



PATIENT

Cookie Hasan

SPECIES

Canine

BREED

Bichon Frise Mix

SEX

Spayed Female

AGE

8 Years 5 Months

WEIGHT

9 kg

INTERPRETED BY

R. McKenzie Daniel,
DVM, DABVP

IMAGING PERFORMED BY

Dr. Jill Rankin

HOSPITAL NAME

Alpine 24 Hour Pet
Hospital

REFERRING VET

Dr. Sasha

INVOICE

12056

DATE

11/03/25

PRESENTING CLINICAL SIGNS

Cookie is a 8y-year 5mo-old patient with a history of chronic vomiting and diarrhea, with a primary concern for severe Inflammatory Bowel Disease (IBD) or other underlying conditions given her age. The patient was previously managed on a Purina gastro low-fat diet but experienced a recurrence of vomiting after a period of inappetence led her owners to switch to a home-cooked chicken diet. While metronidazole would temporarily resolve the vomiting, a cycle of inappetence and dietary changes continued. A recent trial of a "biome" dry diet was started on a recent Friday, but the patient subsequently developed diarrhea again the day before this visit, indicating ongoing gastrointestinal instability.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of – cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic change were noted.

Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 4.8 cm in length. The right kidney measured 4.7 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.62 cm width at the caudal pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.57 cm width at the caudal pole.

Spleen

The spleen exhibited normal size and contour with primarily homogenous parenchyma. A solitary discrete nondisruptive hypoechoic nodule was visualized measuring 0.46 cm in diameter.

Liver

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering. The stomach was nondistended containing a mild amount of retained anechoic fluid and mild lumen gas with no evidence of obstruction to pyloric outflow.

The small intestine presented generalized intact prominent to mildly thickened wall layering exhibiting generalized propensity for prominent to mildly thickened intestinal mucosa. Segmental to generalized variable duodenojejunal hyperechoic mucosal speckling to striations. Minor segmental nonobstructive



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intestinal ileus to the level of the colon. The duodenum wall measured 0.52 cm width. The jejunum wall measured 0.40 cm width.

Normal visible colon wall layers were present with semi formed fecal matter and lumen gas in lumen.

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

Intermittent mildly enlarged mesenteric lymph nodes were present. These lymph nodes were homogenous and mildly hypoechoic with asymmetrical contour. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic inflammation was evident. An example of lymph node size was 3.2 cm x 0.50 cm. Mild segmental peri-intestinal reactive omentum and scant free fluid were present.

ULTRASONOGRAPHIC FINDINGS

- Mild nonobstructive hypomotile stomach.
- Enteropathy exhibiting intact mildly thickened wall and duodenojejunal mucosal speckling/striations.
- Normal area of pancreas.
- Mild peri-intestinal reactive omentum, scant free fluid and intermittent primarily mild mesenteric lymphadenopathy.
- Normal colon with semi formed fecal matter and lumen gas.
- Small nondisruptive splenic nodule.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Nonspecific inflammatory bowel i.e. IBD or other is favored assuming normal albumin levels. Dietary intolerance/indiscretion, infectious disease, occult parasitism, occult Addison's disease, mild pancreatitis (which may present sonographically normal) or potential occult to emerging intestinal neoplasia are all potentials. A GI panel to include PLI, TLI, cobalamin and folate with screening cortisol level are recommended. Long term dietary trial, high colony count probiotics such as Provable, empirical deworming despite fecal testing (Panacur 50 mg/kg SID for 5 days with repeat protocol in 3 weeks), cobalamin supplementation (pending assessment of cobalamin level) and as needed gastroprotectants may prove beneficial. Intestinal biopsies are likely required for a definitive diagnosis and further guidance of therapy.

Potential etiologies for the splenic nodules may include benign processes such as nodular hyperplasia, extramedullary hematopoiesis, hematoma, infection, infarction, or neoplasia. Ultrasound guided FNA of the nodule using 25-gauge needle and assuming normal coagulation parameters may be considered. Otherwise, sonographic monitoring of the splenic nodules for any changes in size or appearance with initial recheck in 3-4 weeks would be a more conservative approach.



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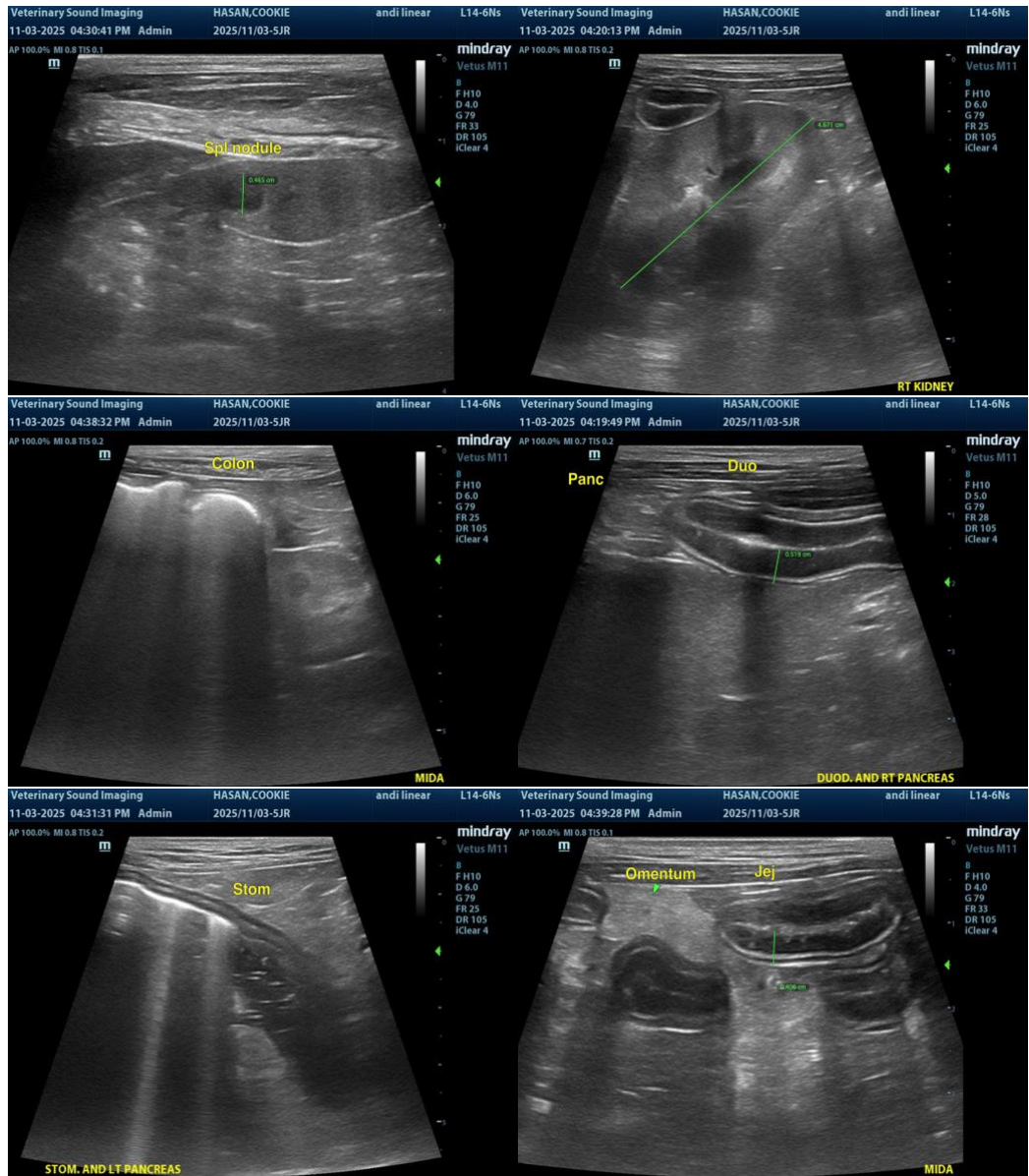
Dr. Sasha

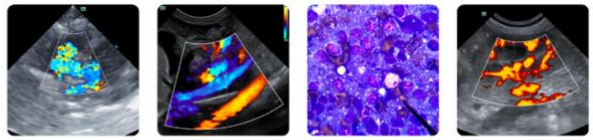
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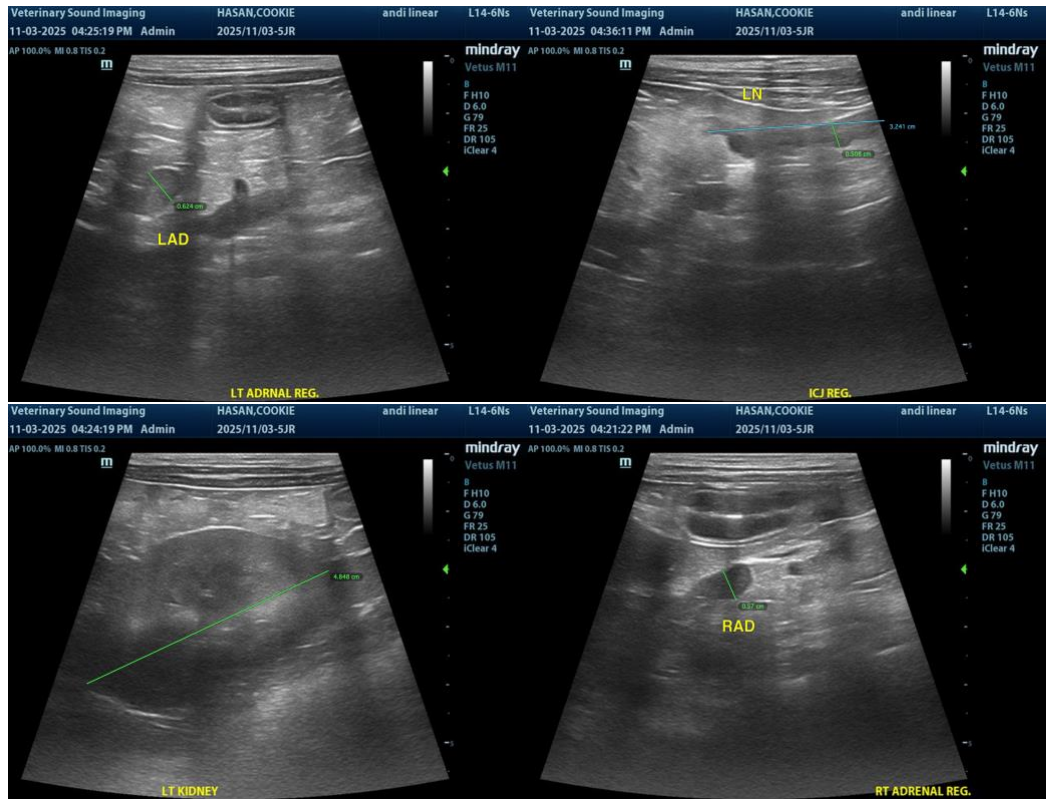
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

info@SonoPath.com