



**PATIENT**

Bea Suddock

**SPECIES**

Canine

**BREED**

Terrier X

**SEX**

Spayed Female

**AGE**

7 Years

**WEIGHT**

9 kg

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**IMAGING PERFORMED BY**

Dr. Callihan/Pacific  
Crest Mobile VS

**HOSPITAL NAME**

Pacific Crest Mobile

**REFERRING VET**

Dr. Foote/Village VH

**INVOICE**

45004

**DATE**

2/9/23

**PRESENTING CLINICAL SIGNS**

Meds: Intermittent Pepcid AC at night Owner reports Cerenia makes dog lethargic and metronidazole made her constipated

Abnormal PE/Chem/CBC/UA Results: -X-rays 2 weeks ago unremarkable. -Has had baseline cortisol checked few years ago when dealing with diarrhea, malaise, vomiting, and level normal/likely ruled out hypoadrenocorticism. -CBC/Chem 17 on 2/3/23 all normal

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder is moderately 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 right kidney is normal in size (4.54 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. A subtle hyperechoic band parallel to the corticomedullary border is present.

The left kidney is normal in size (4.03 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. A subtle hyperechoic band parallel to the corticomedullary border is present.

**Adrenal Glands**

The right adrenal gland is normal in size (0.41 cm at the caudal pole), shape and contour. The cranial pole is not well visualized in these images, but the area is examined without evidence pathology. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.49 cm at the cranial pole and 0.40 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. 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 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. However, given the reported history of fasting, delayed gastric emptying could be considered. Soft (cloth) fluid absorbing 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 cranial lumen 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. The caudal lumen 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 pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

**Free Abdomen**

There is no evidence of free peritoneal effusion noted in these images.

There is no apparent lymphadenopathy noted in these images.

**ULTRASONOGRAPHIC FINDINGS**

- **Subtle bilateral medullary rim sign** - This finding is of unknown clinical significance and can be a normal variant, often idiopathic. Medullary rim sign can be present with renal disease including FIP, lymphoma, hypercalcemic nephropathy, Leptospirosis, tubular disease, other and should be interpreted in combination with other more specific indications of kidney disease such as isosthenuria, proteinuria, azotemia, etc. This is a common incidental finding in patients with diabetes mellitus.
- **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.
- **Full stomach** - Most consistent with normal ingesta. Foreign material can't be ruled out but is considered less likely, and this finding should be interpreted in combination with clinical signs, time of last meal, etc.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Further recommendations are dependent on this patient's clinical signs. If clinical signs are chronic gastrointestinal signs and include diarrhea, next diagnostic recommendations include a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory as well as a fecal enteropathogen PCR panel to Texas A&M GI Laboratory. However, if the clinical signs are primarily vomiting and/or are more acute in nature, recheck eimaging of the stomach after an additional



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12-24 hours of fasting is recommended to rule out gastric foreign material versus what is believed to be normal ingesta.

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Additionally in the meantime, empirical deworming with 5-day course of Panacur is recommended, as is a probiotic such as Visbiome or Provable if the presenting complaint is diarrhea.

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Additionally, if tolerated, a transition in diet based on trial and error response, beginning with a hydrolyzed protein diet, could be considered.

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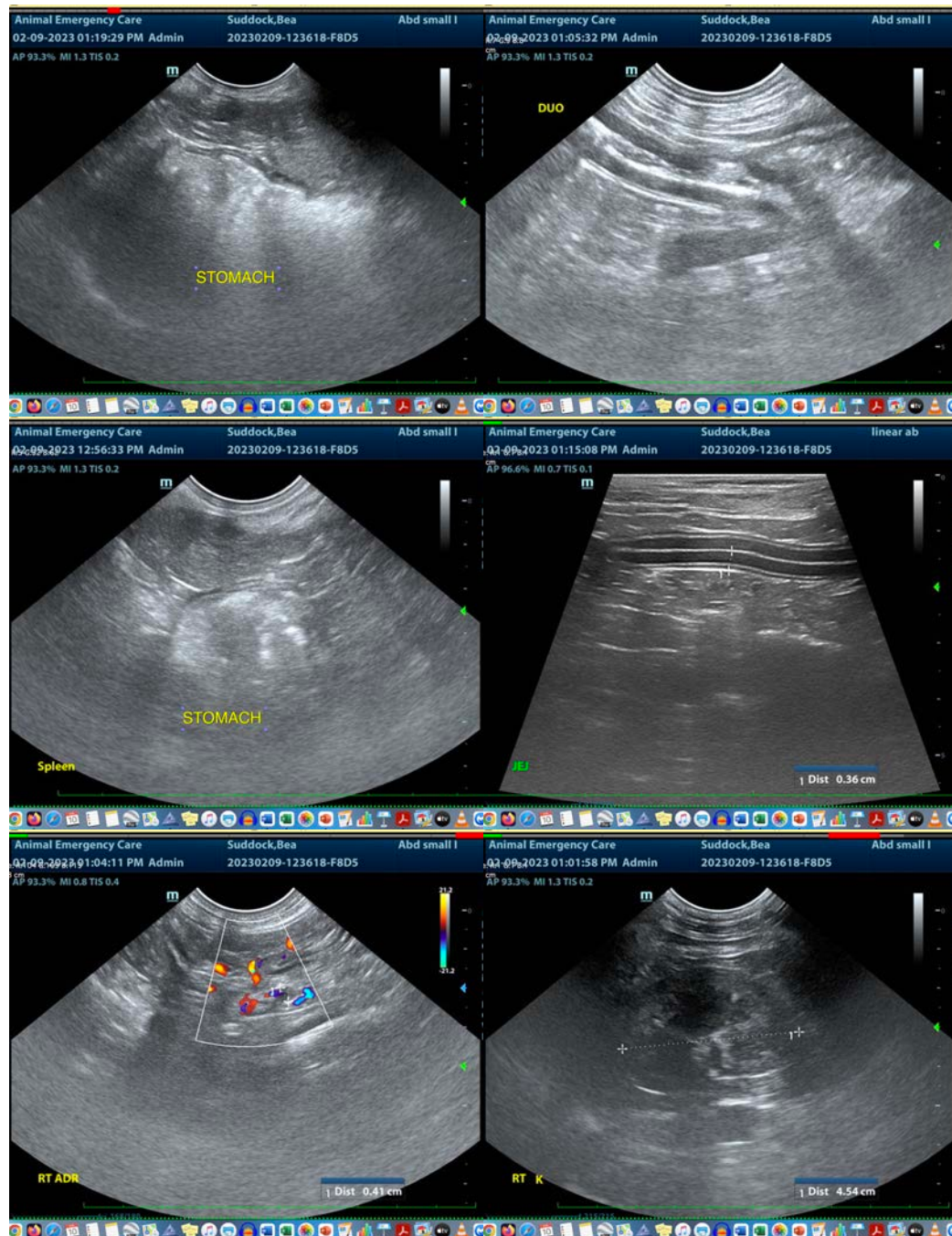
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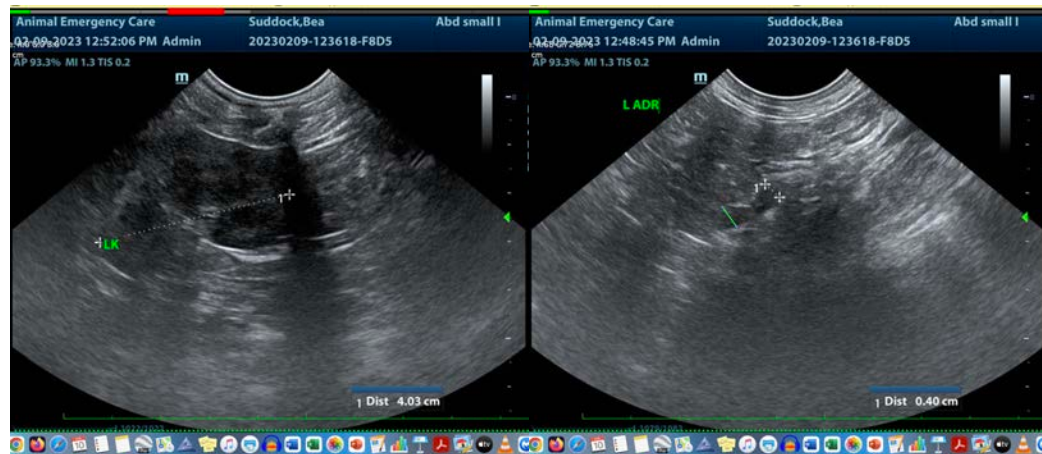
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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**  
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