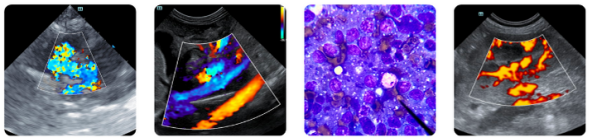


PATIENT

Oscar Cormack

SPECIES

Canine

BREED

West Highland Terrier

SEX

MN

AGE

13 yeras

WEIGHT

7.4 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Dr. Gira

HOSPITAL NAME

Glamorgan AC

REFERRING VET

Dr. Kevin MacAulay

INVOICE

11449

DATE

3/10/2026

PRESENTING CLINICAL SIGNS

- History of chronic diarrhea.

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 bilaterally normal in size, irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no pyelectasia noted and no mineral is observed. Left kidney measures 4.63 cm, and the right kidney measures 4.44 cm.

Adrenal Glands

The right adrenal gland is plump/swollen in size (1.2 cm at the cranial pole and 0.96 cm at the caudal pole). Normal shape and contour are maintained without evidence of capsular invasion. Some likely age related parenchymal heterogenicity is present. Visible surrounding vasculature appears normal. Several hyperechoic suspect mineral densities are noted within the right adrenal gland.

The left adrenal gland is normal in size (0.4 cm at cranial pole and 0.38 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.

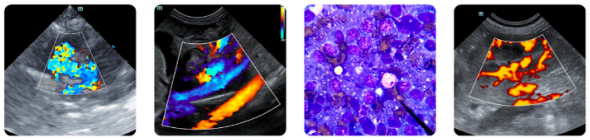
Liver

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.

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 empty with no evidence of obstruction or foreign material

The visible colon is diffusely very mildly thick, measuring 0.26 cm thick with normal intact layering.

Pancreas

The area of the pancreas contains irregular hyperechoic pancreatic remodeling.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

Mesenteric 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.

ULTRASONOGRAPHIC FINDINGS

- Subtle/mild 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.
- The mildly thick colon trends in appearance toward benign, as is seen, secondary to parasitic or infectious, dietary related, or other benign inflammatory conditions with infiltrative neoplasia being possible but considered less likely.
- Hyperechoic pancreas – This finding is suggestive of pancreatic fibrosis, possibly secondary to chronic pancreatitis. A TLI is recommended to rule out exocrine pancreatic insufficiency (EPI), especially if clinical signs (weight loss, diarrhea, etc.) are present.
- Mildly reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Mild 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.
- The right adrenomegaly should be interpreted in combination with patient's clinical history, as emerging adrenal disease, including potentially neoplastic disease effecting the right adrenal gland, can't be definitively ruled out.
- Mild bilateral chronic kidney disease changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given patient's clinical history, combined with the above findings, if not recently evaluated a routine fecal/giardia exam 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.

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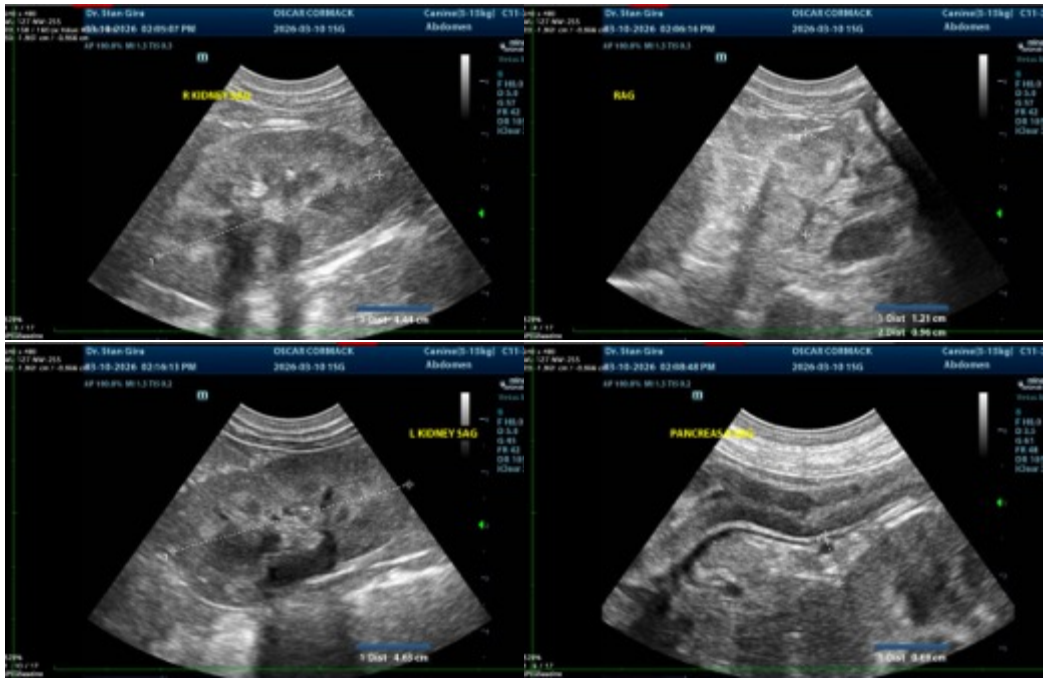
A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

In the meantime, supportive/symptomatic medical management of clinical signs is recommended, including a probiotic (such as visbiome or proviable), empirical deworming with a 5-day course of Panacur and, if tolerated, a transition in diet, based on trial-and-error response, beginning possibly with a gastrointestinal biome diet vs a hydrolyzed protein diet vs other. Some patients respond to one brand/version of a hydrolyzed protein diet better than another brand, so several brand attempts may be required.

The adrenal gland changes are of unknown and likely no significance to patient's reported diarrhea but may warrant further investigation beginning with a blood pressure if not recently evaluated.

Hormone testing could be considered in the form of a low dose dexamethasone suppression test, if patient is clinical for hyperadrenocorticism.

Ultimately, pending the full above workup, advanced imaging such as an abdominal contrast CT scan could be considered. Having said all of that, the adrenal changes could be unrelated, incidental, and even some normal patient variant.



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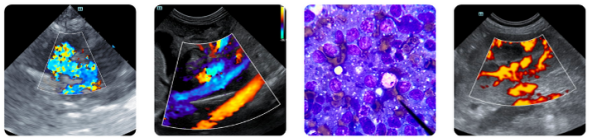

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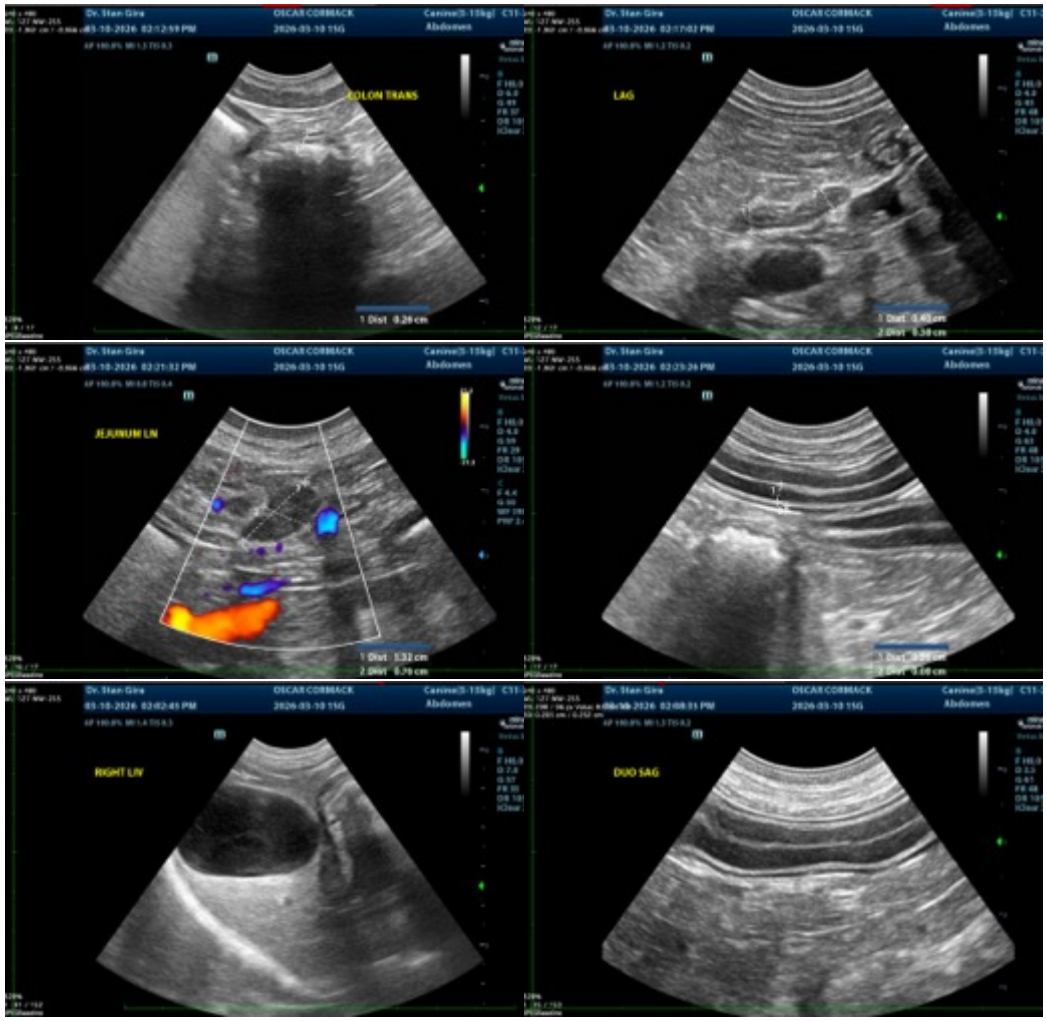

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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