



PATIENT

Jack Poissant

SPECIES

Canine

BREED

Bichon Mix

SEX

Nuetered Male

AGE

15 years

WEIGHT

8.7 kg

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr Sarah Barthelemy

HOSPITAL NAME

Fish Creek Pet Hospital

REFERRING VET

Dr. Willson

INVOICE

11237

DATE

2/4/2026

PRESENTING CLINICAL SIGNS

- ADR presentation starting 2 wks ago.
- Severe thrombocytopenia, anemia.

Abnormal PE/Chem/CBC/UA Results: Severe thrombocytopenia Anemia.

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.

Prostate is normal in size, echotexture, and echogenicity for a neutered male.

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 mineral or infarcts observed. Left kidney measures 4.47 cm and there is mild pyelectasia noted. The right kidney measures 4.57 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.39 cm at cranial pole and 0.39 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.4 cm at cranial pole and 0.4 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.

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.

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.



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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 mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction or foreign material noted. In the mid abdomen around the mesenteric root, and one loop of jejunum, is some subtly enhanced hyperechoic mesenteric fat.

The visible colon is normal, but the lumen is diffusely mildly distended with soft stool.

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.

Mesenteric and medial iliac lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

PRIMARY FINDINGS

- 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.
- Moderately reactive mesenteric and medial iliac lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- The subtly enhanced hyperechoic mesenteric fat adjacent to the bowel and the enlarged lymph nodes is concerning for possible focal peritonitis consistent with early or emerging infiltrative bowel disease. There is no ultrasonographically visible evidence of infiltrative neoplasia affecting the bowel but it can't be definitively ruled out.
- 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.
- 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.

SECONDARY FINDINGS

Age related kidney changes with mild pyelectasia in the left kidney.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given patient's reported thrombocytopenia and anemia, further workup for underlying causes include 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.

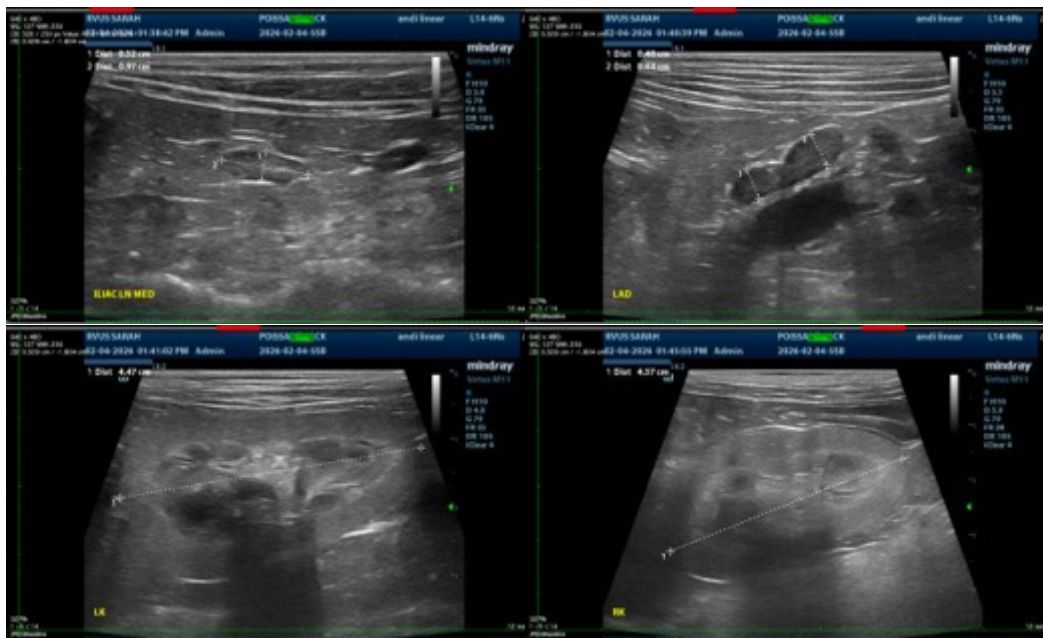
Comprehensive infectious disease evaluation could be considered.

When and if coagulation status is appropriate, fine needle aspirates of the enlarged lymph nodes +/- spleen could be considered. In the meantime, further gastrointestinal workup may also be warranted including:

- 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 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.

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

Pending patient's clinical status, workup results, etc., recheck imaging of the bowel and focally enhanced fat could be considered in 4-6 weeks.





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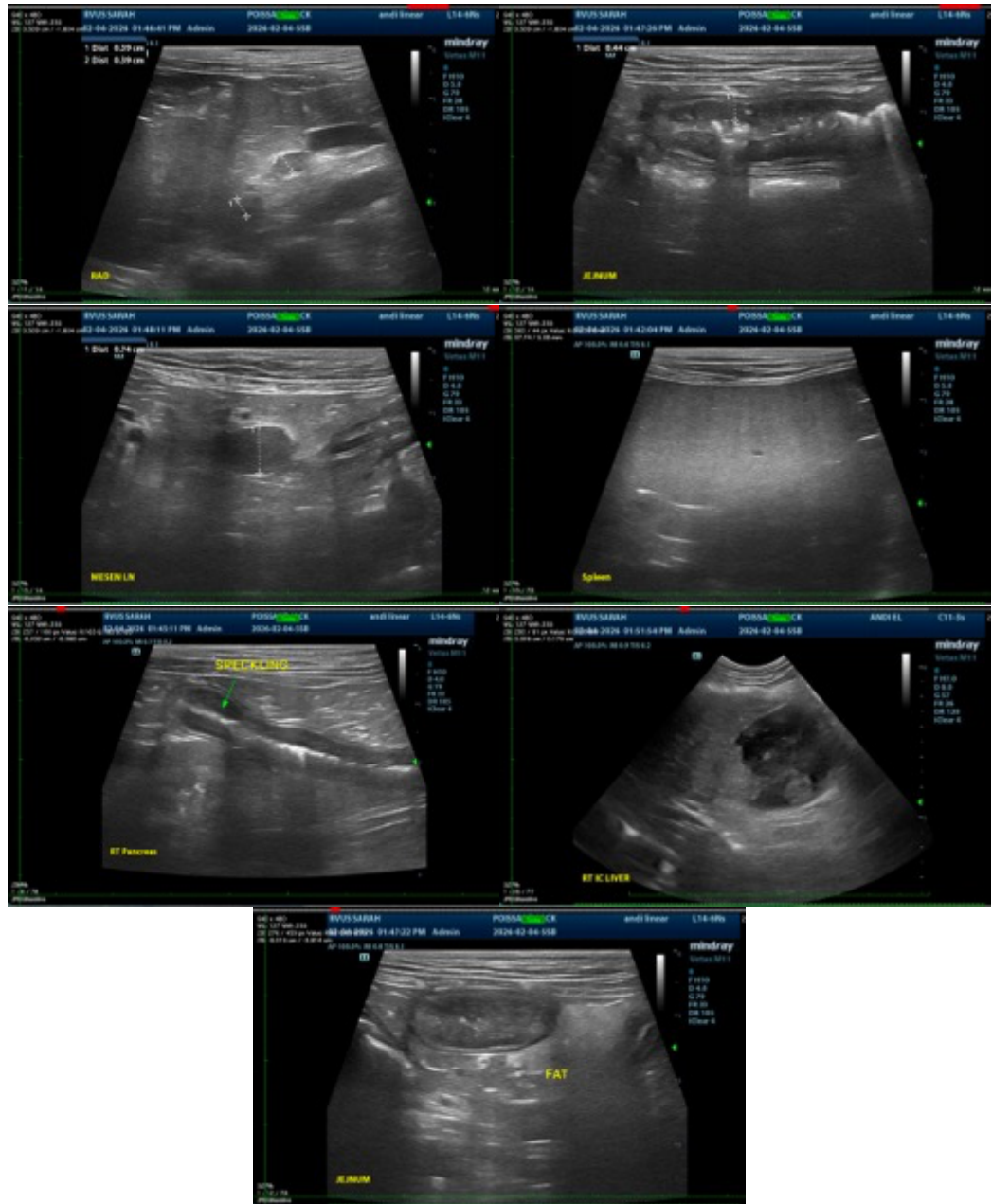
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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