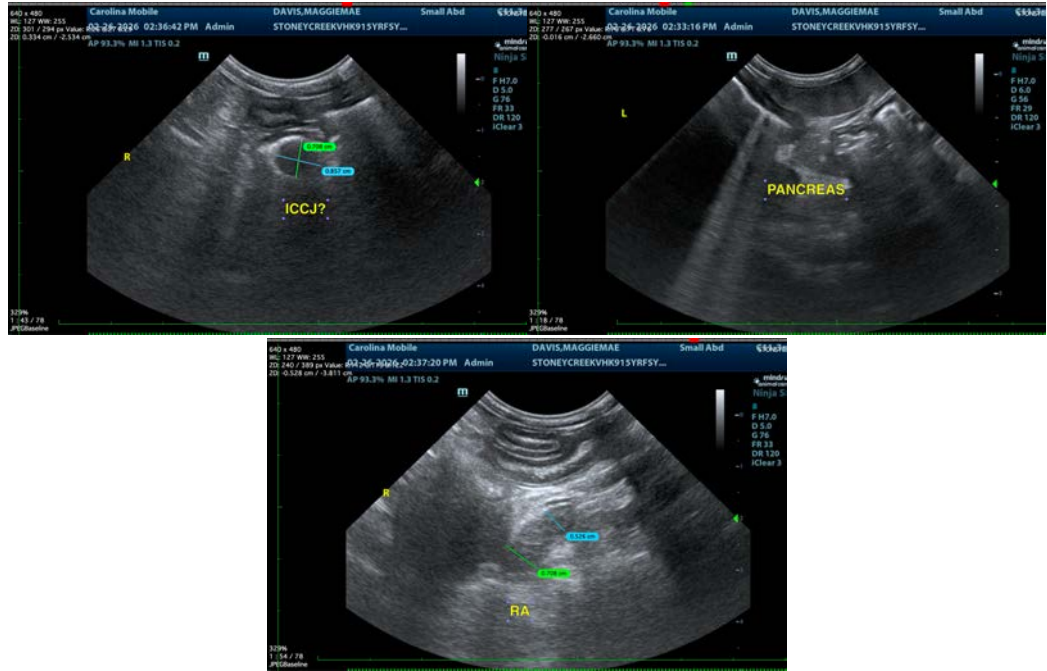
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
 info@sonopath.com