



**PATIENT**

Rufus Clemens

**SPECIES**

Canine

**BREED**

German Shorthair  
Pointer

**SEX**

Neutered Male

**AGE**

4 Years

**WEIGHT**

70 Pounds

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**IMAGING PERFORMED BY**

Dr. Jack Reese

**HOSPITAL NAME**

Willow Run VC

**REFERRING VET**

Dr. Jack Reese

**INVOICE**

38766

**DATE**

6/16/22

**PRESENTING CLINICAL SIGNS**

Several month history of intermittent inappetence and vomiting. Owner reports recently that Rufus very reluctant to eat and is losing weight (76lbs on 6/11/22). Recent ingestion of chicken bone seemed to trigger most recent GI upset, previously had been doing OK on Purina Pro Plan Sensitive Skin and Stomach (last episode in April 2022).

Abnormal PE/Chem/CBC/UA Results: CBC WNL TBil - 1.1 (0.0-0.9) All other values WNL Pending maldigestion panel

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder is moderately 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 (neutered) is normal in size, echotexture and echogenicity for a neutered male.

The right kidney is normal in size (5.92 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. A hyperechoic band parallel to the corticomedullary border is present.

The left kidney is normal in size (6.52 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. A hyperechoic band parallel to the corticomedullary border is present.

**Adrenal Glands**

The right adrenal gland is normal in size (0.49 cm at the cranial pole and 0.59 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.59 cm at the cranial pole and 0.48 cm at the caudal pole), shape and contour. Corticomedullary structure is unremarkable. 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.

**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.

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.



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**Gastrointestinal**

The stomach wall is normal in thickness (canine < 0.5 cm and feline < 0.4 cm) 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, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering (canine duodenum < 0.5 cm and feline duodenum < 0.4 cm; other < 0.3 cm). Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty, except for the duodenum, which contains some echogenic chyme/ingesta. This could be consistent with bone fragments. However, there is no evidence of enhanced tissue to signify inflammation, no obstructive pattern, no plication, etc.

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

**Pancreas**

The pancreatic parenchyma is appropriately isoechoic to surrounding tissue. Visible capsule is smooth and normal in contour. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

**Free Abdomen**

There is no evidence of peritoneal effusion. There is no apparent lymphadenopathy.

**ULTRASONOGRAPHIC FINDINGS**

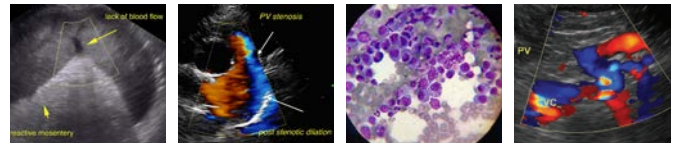
- Medullary Rim Sign - of unknown clinical significance and can be a normal variant. Medullary rim sign(s) should be interpreted in combination with other more specific indications of kidney disease such as isosthenuria, proteinuria, azotemia, etc.
- Relatively unremarkable abdomen otherwise

\*\*There is some echogenic chyme/ingesta in the stomach and proximal duodenum that could be consistent with bone fragments. However, there is no evidence of obstructive pattern, plication, or enhanced peribowel fat to imply inflammation.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Based on this patient's history, ultrasound, etc., top differential for the acute clinical signs is potentially a dietary indiscretion flare up of mild food allergy or inflammatory bowel disease, etc. Therefore, recommendations to further workup gastrointestinal disease include the already reportedly pending maldigestion panel to Texas A&M GI laboratory. A baseline cortisol could be considered, followed by full ACTH stimulation test if the baseline cortisol is <2.0.

In the meantime, empirical deworming with a 5-day course of Panacur is recommended, as well as transition to a novel or hydrolyzed protein diet as a diet trial. If diet change does not result in an improvement of the intermittent clinical signs, ultimately biopsies of the gastrointestinal tract may be warranted.



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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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