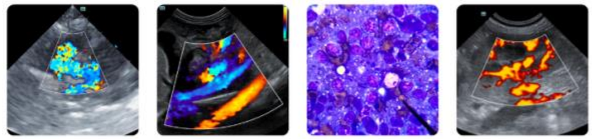


PATIENT
Molly Mae Landers

SPECIES
Canine

BREED
Dachshund

SEX
Spayed Female

AGE
2 Years

WEIGHT
4.1 kg

INTERPRETED BY
Beth Johnson, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY
Jessica Milligan, DVM

HOSPITAL NAME
Dockside VI

REFERRING VET
Dr. Patel, DVM

INVOICE
36843

DATE
4/28/26

PRESENTING CLINICAL SIGNS

History: 4/21: vomiting, lethargy, diarrhea - out patient with Cerenia and fluids. no diagnostics elected. 4/24: Hospitalized for not improving and continued anorexia. Hospitalized on supportive care. Discharged next day cause responded and was eating normally. CBC: unremarkable, Chem/Lytes: low amylase otherwise unremarkable, PL: WNL, Cortisol: 3, Rads: 1. The material in the stomach may be digestible or non-digestible. Consider retake radiographs after 8-12 hours of medical management, fluid resuscitation and fasting to monitor the gastrointestinal pattern. 2. Unremarkable intrathoracic structures. Recheck rads: Progressive gastric emptying. The upper GI tract is normal in size without evidence of obstruction. Serosal detail is thought to be adequate for body condition, and the abdomen is currently unremarkable. A clear cause of recent inappetence/anorexia is not identified. 4/27: diarrhea, vomiting, not eating since discharge. UA: glucosuria (most likely from stress) otherwise WNL, PCV/TS: 44% and 6.2g/dL BG: 91 Lactate: 1.3

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

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.

Left kidney is normal in size (4.07 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.

Right kidney is normal in 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

Left adrenal gland is normal in size (0.49 cm at cranial pole and 0.57 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

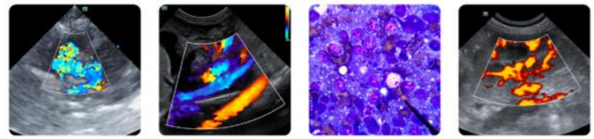
Right adrenal gland is normal in size (0.81 cm at cranial pole and 0.57 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

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

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.



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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.

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 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.

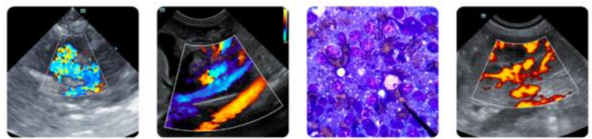
There is very subtle subjectively enhanced hyperechoic fat and mesentery appreciated throughout parts of the cranial and mid-abdomen.

ULTRASONOGRAPHIC FINDINGS

- Possibly enhanced mesentery and fat throughout the cranial and mid-abdomen, could indicate some mild or chronic low-grade smoldering versus emerging pancreatitis, or could just be secondary to ongoing or resolving gastroenteritis. The change is very subtle, however, and could be normal patient variant.
- Otherwise, this is a largely unremarkable/normal structural abdomen without a definitive ultrasonographically visible intraabdominal explanation for patients reported gastrointestinal signs.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A routine fecal/Giardia exam is recommended 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.



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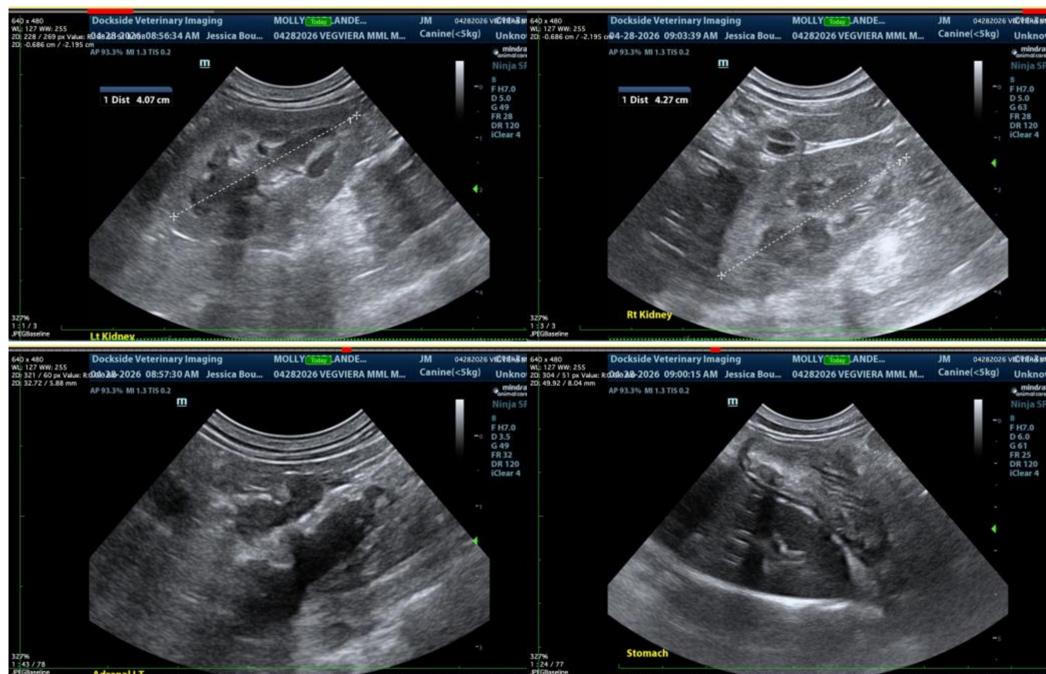
- As was reportedly already evaluated, a baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.
- Supportive/symptomatic medical management of clinical signs is recommended, including anti-emetics, gastroprotectants (+/- 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.



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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