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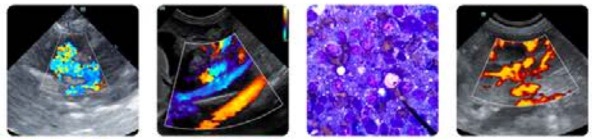


Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT
Wallace Hurd

SPECIES
Canine

BREED
Shih Tzu

SEX
Intact Male

AGE
4 Years

WEIGHT
10.7 lbs

INTERPRETED BY
Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY
Dr. Wasserman

HOSPITAL NAME
Village Pet Clinic

REFERRING VET
Dr. Defabio

INVOICE
74750

DATE
4/23/26

PRESENTING CLINICAL SIGNS

2-3 days history of worsening lethargy and inappetence. Not on hw/fecal parasite, and/or tick prevention. Fleas seen on exam. Initially presented 4/21/26 for abnormal behavior. Suspected thoracolumbar pain was detected on exam. Although, no neurological deficits detected. Patient was started on 125mg Methocarbamol PO BID/TID as needed, Gabapentin 50mg PO BID/TID as needed, and Prednisone 2.5mg PO SID q 3 days, and then to start taper 2.5mg PO EOD for 3 days. Sedated with butorphanol IM for sonogram. At SDEP position 11, patient had abdominal discomfort, administer 0.1ml dexdomitor 0.5mg/ml IM. This was adequate to continue the sonogram.

It is questionable whether this patient ever recieved the prednisone dispensed 2 days ago in this case. Patient is inappetent. Referring veterinarian suspects no oral medications were given since patient is inappetent reported at home.

Abnormal PE/Chem/CBC/UA Results: Intact Male, no masses felt on testicles, Diagnostics obtained today: CBC: WBC: 58k, Neutrophils 53k Chemistry: NA 136mmol, K 3.0mmol, ALB: 1.9g/dl, ALP 269, Baseline Cortisol: 12. 6ug/dL No other abnormals on in house bloodwork. No azotemia. Fecal not current. Urinalysis by cystocentesis pending. 4dx negative x 4.

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 (2.1 cm wide in the transverse view) for an intact male. Parenchyma is diffusely homogenous and relatively hyperechoic. Normal distinct margins and symmetrical bilobed shape are maintained.

Polycystic kidneys -
Multiple cortical anechoic cysts of various sizes are present. Overall echogenicity is increased (hyperechoic cortex) as the result of acoustic enhancement from the cysts and kidney shape is distorted. Left kidney measures 4.98 cm. The largest cyst is in the caudal pole of the left kidney measuring 2.0 cm. The right kidney measures 5.17 cm.

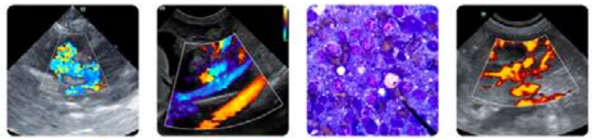
Adrenal Glands

The right adrenal gland is normal in size (0.67 cm at cranial pole and 0.49 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.39 cm at cranial pole and 0.48 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.



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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 is mildly distended with primarily fluid as well as some echogenic non-shadowing luminal contents and gas consistent with normal chyme. There is no evidence of obstruction, foreign material, or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The colon is mildly thick in the proximal descending portion, measuring 0.40 cm thick, with normal intact layering and an empty lumen.

Pancreas

Pancreas is prominent (enlarged) in size and mildly irregular in shape with a slightly undulating contour. Parenchyma is coarse in echotexture and heterogenous to hypoechoic in echogenicity.

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.

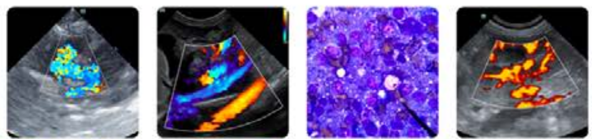
Both testicles are visualized without evident testicular pathology.

ULTRASONOGRAPHIC FINDINGS

- Polycystic kidneys – Cysts may be inherited or acquired and may be a subclinical incidental finding or the result of chronic degenerative kidney disease. This finding should be interpreted in combination with breed (inherited polycystic renal disease is more common in some breeds including, but not limited to, Persian cats, cairn terriers and bull terriers), laboratory findings and clinical signs.

- Chronic low-grade smoldering pancreatitis can’t be ruled out and should be suspected in the face of appropriate clinical signs.

- The mildly thick colon trends in appearance toward benign as is seen with infectious or parasitic, dietary related, other benign inflammatory colitis, with infiltrative neoplasia being



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possible but exceedingly less likely. This finding should be interpreted in combination with patient's clinical signs as it is subtle.

- 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.

- Mild reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes described above are largely subtle and of unknown if any contribution to patient's reported inappetence, marked leukocytosis, hypoalbuminemia, etc. Therefore, further general metabolic evaluation is recommended, beginning with definitively determining whether the patient was receiving steroids when the cortisol level was evaluated, because a reliable baseline cortisol is recommended.

A routine fecal/giardia exam is recommended.

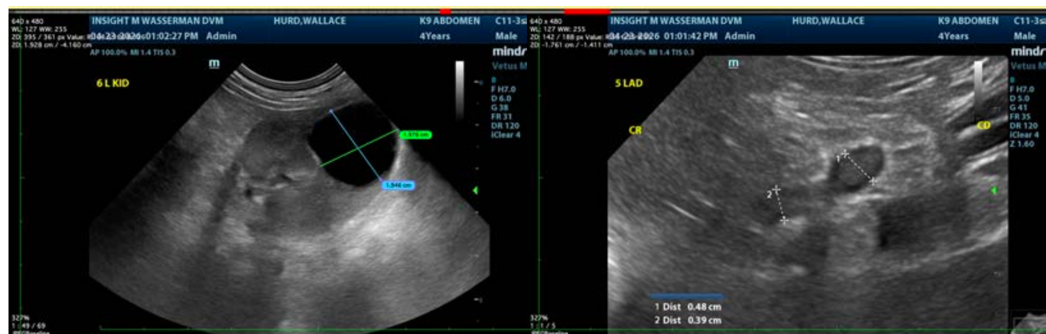
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

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.

As is reportedly already pending, 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 ratio is recommended.

If a reason for the leukocytosis i.e., infectious disease, potentially a leukemoid reaction from the steroids if the timing is appropriate versus other is not diagnosed, additionally a pathology review of the CBC could be considered.

Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.



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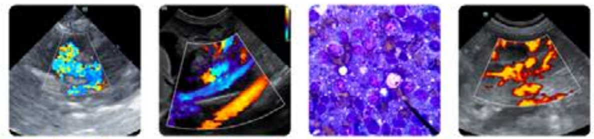

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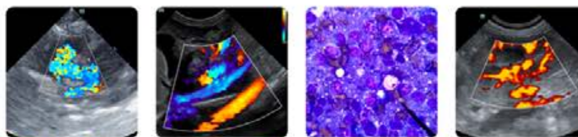

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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
info@sonopath.com