

PATIENT

Lexie Kelly

SPECIES

Canine

BREED

Yorkshire Terrier

SEX

Spayed Female

AGE

8 Years

WEIGHT

18.2 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Quinn Robinson, RVT

HOSPITAL NAME

Hess Ridge Animal
Hospital

REFERRING VET

Kevin Frint, DVM

INVOICE

73367

DATE

3/3/26

PRESENTING CLINICAL SIGNS

Acute vomiting, ADR, decreased appetite, doing well after supportive care

Abnormal PE/Chem/CBC/UA Results: Neutrophils 10.7k, Platelets 681k, Calcium 7.6, TP 3.1, Albumin 1.5, Globulins 1.6, Cholesterol 84 Concern for IBD, lymphangiectasia, etc

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 right kidney is normal is size (4.67 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.

The left kidney is normal is size (4.15 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.

Adrenal Glands

The left adrenal gland is small (flattened contour), measuring 0.33 cm at the cranial pole and 0.29 cm at the caudal pole. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The area of the right adrenal gland is examined but the adrenal gland is unable to be well visualized.

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.

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.

Small intestine is diffusely mildly thick with a relatively thick mucosa compared to other layers. Normal wall layering is preserved; however, the mucosa is more echogenic than normal and contains



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hyperechoic striations perpendicular to the lumen. 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.

ULTRASONOGRAPHIC FINDINGS

- Lymphangiectasia – Small bowel findings are most consistent with lacteal dilation. These findings can be observed with protein-losing enteropathies caused by either primary lymphangiectasia or primary infiltrative inflammatory disease with secondary lymphangiectasia. Infiltrative neoplasia is possible but considered less likely. Histopathology is necessary to definitively determine underlying cause.
- Suspect subjectively flat adrenal glands – This can be a normal patient variant and/or a sign of exogenous cortisol administration. If exogenous steroids are not being administered, hypoadrenocorticism (either relative or absolute) should be considered.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- 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.
- Especially in the face of concurrent diarrhea, additionally 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.
- Ideally, biopsies of the GI tract are recommended to definitively diagnose and therefore manage the infiltrative bowel process.
- If biopsies cannot be obtained safely due to low albumin or patient stability, etc., empirical therapies could include diet change to an ultra-low-fat diet, empirical deworming with a 5-day course of Panacur, cobalamin supplementation (unless cobalamin level is evaluated and supplementation is not warranted) a probiotic and prednisolone (if not contraindicated based on patient contraindications, co-morbidities, etc.).



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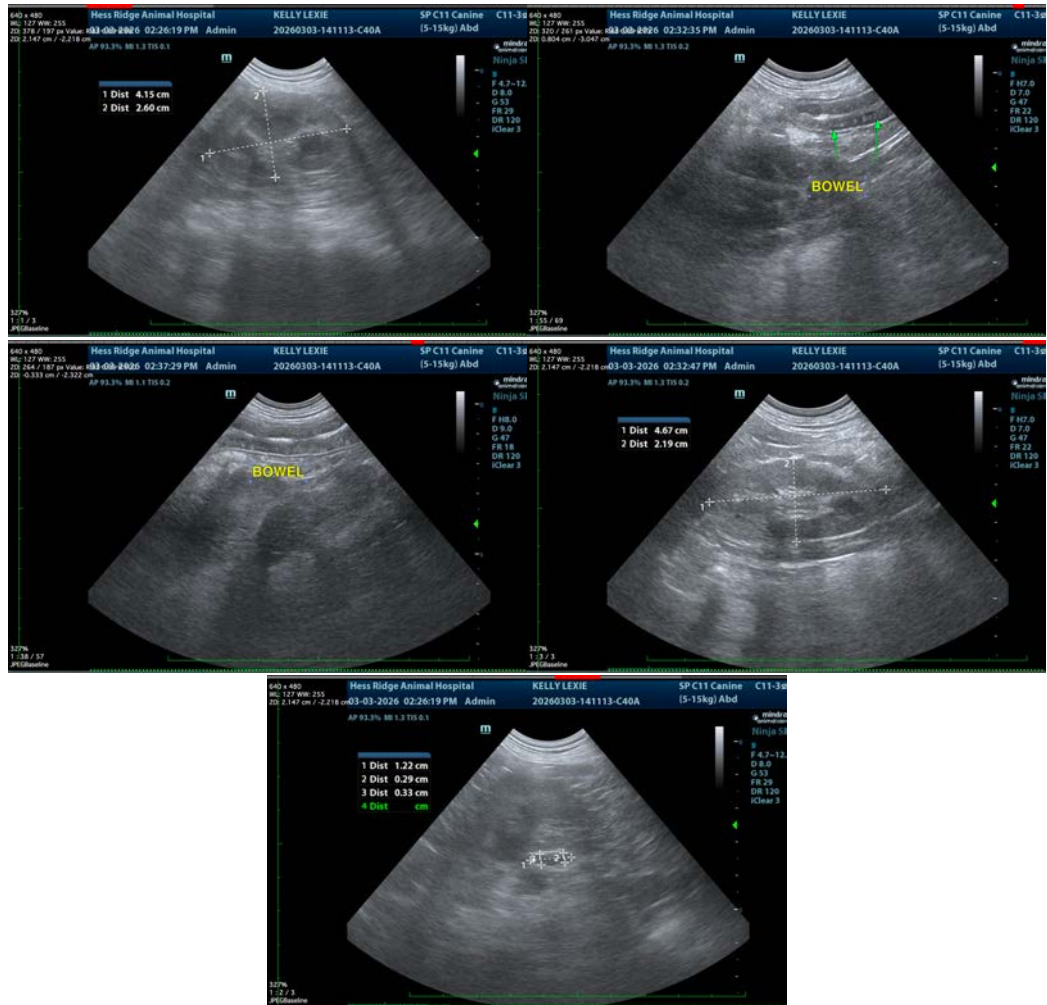
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- Calcium monitoring, and supplementation, if necessary, is also recommended.
- Additionally, if patient's coagulation status is otherwise appropriate, anti-thrombotics such as clopidogrel or low dose aspirin may also be warranted.
- If not recently evaluated, ruling out concurrent proteinuria is recommended via 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 ration is recommended.



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