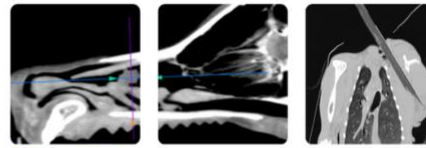


PATIENT

Bear Thompson

SPECIES

Canine

BREED

Rough Collie

SEX

Neutered Male

AGE

11 Years

WEIGHT

38 kg

INTERPRETED BY

Beth Johnson, DVM, DACVIM (SAIM)

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Acton VC

REFERRING VET

Dr. Shah

INVOICE

37065

DATE

5/11/26

PRESENTING CLINICAL SIGNS

History: Apr/21/2026, Has vomited before but this is too frequent, Vomited about 6 times in small clear bile like, Softer stool than normal, P is currently on budesonide 1mg EOD of IBD dx years ago and Omega 3 EOD (opposite of budesonide), P is constantly pacing around the house unless sleeping, Seems restless at all times, Cognitive dysfunction has escalated since late time, Changed in personality in the last couple of weeks, ADR, P was treated with Tylosin, Omeprazole and Sulcrate, but the diarrhea continued, Then P was increased to 2mg Budesonide SID, still no change in diarrhea

Current Medications: Budesonide 2mg SID, Fortiflora, Omeprazole 20 mg SID, Sulcrate 1g TID

Abnormal PE/Chem/CBC/UA Results: 1. neutrophilia 12.98 X 10^9/L 2. ALP 220U/L and ALT 200U/L 3. cholesterol 13.02mmol/L Radiographic Findings Not done Primary Question to Be Answered in This Exam IBD Flare up or cancer BW attached.

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.

The area of the prostate is examined without evident prostatic pathology.

Left kidney is normal in size (6.94 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 (6.19 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

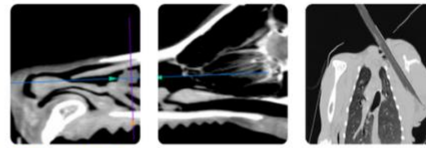
Left adrenal gland is small (flattened contour). Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. The left adrenal gland measures 0.25 cm at the cranial pole and 0.35 cm at the caudal pole.

Right adrenal gland is normal in size (1.8 cm at cranial pole and 0.91 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



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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.

Gallbladder is moderately overdistended with organized, aggregated and centralized non-gravity dependent sludge. Striations of sludge separated by anechoic areas are noted extending from the lumen to the luminal wall. The wall is mildly thick, irregular and hyperechoic. There is no evidence of CBD 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 of the small intestine 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.

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

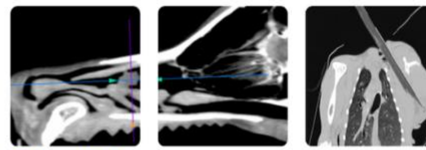
There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Gallbladder mucocele
- Mildly heterogenous liver- These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.
- The flat left adrenal gland is likely secondary to patient's reported steroid history.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS



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A flare-up of patients reported previously diagnosed inflammatory bowel disease can't be ruled out and further investigation for possible concurrent parasitic and/or infectious disease, as well as assessment of absorption and digestion is recommended, beginning with a routine fecal/Giardia exam if not recently evaluated.

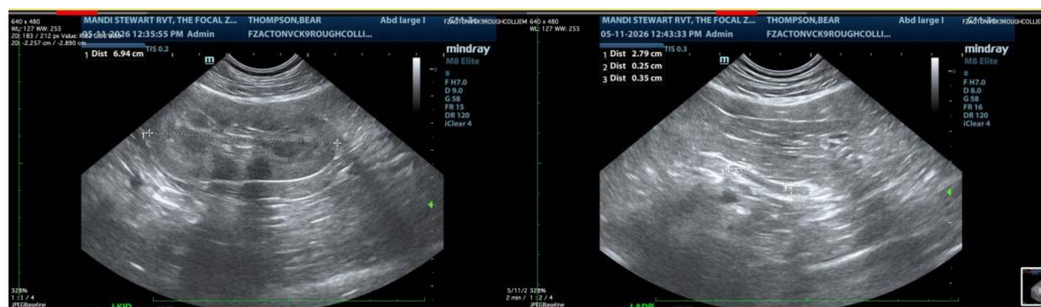
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

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.

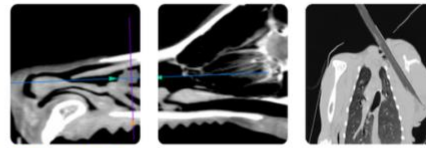
Additionally, however, the suspected mucocele is of unknown contribution and should potentially be suspected as a contributing factor, contributing to the vomiting, especially if accompanied by decreased appetite, cranial abdominal pain, etc., although it could be a non-clinical incidental finding. Treatment recommendations for the mucocele range from empirical supportive medical management in the form of hepatic nutraceuticals such as ursodiol, etc., up to and including a possible cholecystectomy if clinical signs persist and they're believed to be related to the mucocele.

In the meantime:

- 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.



The Focal Zone
FUELED BY SONOPATH VETERINARY ULTRASOUND



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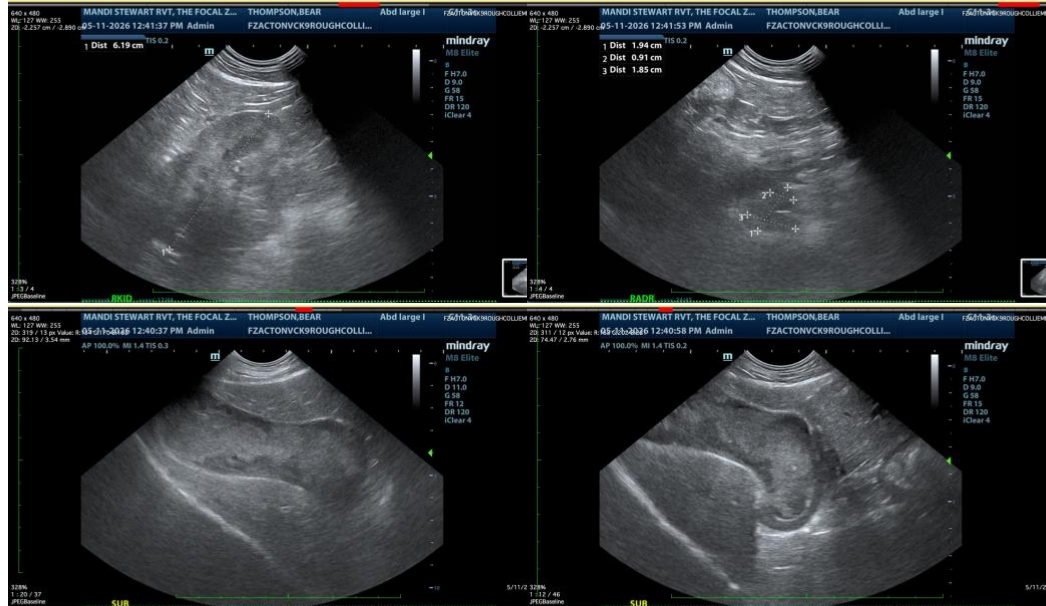

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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