



PATIENT

Tipper Sutton

SPECIES

Canine

BREED

Border Collie

SEX

Spayed Female

AGE

6 Years

WEIGHT

56 Pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Kelly Vazquez

HOSPITAL NAME

New Bridge VP

REFERRING VET

Dr. Abina Glennon

INVOICE

45752

DATE

3/8/23

PRESENTING CLINICAL SIGNS

Patient presents for inappetence since Sunday, concern for ingesta remaining in stomach. R/O hypomotility vs. FB vs. other. Had Cerenia injection.

Abnormal PE/Chem/CBC/UA Results: Normal Chem17 in-house.

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 (4.79 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 in size (6.15 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

Adrenal glands are small (flattened contour). Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. The right adrenal gland measures 2.59 cm long x 0.92 cm at the cranial pole and 0.32 cm at the caudal pole. The left adrenal gland measures 3.12 cm long x 0.27 cm at the cranial pole and 0.29 cm at the caudal pole.

Spleen

Spleen is generally normal in size and shape with a smooth capsular contour. Parenchyma is diffusely nodular in appearance characterized by small discrete hypoechoic nodules. 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 mildly distended with very echogenic reverberation artifact from intraluminal gas. Some fluid and non-shadowing luminal contents are also possible. There is no evidence of obstruction, foreign material or infiltrative disease; however, complete visualization of far wall is partially inhibited by gas. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). Small intestinal motility appears adequate (1-3 contractions



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per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

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The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

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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.

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Free Abdomen

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

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There is no apparent lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

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- **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.
- **Splenic micronodular hyperplasia pattern** – This nodular change is often associated with benign aging nodular hyperplasia. Infiltrative neoplasia, however, including both early hemangiosarcoma as well as round cell neoplasia cannot be ruled out.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is no visible evidence or concern of delayed gastric outflow or especially of gastric outflow obstruction. No gastric distention, etc. is present in these images at this time.

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Given this patient's decreased appetite, finishing the general metabolic health screening including, if not already evaluated in addition to the reported chemistry, a CBC, electrolytes, a urinalysis and, if indicated based on urinalysis results, urine culture are recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

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A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

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Pending results of the above, especially of the baseline cortisol/ACTH stimulation test, a fine needle aspirate of the spleen could be considered if patient's coagulation status is appropriate.

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If a diagnosis still is not obtained, next recommended steps are a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory for further evaluation of GI and pancreatic function.

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In the meantime, antiemetics, gastroprotectants, and appetite stimulants are recommended to help address subclinical nausea as well as the decreased appetite. Additionally, empirical deworming with a 5-day course of Panacur is recommended.

If vomiting begins as food is reintroduced, recheck imaging should be considered pending results of the above recommended diagnostic tests.



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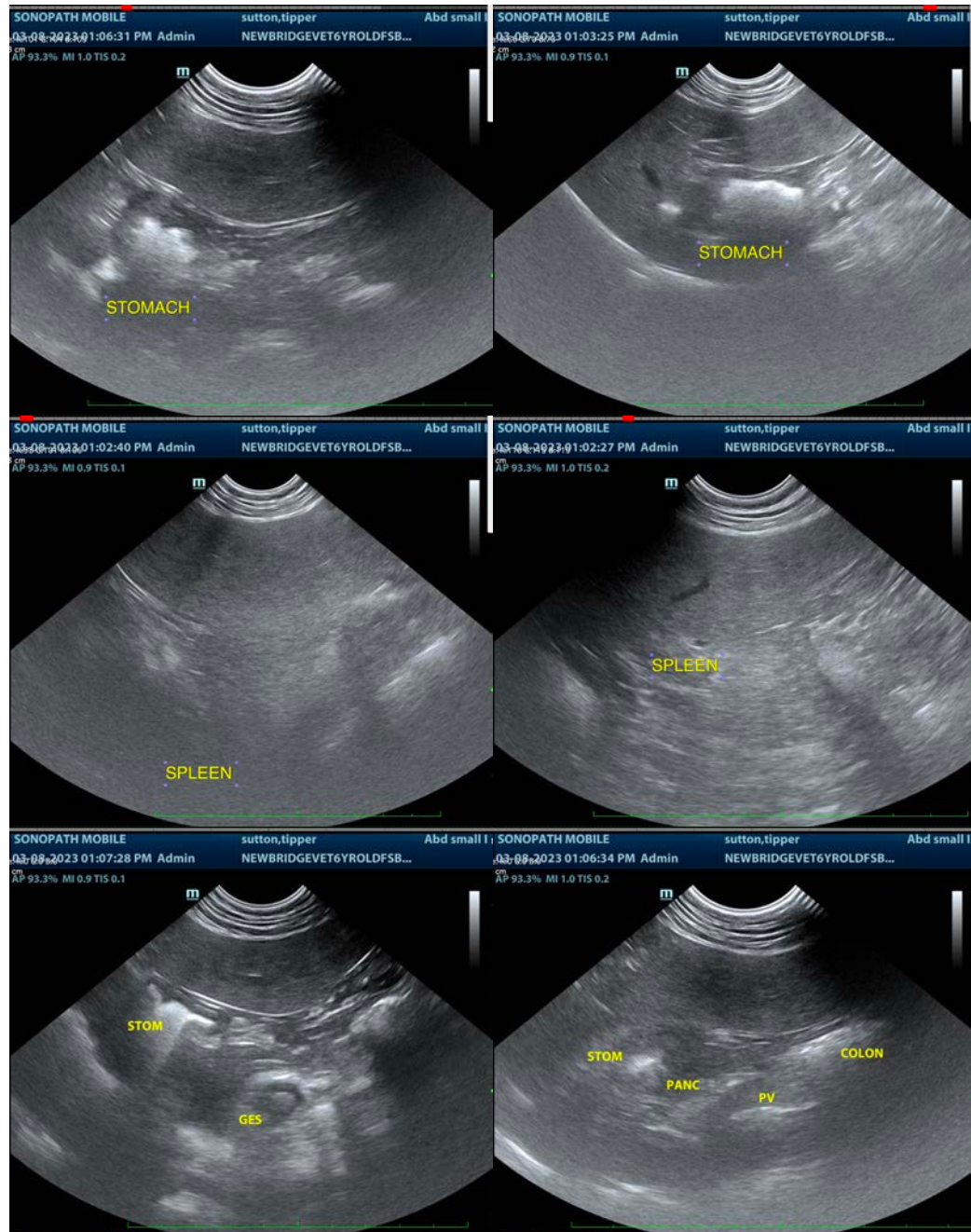
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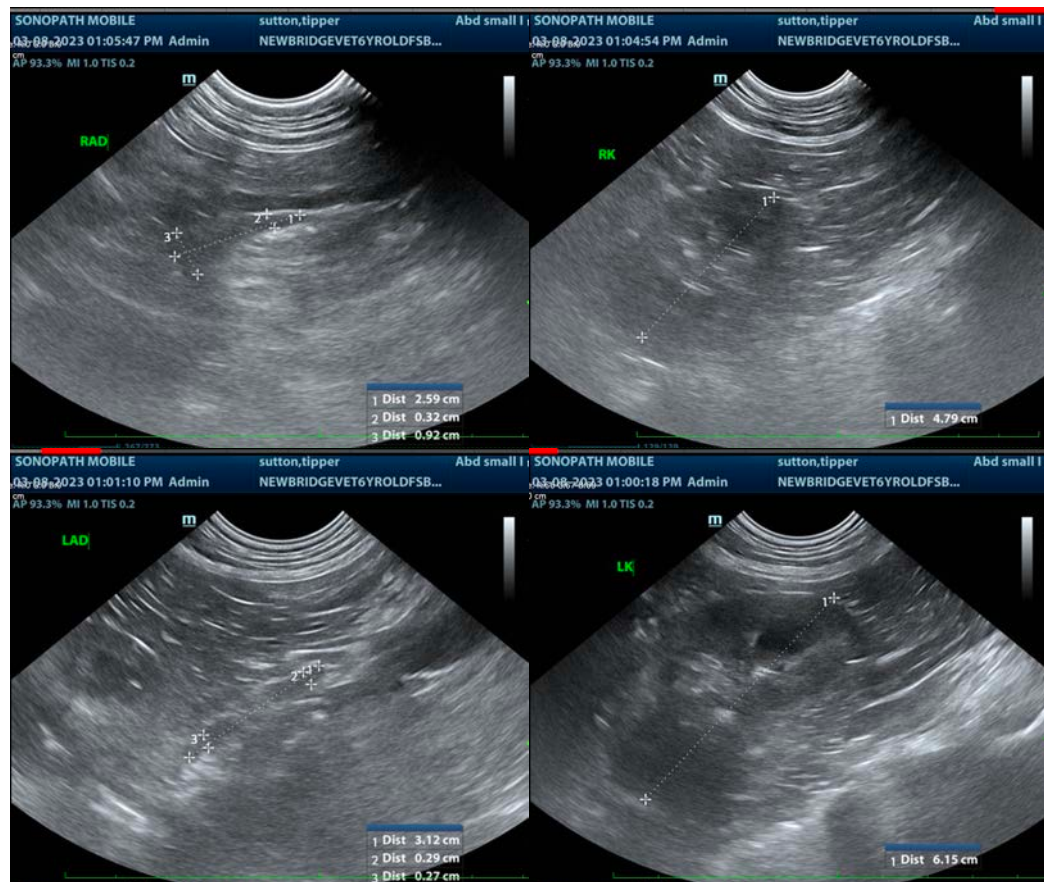
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
Beth.Johnson@sonopath.com