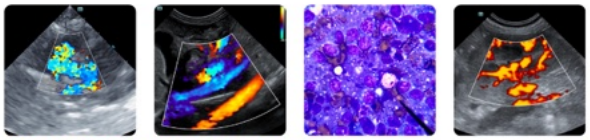


PATIENT

Shay Kiszewski

SPECIES

Canine

BREED

Chihuahua Mix

SEX

Spayed female

AGE

7 years

WEIGHT

16.4 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Brandi Kurzowski

HOSPITAL NAME

Corfu VC

REFERRING VET

Dr. Kelver

INVOICE

69450

DATE

12/9/25

PRESENTING CLINICAL SIGNS

History: P originally presented 10/14/25 for chronic intermittent diarrhea and lethargy. Started metronidazole, probiotics, and biome diet at this time. After minimal improvement, steroid trial started on 11/3/25. P is still currently on prednisone 5mg EOD. P continues to decline clinically, also treated with ondansetron and cerenia after developing vomiting on 11/10. 12/4 visit- weight loss of about 2.5 lb since initial visit in Octobter, firm flat mass palpated in ventral cranial abdomen- Concern for neoplasia or possible PLE.
Abnormal PE/Chem/CBC/UA Results: 10/14/25 CBC- WBC 21.44 K/L, NEU 18.95 K/uL, PLT 497 K/uL, PCT 0.64 %, Rest WNL Chem- PHOS 2.3 mg/dL, TP 3.8 g/dL, ALB 1.3 g/dL, CHOL 100 mg/dL 12/4/25 CBC- RBC 5.34 M/uL, HGB 12.2 g/dL, MCV 74.9 fL, MCHC 30.5 g/dL, WBC 33.19 K/uL, NEU 29.84 K/uL, MONO 1.61 K/uL, EOS 0.02 K/uL, PLT 580 K/uL, MPV 13.8 fL, PCT 0.80 %, Rest of CBC WNL Chem- CREA 0.4 mg/dL, TP4.5 g/dL, ALB 1.6 g/dL, ALT 805 U/L, ALKP 1924 U/L, GGT 17 U/L, Rest of chemistry and electrolytes WNL

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is normally distended, and the urinary bladder wall appears thin and smooth. The urine is anechoic. The proximal urethra and vesicoureteral junction appear normal. No calculi or evidence of inflammatory or neoplastic changes are identified.

The left kidney is normal in shape and size: 4.05 x 2.76 cm, with a cortical thickness of 0.39 cm in the sagittal plane. The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is normal and corticomedullary definition is preserved. No pyelectasia, nephroliths, or hydronephrosis are observed. Color Doppler shows a normal pattern.

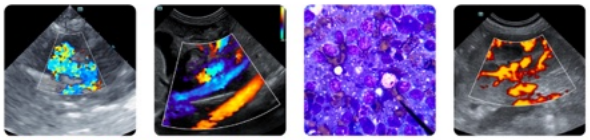
The right kidney has a slightly irregular contour but is normal in size: 4.51 x 2.56 cm, with a cortical thickness of 0.41 cm in the sagittal plane. The cortex is isoechoic to the liver parenchyma, with a normal corticomedullary ratio and preserved corticomedullary definition. No pyelectasia, nephroliths, or hydronephrosis are identified. Color Doppler shows a normal pattern.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. Left adrenal gland: 0.42 cm cranial pole, 0.40 cm caudal pole. Right adrenal gland: 0.38 cm cranial pole, 0.39 cm caudal pole.

Spleen

Splenic thickness is 1.25 cm. The parenchyma demonstrates normal echogenicity and a fine, homogeneous echotexture, except for a focal hypoechoic nodule measuring 0.51x0.95 cm. The splenic capsule is smooth and regular, and splenic vasculature appears normal.



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Liver

The liver is subjectively normal in size, with sharp edges and a regular contour. Hepatic parenchyma appears uniform and slightly hyperechoic compared to the renal cortex, with a normal echotexture. No hepatic lymphadenopathy is observed.

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

Gastrointestinal

The stomach is mildly distended with food remnants, with mural thickness of 2.29 mm and preserved wall layering. Clear images of the pylorus were not available.

Duodenum: 3.56 mm. Jejunum: 2.87–3.34 mm (mucosa 1.44 mm, submucosa 0.84 mm, muscularis propria 0.44 mm). Ileum: 1.90 mm (mucosa 0.93 mm, submucosa 0.48 mm, muscularis propria 0.40 mm). All segments show preserved wall layering. The ileocecal junction was not visualized. No signs of obstruction, ileus, or foreign material are identified.

Colon: transverse colon 1.18 mm with semi-formed feces; descending colon 1.00 mm with formed feces.

Pancreas

The pancreas itself is not clearly visualized in any of the videos. The region corresponding to the left pancreatic lobe does not show visible abnormalities; however, the region corresponding to the right pancreatic lobe demonstrates marked peritoneal reaction.

Peritoneal Cavity

Mild anechoic effusion is present. There is pronounced thickening and marked hyperechogenicity of the peritoneum surrounding the duodenal and right pancreatic regions, extending into portions of the perihepatic fat. No evidence of pneumoperitoneum is observed.

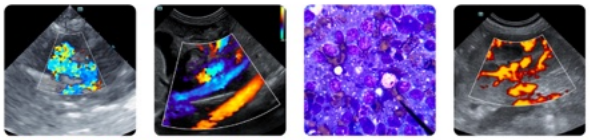
Cranial mesenteric and ileocecal lymph nodes are not visualized, though the surrounding regions appear unremarkable.

The iliac trifurcation is normal.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Marked focal peritoneal thickening and hyperechogenicity surrounding the right pancreatic and duodenal region, consistent with localized peritonitis.
- Mild abdominal effusion.
- Duodenal mural thickening (3.56 mm) with preserved layering.



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SECONDARY FINDINGS

- Focal hypoechoic splenic nodule under 1 cm.
- Mild biliary sludge within an otherwise normal gallbladder

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Overall, the findings indicate a significant localized peritonitis centered in the cranial abdomen, with no definitive underlying cause identified on the current study.

There is marked, focal peritoneal thickening and hyperechogenicity involving the right pancreatic region and adjacent duodenum, accompanied by a mild amount of free abdominal effusion. These findings are consistent with moderate to severe localized peritonitis.

The differential diagnoses for the regional peritonitis include:

- Severe pancreatitis (including steroid-associated pancreatitis).
- Localized septic peritonitis secondary to an occult perforation or necrotic pancreatic process.
- Less likely: Pancreatic or duodenal neoplasia, although it is not readily apparent in the available imaging planes.

The mild free effusion may reflect: Inflammatory exudate, protein-losing enteropathy–related transudation, or early septic effusion. Ultrasound alone cannot differentiate these possibilities.

The liver appears slightly hyperechoic but structurally normal, consistent with reactive hepatopathy given the significant biochemical abnormalities.

A small focal hypoechoic splenic nodule is present; this is nonspecific and may represent nodular hyperplasia.

The origin of the palpable cranial abdominal mass remains undetermined on the current study; it may be obscured by overlying inflammation, difficult imaging windows, or may represent a lesion in poorly visualized structures (pylorus, right pancreatic lobe).

Recommendations

- Measurement of canine-specific pancreatic lipase.
- Abdominocentesis and characterization of the abdominal effusion will help clarify whether the underlying process is inflammatory or septic in nature, which has important implications for determining whether surgical intervention is warranted.
- Re-evaluation with advanced ultrasonography may be beneficial if clinically warranted, particularly in an environment where full assessment of the right pancreatic region and pylorus can be achieved. An exhaustive evaluation using right lateral intercostal acoustic windows is recommended, as this approach often markedly improves visualization of the pancreas and pyloric outflow tract in subsequent imaging studies.
- Further evaluation of the palpable cranial abdominal mass via CT or surgical exploration (if the patient is stable) is recommended as an alternative.

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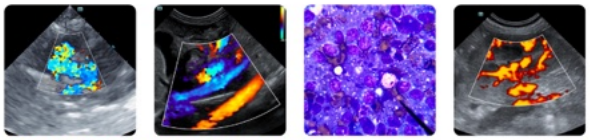

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Educational Teleconsultation Services™

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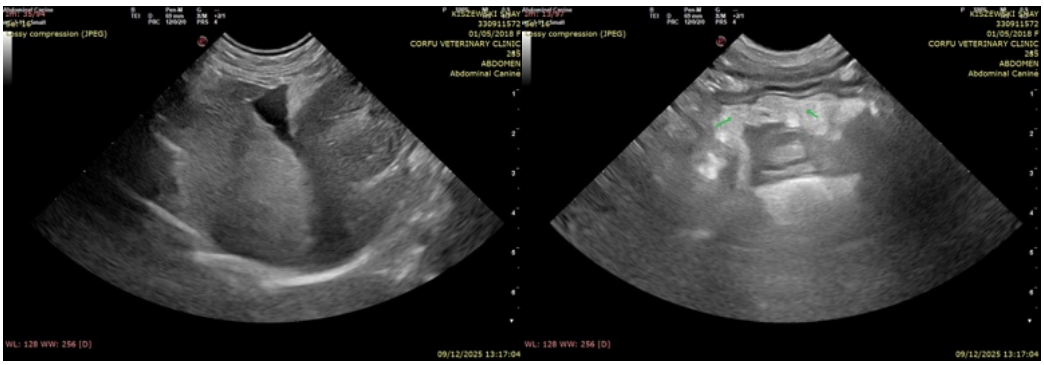

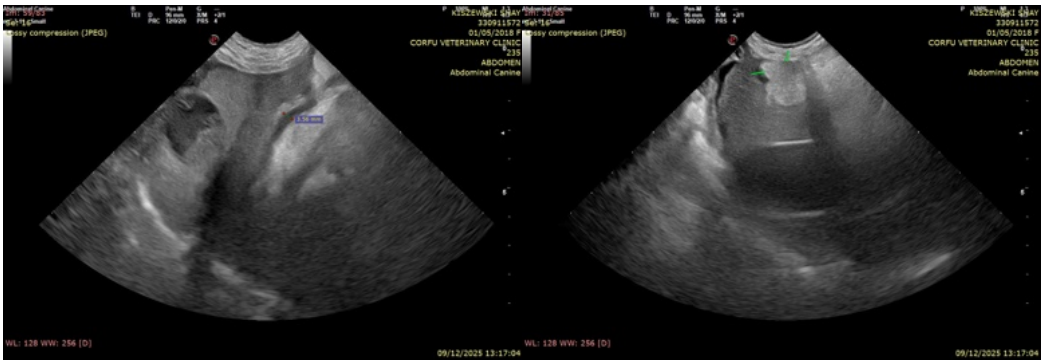

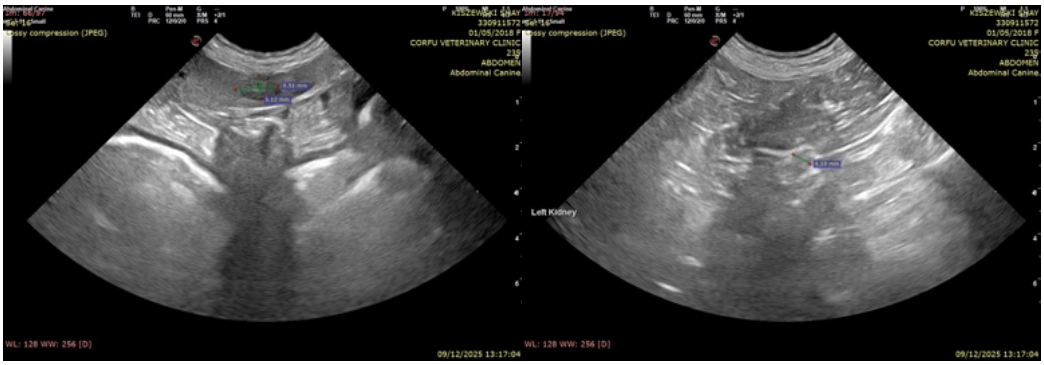

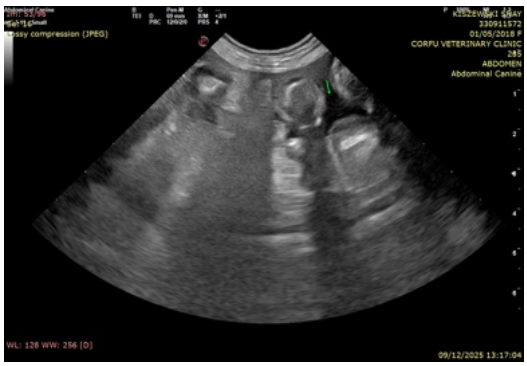

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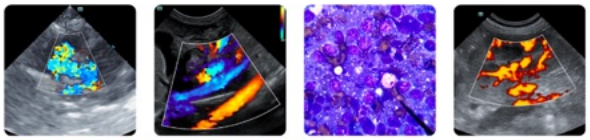

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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