



PATIENT

Gunther Munir

SPECIES

Canine

BREED

Boster Terrier X

SEX

MN

AGE

10 years

WEIGHT

9.7

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Gira

HOSPITAL NAME

Little Creek PH

REFERRING VET

Dr. Mutlow

INVOICE

11807

DATE

4/27/2026

PRESENTING CLINICAL SIGNS

Gunther presented for a history of pray posturing which started back in the fall. He had been better on a gastro diet. Yesterday he started prayer posturing again and vomited a large volume of bile. He was not interested in his breakfast. Vomiting /diarrhea (chronic) , previously borderline low ALB levels. Tried multiple diets and medications in the past.

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.

The right kidney is normal is size (4.58 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 (4.27 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 right adrenal gland is normal in size (0.46 cm at cranial pole and 0.57 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.53 cm at cranial pole and 0.49 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large 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.

The spleen is folded upon itself, which is a positional non-pathologic variant.

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. In the right liver there is a discrete homogenous, hypo- to anechoic density/nodule measuring 0.9 cm in diameter. 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



PATIENT

Gunther Munir

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction or foreign material noted. Pyloric outflow tract appears patent.

SPECIES

Canine

Diffusely 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 mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction or foreign material noted.

BREED

Boster Terrier X

However, focally in the mid abdomen there is a loop of jejunum that depending on view ranges between 0.53 cm and 0.7 cm thick, with some less distinct than normal layering appreciated in the area depending on view. Having said that, layering/mural detail is not fully lost.

SEX

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

MN

Pancreas

AGE

10 years

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.

WEIGHT

9.7

Free Abdomen

INTERPRETED BY

Beth Johnson, DVM
DACVIM

There is a very scant/trace amount of anechoic free fluid in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

IMAGING PERFORMED BY

Dr. Gira

- Diffusely 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 focal thickness described above may represent just a more severe area of the same diffuse disease or a focally different disease with both benign inflammatory, as well as infiltrative neoplastic differentials being possible and unable to be differentiated without tissue sampling.
- Trace/scant free fluid is of unknown origin. Differentials (unless already ruled out) could include increased hydrostatic pressure (cardiac disease and/or vascular or lymph blockage), decreased oncotic pressure (low albumin), vasculitis, paraneoplastic fluid, rupture/leakage of/from an organ (GI, GB, UB, other), blood (hemoabdomen), other.
- The liver nodule trends in appearance toward benign as is seen with nodular hyperplasia, cysts, hematoma, other benign inflammatory lesion, although infiltrative neoplasia including a metastatic nodule, while thought much less likely, can't be ruled out.
- 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.

HOSPITAL NAME

Little Creek PH

REFERRING VET

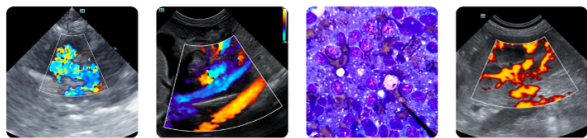
Dr. Mutlow

INVOICE

11807

DATE

4/27/2026



PATIENT

Gunther Munir

SPECIES

Canine

BREED

Boster Terrier X

SEX

MN

AGE

10 years

WEIGHT

9.7

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Gira

HOSPITAL NAME

Little Creek PH

REFERRING VET

Dr. Mutlow

INVOICE

11807

DATE

4/27/2026

- Splenomegaly- can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

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.

Pending results of above, ultimately, biopsies of the GI tract being sure to include the focally thicker area described above, if possible, may be necessary for a definitive diagnosis and therefore to further guide medical management. If elected, less invasive tissue sampling could be considered prior to obtaining biopsies, beginning with fine needle aspirates of the spleen +/- the liver nodule and potentially even the focally thick bowel, if patient's coagulation status is appropriate.

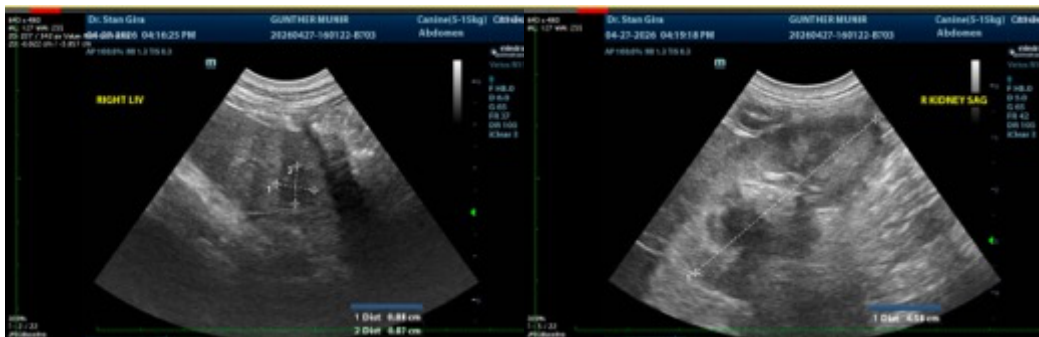
Supportive/symptomatic medical management of clinical signs is recommended, including anti-emetics, gastroprotectants (+/- sucralfate, especially with any history of hematemesis), an appetite stimulant and fluid therapy if indicated, etc.

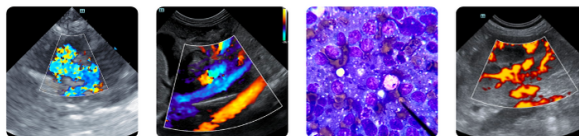
Additionally, empirical deworming with a 5-day course of Panacur is recommended.

A full course of empirical Helicobacter triple therapy could be considered.

A probiotic, such a visbiome or proviable, may be helpful.

Finally, if tolerated, a transition in diet could be considered, based on trial-and-error response with some options to consider including a gastrointestinal biome diet vs a hydrolyzed protein diet (sometimes several trials with different brands are necessary) vs an easy to digest, bland or low-fat diet vs other.





PATIENT

Gunther Munir

SPECIES

Canine

BREED

Boster Terrier X

SEX

MN

AGE

10 years

WEIGHT

9.7

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Gira

HOSPITAL NAME

Little Creek PH

REFERRING VET

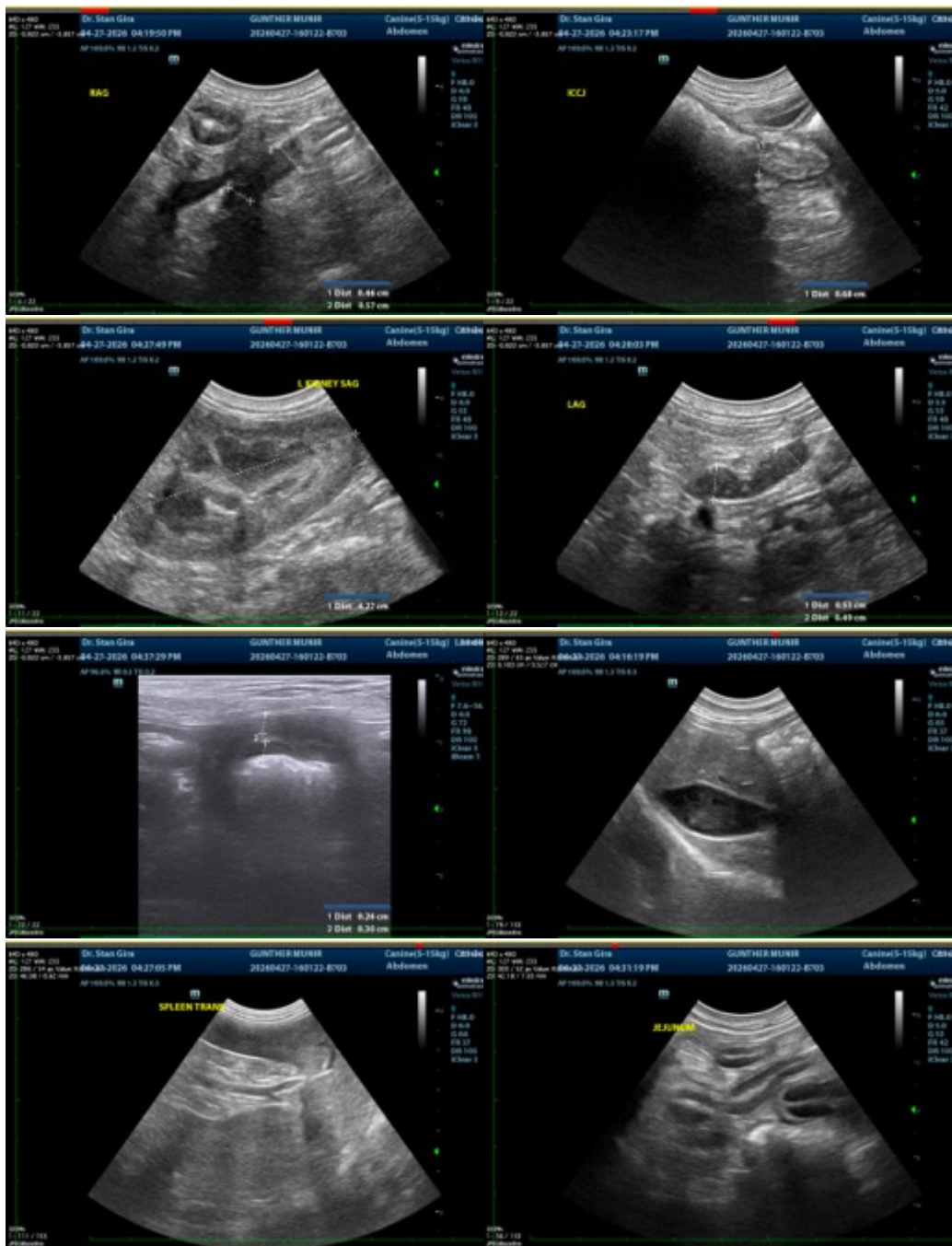
Dr. Mutlow

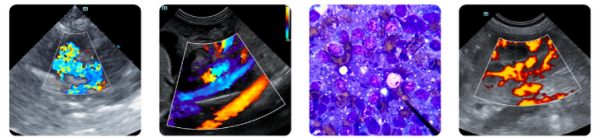
INVOICE

11807

DATE

4/27/2026





PATIENT

Gunther Munir

SPECIES

Canine

BREED

Boster Terrier X

SEX

MN

AGE

10 years

WEIGHT

9.7

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Gira

HOSPITAL NAME

Little Creek PH

REFERRING VET

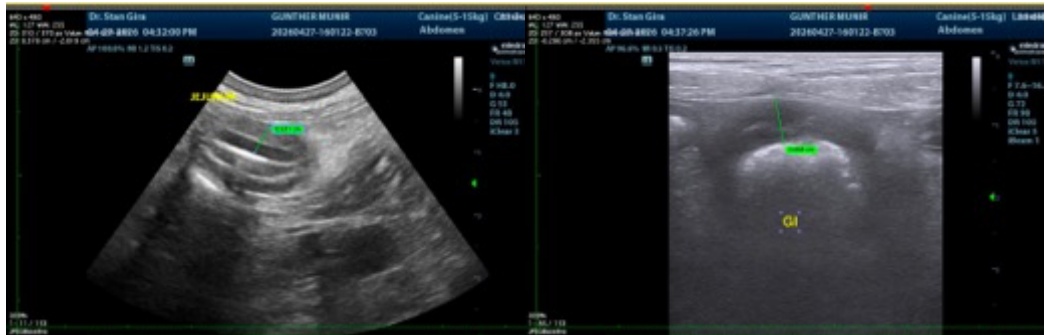
Dr. Mutlow

INVOICE

11807

DATE

4/27/2026



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