



PATIENT

Mokie Newman

SPECIES

Canine

BREED

Soft Coated Wheaten
Terrier

SEX

Neutered Male

AGE

12 Years

WEIGHT

35 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Julia Bakker, DVM

HOSPITAL NAME

Orange Blossom
Veterinary Imaging

REFERRING VET

Josie Hamilton, DVM

INVOICE

74529

DATE

4/16/26

PRESENTING CLINICAL SIGNS

Relevant Patient History and Primary Purpose for this Exam: Starting 1/30/26, I noticed during an exam that P was slow and stiff when rising laying down. Then, 2/27/26, P presented for cervical pain as he would not allow his O or the trainer to remove his harness (that goes over P's head) after a training session. P was sent home w/NSAIDs, Gabapentin, & Methocarbamol and seemingly improved. However, then P presented 4/7/26 because P won't let O touch/pet anywhere from the mid-thoracic region caudally for the past week or so. If O or us tries to pet him anywhere past head, chin, neck region - P turns around to snap at us and then moves away. O also notes P hasn't been as affectionate recently, isn't sleeping in her bed anymore, and frequently prefers to go off into "his room" and hang out by himself (pretty atypical for P). But, P gets groomed routinely and the groomer has never had an issue touching/grooming. There may be nothing wrong & P's current CS may all be behavioral, but we can't tell. Sedated today to take orthopedic rads and get an AUS for general screening

Abnormal PE/Chem/CBC/UA Results: FNA of splenic lesion A and B taken today for cytology

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 pyelectasia, mineral or infarcts observed. Left kidney measured 5.59 cm. Right kidney measured 5.23 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.89 cm at cranial pole and 0.91 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.69 cm at cranial pole and 0.52 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). Near the cranial aspect of the spleen is an approximately 1.0 cm x 1.5 cm non-capsule disrupting, non-expansive, mildly mixed, primarily hyperechoic density. Adjacent to that area is a 2nd 1.7 cm x 2.2 cm expansive, non-disruptive, hypo- to anechoic nodule. Splenic vasculature appears normal.



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Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is mildly heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. 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 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. If patient was appropriately fasted, delayed gastric emptying could be considered. Non-shadowing 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. Small intestinal motility appears adequate (1-3 contractions per min). The lumen is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta/chyme. There is no evidence of obstruction, foreign material or infiltrative disease.

In the caudal abdomen, adjacent to the urinary bladder, there is a loop of bowel that I believe is descending colon that is mildly to moderately thick, measuring 0.53 cm thick with normal intact layering. The lumen is empty.

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.

PRIMARY FINDINGS

- Suspect mildly to moderately thick descending colon – Trends in appearance toward a benign colitis i.e., parasitic, infectious, dietary related, other benign inflammatory versus other. Infiltrative neoplasia is possible but considered less likely.
- The hyperechoic splenic nodule is consistent with probable myelolipoma versus fibrosis or calcification of an old hematoma or infarct or other benign inflammatory density. Infiltrative or metastatic neoplasia can't be ruled out but is considered less likely. The hypo- to anechoic nodule similarly could represent a benign process such as nodular hyperplasia, extramedullary hematopoiesis, etc., but infiltrative neoplasia can't be ruled out without tissue sampling.



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SECONDARY FINDINGS

- Moderate age related kidney changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

As is reportedly already pending, fine needle aspirates of the spleen could be considered if patient's coagulation status is appropriate.

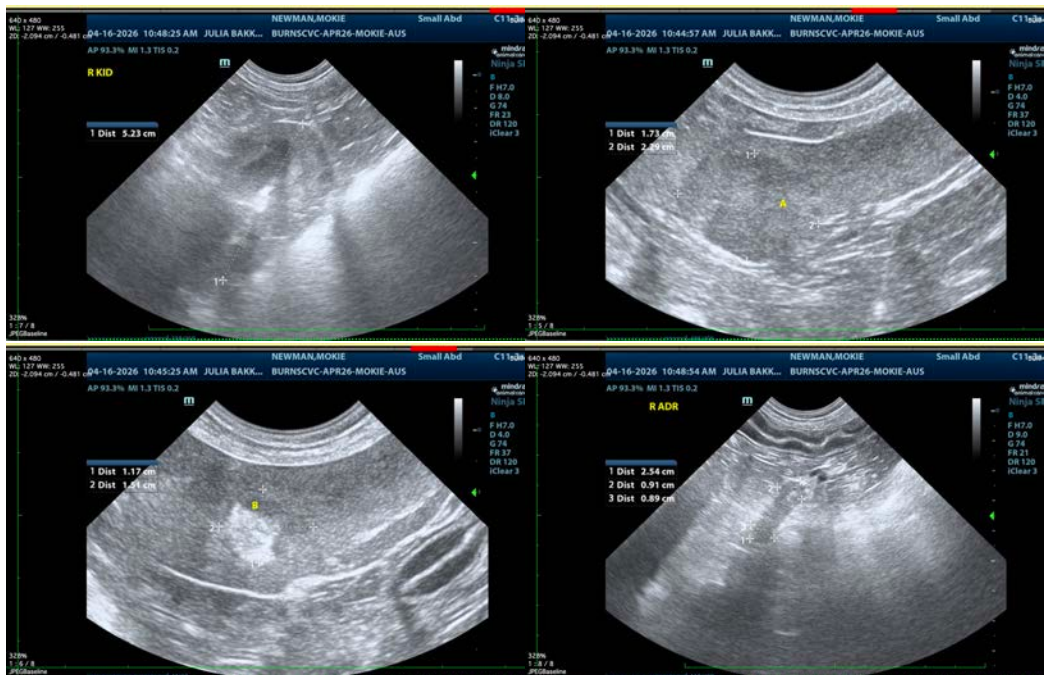
I suspect neither the spleen nor the colon are contributing to patient's reported clinical signs, but especially in the face of any concurrent gastrointestinal signs could warrant further gastrointestinal workup including a routine fecal/giardia exam if not recently evaluated.

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.

Ultimately, sampling of the colon may be warranted.

In the meantime, however, additional evaluation for contributing orthopedic and/or neurologic/spinal pain is recommended.





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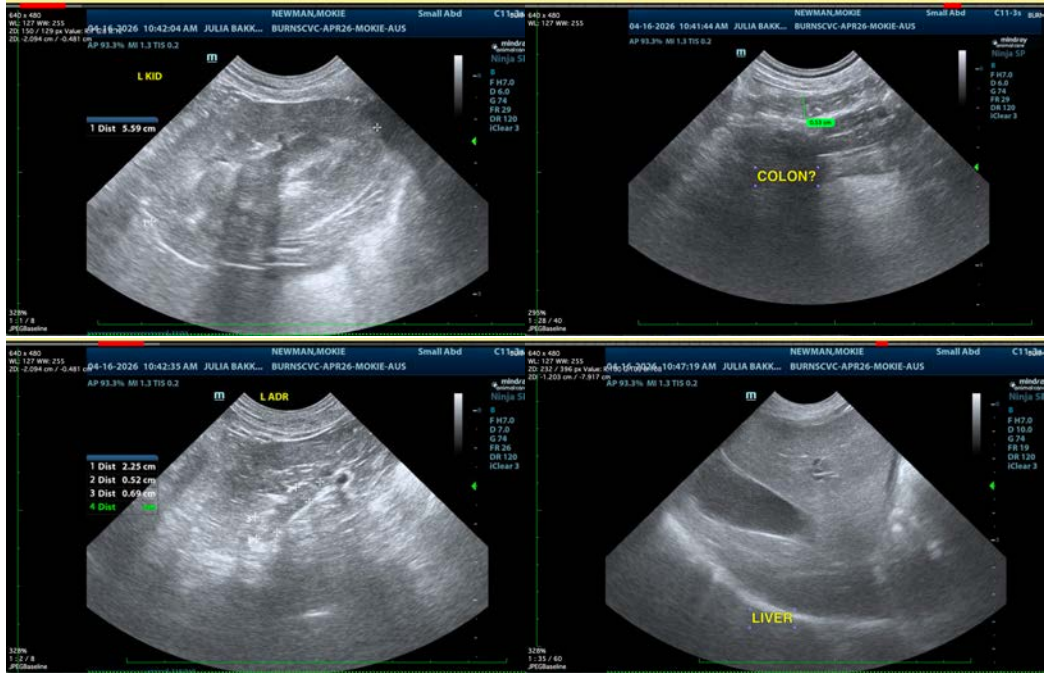
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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