



**PATIENT**

Buster Markland

**SPECIES**

Canine

**BREED**

Border Collie Cross

**SEX**

Neutered male

**AGE**

13 years

**WEIGHT**

22.4 kg

**INTERPRETED BY**

Beth Johnson, DVM  
DACVIM

**IMAGING PERFORMED BY**

Dr Markland

**HOSPITAL NAME**

Island Mobile Paws VS

**REFERRING VET**

Dr. Markland

**INVOICE**

31270

**DATE**

6/28/22

**PRESENTING CLINICAL SIGNS**

History: Buster is my dog. In April, he began having focal seizures. He has an exam scheduled with a neurologist tomorrow. PE, CBC/Chem, T4/TSH, and UA are all unremarkable. 3-view thoracic radiographs are unremarkable. ECG and echo will be sent to IDEXX. Preliminarily, I see a mild MV regurg with good function, but I have not done a complete echo yet. No murmur is noted on auscultation. Buster is on multiple OA medications with no changes in the past few years. OA drugs: Galliprant, 50 mg PO SID Gabapentin, 300 mg PO BID Dasuquin, 1 large dog tab PO SID CBD (no THC) 33 mg PO BID 4-Cyte supplement SID Buster also has anxiety, treated with trazodone. I did reduce his trazodone dose from 100 mg PO BID (he had been on this for > 4 years) to 50 mg PO SID about a month ago with no apparent change in focal seizures noted. He has been on ursodiol since an abdominal ultrasound in April showed likely calculus in the gallbladder. This limited study is similar to the April study. Buster has had a large and somewhat coarse spleen for at least 3 years.

**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 prostate is normal for a neutered dog.

Left kidney is normal is size (6.07 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 is size (6.28 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 (2.0 cm long, 0.61 cm at cranial pole and 0.6 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (1.84 cm long, 0.63 at cranial pole and 0.53 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

**Spleen**

Spleen is subjectively large in size with normal smooth margins. Parenchyma is normal in echogenicity with a coarse/heterogenous echotexture. No focal nodules or masses are observed. Splenic vasculature appears normal.



**PATIENT** *Liver*

Buster Markland

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.

**SPECIES**

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Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. Cholecystoliths were noted. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

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**Gastrointestinal**

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The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material or infiltrative disease; however, complete visualization of far wall is partially inhibited by gas. Pyloric outflow tract appears patent.

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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.

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

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**Pancreas**

The observed pancreas 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.

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**Free Abdomen**

There is no evidence of peritoneal effusion or apparent lymphadenopathy noted in these images.

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**ULTRASONOGRAPHIC FINDINGS**

**Primary Findings**

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**Coarse 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, amyloidosis (leave amyloidosis out if canine) as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.

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**Cholecystoliths.**

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

1. Blood pressure measurements are recommended if not recently evaluated.



**PATIENT**

Buster Markland

- The neurologic evaluation as is reportedly planned/scheduled. In the meantime, and or if something changes therapy with Kepra could be considered due to the seizures reported.

**SPECIES**

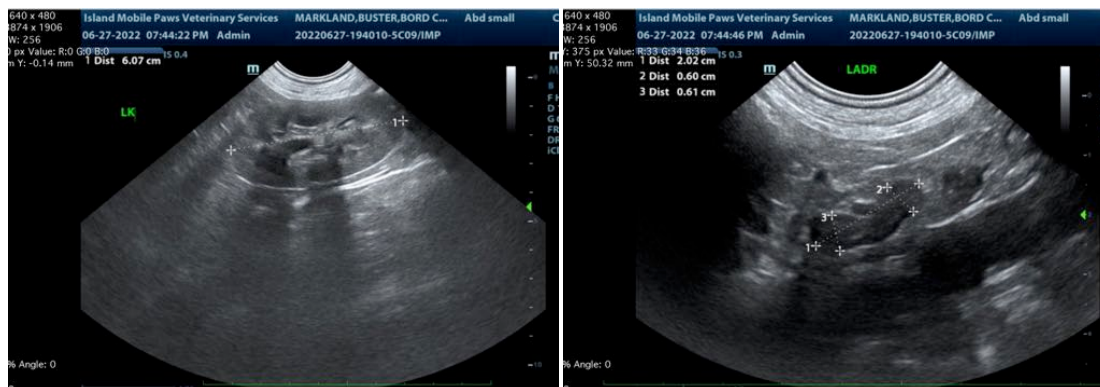
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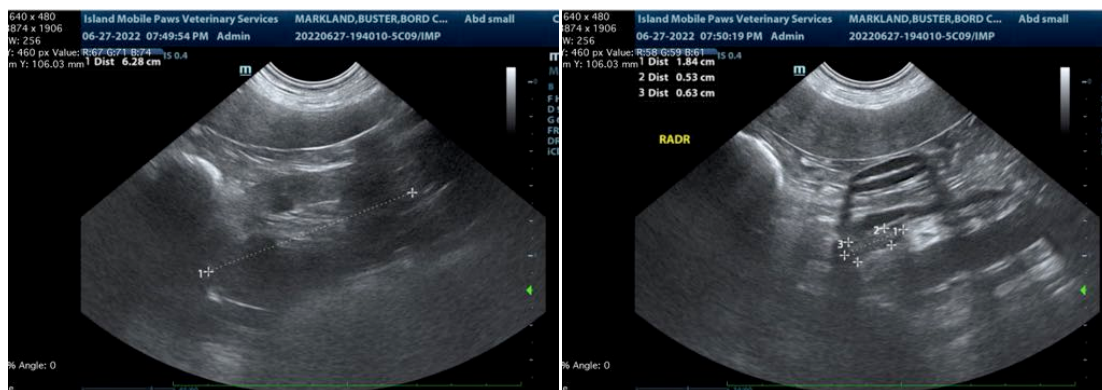


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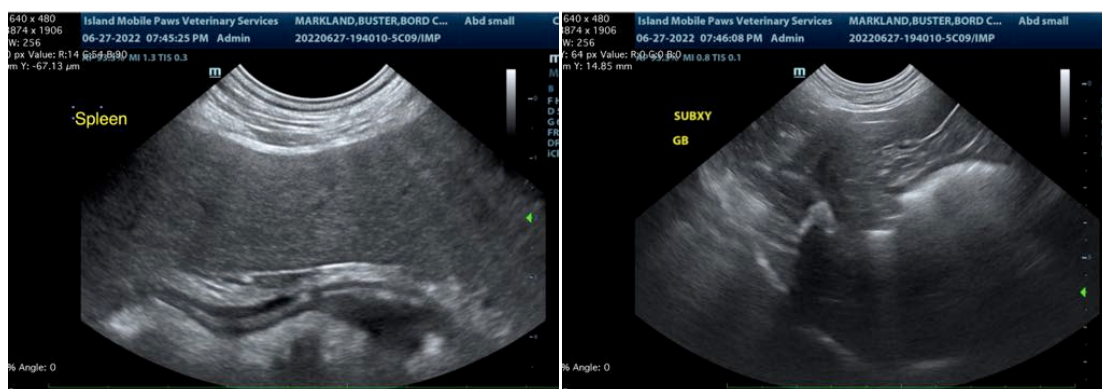
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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.

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Beth Johnson, DVM DACVIM

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