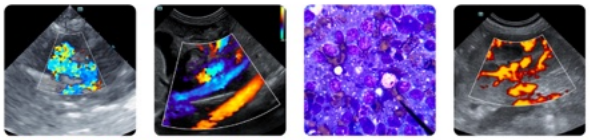


PATIENT

Eesha Kostick

SPECIES

Canine

BREED

Mix

SEX

Spayed female

AGE

10 years

WEIGHT

18 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Dr. Pascucci

HOSPITAL NAME

American AH

REFERRING VET

Dr. Pascucci

INVOICE

70902

DATE

1/22/26

PRESENTING CLINICAL SIGNS

- Hx of IBD based on AUS with diarrhea flare ups
- Acute bloody liquid diarrhea with frank blood, vomited twice as well, weight loss
- last AUS about 1yr ago or longer
- very picky with food and mainly eats chicken and baby rice
- On budesonide, sucralfate, B12, just started metro (also on tramadol, amantadine and methocarbomol for chronic neck pain). Just added gabapentin for uncontrolled pain.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly underdistended. The bladder wall measures approximately 2.77 mm; however, due to underdistension, wall thickness may be overestimated. The urine is anechoic. The bladder neck and proximal urethra appear normal. No uroliths are identified, and there is no sonographic evidence of inflammatory or neoplastic bladder wall changes.

The left kidney is normal in shape and size (3.94×2.62 cm). Cortical thickness measures 0.40 cm in the sagittal plane. The right kidney is normal in shape and size (4.47×2.67 cm). Cortical thickness measures 0.34 cm in the sagittal plane. In both kidneys, the renal cortex is isoechogenic relative to the liver parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

Adrenal Glands

The left adrenal gland is partially visualized and measures approximately 0.46 cm. The right adrenal gland is incompletely visualized at the cranial pole; the caudal pole measures approximately 0.49 cm.

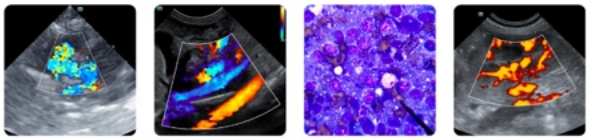
Spleen

Splenic thickness is 1.14 cm. The splenic parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal abnormalities. The splenic capsule is smooth and regular.

Liver

The liver is subjectively normal in size, with sharp margins and a regular contour. The hepatic parenchyma is uniform and isoechoic to falciform fat, with normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder is normally distended. The wall is thin. Luminal contents are primarily anechoic with a small amount of biliary sludge. No dilation of the cystic duct or common bile duct is identified.



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Gastrointestinal

The stomach is empty and folded, with a gas pattern. Gastric wall thickness measures approximately 2.07 mm, with preserved wall layering. The pylorus measures approximately 3.17 mm.

The duodenum measures 4.72 mm. Different segments of the jejunum measures from 2.97–4.26 mm, with preserved wall layering. The mucosa measures up to 2.81 mm, the submucosa 0.83 mm, and the muscularis propria 0.53 mm. The ileum measures approximately 1.80–2.15 mm, with preserved wall layering. No alterations in mural stratification, no hyperechoic mucosal stippling, and no sonographic evidence of lacteal dilation are identified. The ileocecal junction is not clearly visualized.

The colon appears largely empty. The ascending colon is collapsed and folded, precluding reliable wall measurement. The transverse colon measures approximately 2.40 mm and contains minimal gas. The descending colon is empty, with preserved wall layering throughout. No liquid fecal pattern is observed.

Pancreas

The right limb of the pancreas measures approximately 9.81 mm in width. The pancreatic parenchyma is isoechoic to the adjacent omental fat. No sonographic evidence of is identified in the videos provided.

Peritoneal Cavity

No abdominal effusion or evidence of peritonitis is observed. Cranial mesenteric lymph nodes are not visualized; surrounding regions appear unremarkable. The iliac trifurcation appears normal.

ULTRASONOGRAPHIC FINDINGS

A few intestinal segments have wall thickness measurements at the upper limits of normal, with preserved wall layering.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The measured gastrointestinal wall dimensions fall within the upper limits of accepted normal ranges and, critically, maintain normal wall layering throughout. The duodenal measurement (4.72 mm) and maximal jejunal measurements (up to 4.26 mm) lie at the upper end of normal, but do not exceed expected limits and are not accompanied by architectural distortion, disproportionate mucosal thickening, submucosal or muscularis hypertrophy, hyperechoic mucosal stippling, or lymphangiectasia—features typically associated with active or uncontrolled inflammatory bowel disease.

The absence of mesenteric lymphadenopathy, preservation of mural stratification, and lack of chronic structural changes indicate that there is no ultrasonographic evidence of structurally active chronic inflammatory enteropathy or protein-losing enteropathy at this time.

However, the absence of significant ultrasonographic abnormalities does not exclude clinically relevant gastrointestinal disease. In patients with a history of chronic enteropathy, acute gastrointestinal flare-

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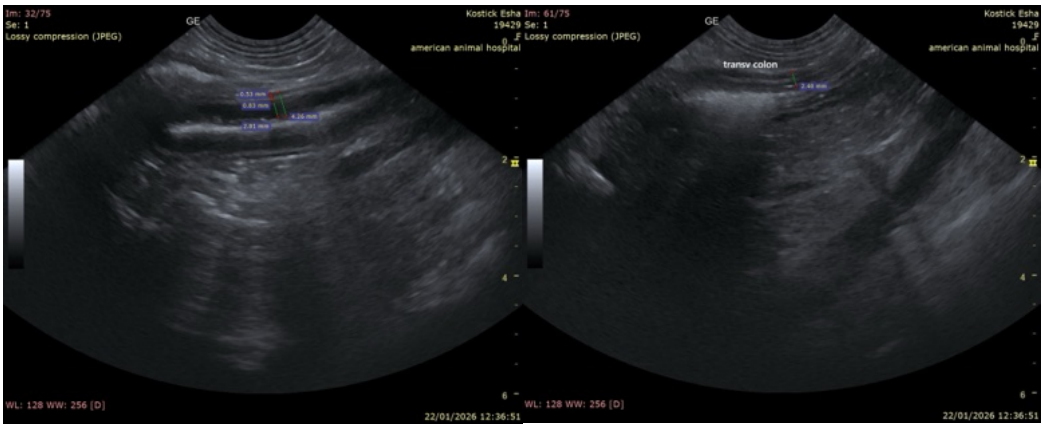
ups may arise from functional disturbances such as transient intestinal barrier dysfunction and exaggerated mucosal immune responses, processes that are not expected to produce consistent structural changes detectable by ultrasonography. In this context, a hypersensitive or functionally unstable gastrointestinal tract may be influenced by luminal factors, including diet composition, as well as concurrent medical therapies. Such episodes may manifest as acute hemorrhagic diarrhea and gastroenteritis despite preserved intestinal wall thickness and mural layering.

Recommendations

- The current ultrasonographic findings do not demonstrate features of active structural inflammatory bowel disease at this time. This may reflect adequate disease control under the current medical management, rather than absence of underlying chronic enteropathy. Accordingly, escalation of immunosuppressive therapy is not supported by the present imaging findings.
- Given the patient's long-term dietary restriction and gastrointestinal hypersensitivity, transition to a strict hydrolyzed diet or a truly novel protein diet (one the patient has not been previously exposed to) is advised. The diet should be fed exclusively for a minimum of 6–8 weeks, with complete avoidance of chicken-based products and dietary indiscretions.
- Medication burden should be critically reviewed and simplified where clinically feasible. In dogs with functionally unstable gastrointestinal tracts, polypharmacy may contribute to mucosal irritation and altered motility.
- Supportive care for acute hemorrhagic episodes should be continued as clinically indicated, with reassessment based on response rather than routine escalation of treatment.
- Serial weight measurements and clinical evaluation should guide further decision-making.
- Further diagnostic investigation (including repeat imaging or endoscopic biopsy) should be reserved for cases with persistent clinical deterioration, development of hypoalbuminemia, or lack of response to dietary and medical optimization.



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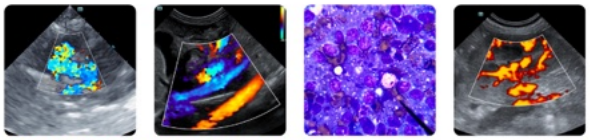

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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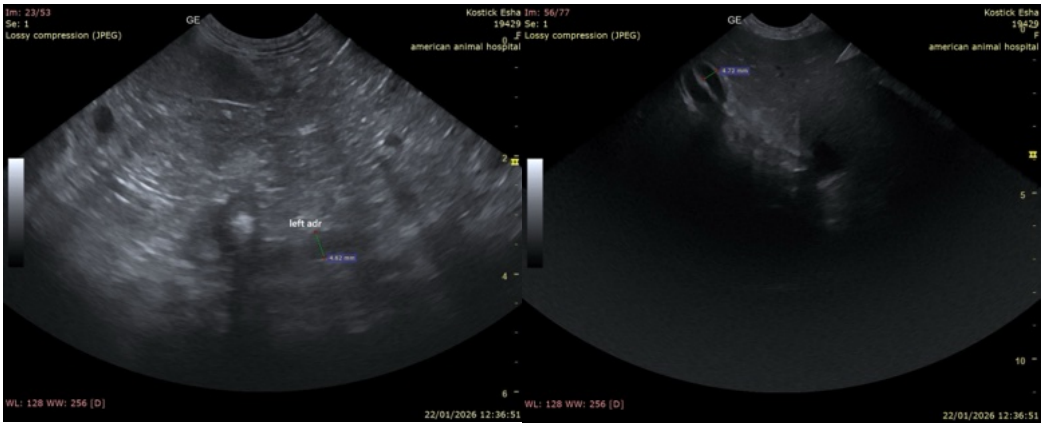

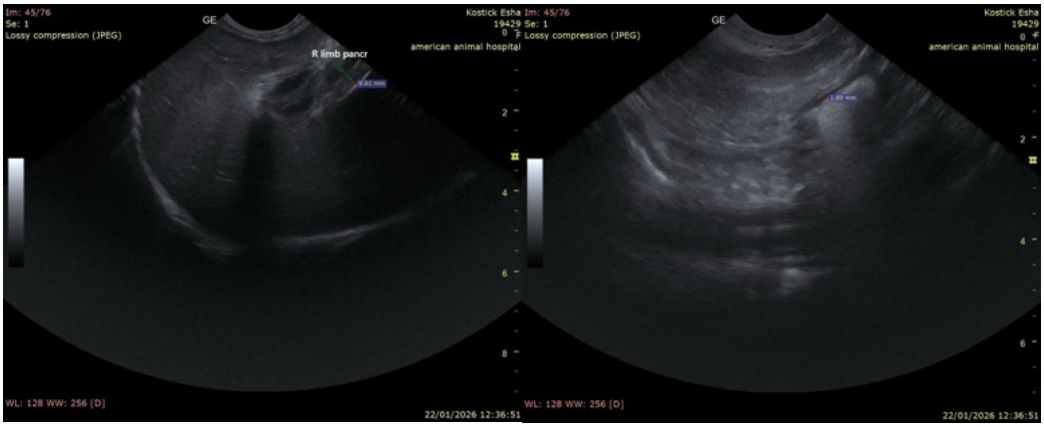

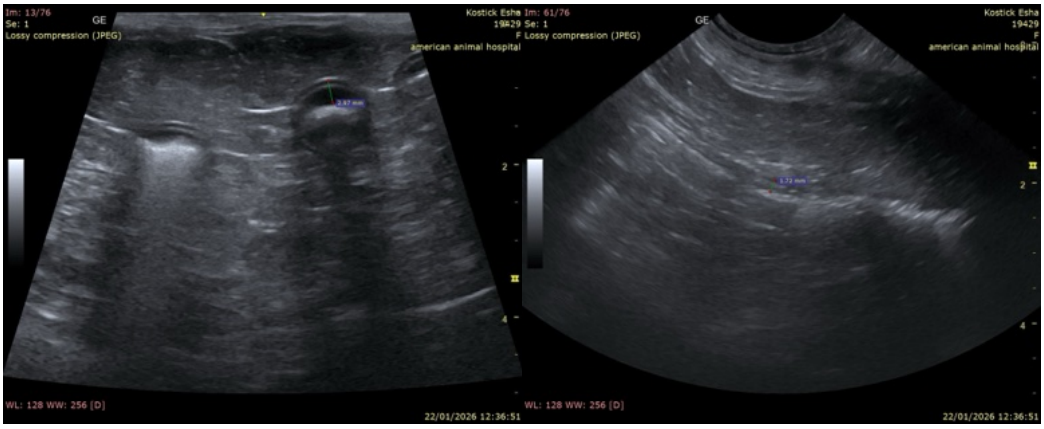

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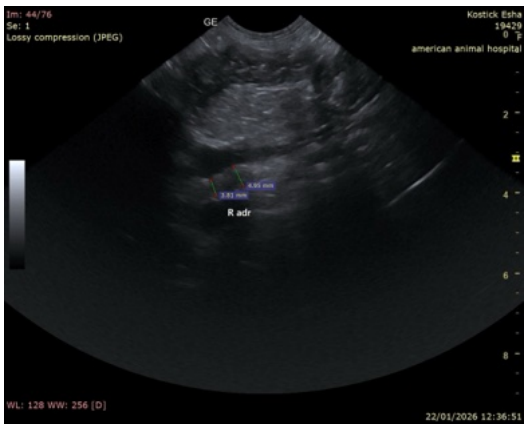

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

MV Esp Ultrasound in Domestic and Wild Animals

info@SonoPath.com