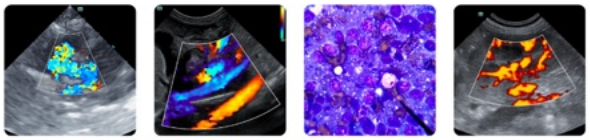


PATIENT

Minny Meadows

SPECIES

Canine

BREED

Hound Mix

SEX

Spayed female

AGE

6 years

WEIGHT

49 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Isabel Plourde

HOSPITAL NAME

Riverbend Veterinary PetCare Hospital

REFERRING VET

Dr. Plourde

INVOICE

71651

DATE

2/17/26

PRESENTING CLINICAL SIGNS

- Pt has had about 2-3 episode of GI upset that started back in the Summer of /24. X-rays and majority of bw have been fairly unremarkable, aside from PLI, which is usually elevated. A resting cortisol in '24 was 7.4, but it has not been rechecked since. Episodes typically consist of vomiting, diarrhea, lethargy and decreased appetite. Pt is now on a low fat food all the time. Current episode of diarrhea started over the weekend while patient was boarding. She does have a lot of anxiety, so current episode may be stress colitis.
- PLI currently 490 (>400 consistent with pancreatitis), but it has been up over 1,000 before BW and x-rays not repeated today

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended. The wall is thin and smooth. The urine is anechoic. The bladder neck and proximal urethra appear normal. No uroliths or ultrasonographic evidence of inflammatory or neoplastic change are identified.

Left kidney: 6.64×3.42cm. Cortical thickness 0.58cm (sagittal plane). Right kidney: 6.97×3.89cm. Cortical thickness 0.57cm (sagittal plane). Both kidneys are normal in size for a 49lb dog. Cortices are isoechoic relative to hepatic parenchyma. Corticomedullary distinction and ratio are preserved. No pyelectasia, nephrolithiasis, or hydronephrosis is identified. Doppler color flow is normal.

Adrenal Glands

Left adrenal gland partially visualized, dorsoventral dimension 0.71cm. Right adrenal gland measures 0.58cm (cranial pole) and 0.55cm (caudal pole).

Spleen

Splenic thickness 2.79–3.0cm. The parenchyma is homogeneous with normal echogenicity. Capsule smooth. Vasculature normal. Splenic thickness is appropriate for a dog of this size.

Liver

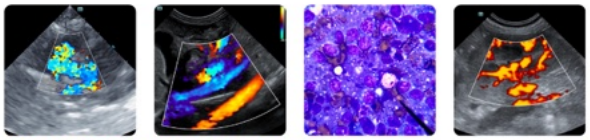
The liver is subjectively normal in size, with sharp margins and uniform echotexture. No focal lesions are identified. No hepatic lymphadenopathy is observed.
The gallbladder is normally distended. The wall is thin. Contents are anechoic. No cystic duct or common bile duct dilation is observed.

Gastrointestinal

Stomach empty and folded; 3.22 mm, layering preserved. Pylorus: 4.99mm.

Duodenum: 5.23mm. Jejunum: 3.88–4.67mm

- Mucosa: 2.72mm, Submucosa: 0.78mm, Muscularis: 0.32mm



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Ileum: 2.16mm

- Mucosa: 0.99mm, Submucosa: 0.95mm, Muscularis: 0.37mm

For a dog of this size, small intestinal wall thickness typically ranges:

- Duodenum/jejunum: up to ~5mm
- Ileum: up to ~4mm

All measurements fall within accepted reference ranges. Layering is preserved throughout. No focal thickening, obstruction, or mass lesion is identified.

Colon: Transverse: 2.20mm. Descending: 2.02mm. Normal layering. Soft fecal material present; no liquid diarrhea noted ultrasonographically.

Pancreas

The visualized pancreatic regions show normal size and echogenicity. No hypoechogenicity, enlargement, peripancreatic fat hyperechogenicity, fluid, or mass effect is observed.

Peritoneal Cavity

No abdominal effusion. Abdominal lymph nodes are unremarkable. Iliac trifurcation normal.

ULTRASONOGRAPHIC FINDINGS

None identified.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

This abdominal ultrasound examination is structurally unremarkable. The pancreas is normal in size and echogenicity, without evidence of enlargement, hypoechogenicity, peripancreatic fat inflammation, fluid accumulation, or mass effect. The gastrointestinal tract is within normal wall thickness limits for a dog of this size, with preserved layering throughout. The liver, biliary system, kidneys, spleen, and adrenal glands are within normal ultrasonographic limits.

Primary large-bowel stress colitis alone is unlikely to explain the historical magnitude of cPLI elevations. Similarly, there is no ultrasonographic evidence to support obstructive, infiltrative, biliary, or structural gastrointestinal disease at this time.

Despite the absence of ultrasonographic pancreatic abnormalities, the patient has a documented history of recurrent gastrointestinal episodes associated with markedly elevated canine pancreatic lipase. It is important to emphasize that ultrasonography has limited sensitivity for mild, early, or chronic pancreatitis, particularly between clinical flares. Therefore, a normal pancreatic appearance does not exclude clinically significant chronic or recurrent pancreatitis. The recurrent nature of the episodes, systemic signs, and repeated marked elevations in cPLI strongly support chronic pancreatitis with intermittent acute exacerbations as the primary working diagnosis. Stress may act as a trigger rather than the primary cause of disease.

A prior resting cortisol of 7.4 µg/dL makes hypoadrenocorticism unlikely at that time; however, if clinical suspicion persists or biochemical abnormalities emerge, repeat adrenal testing may be considered.

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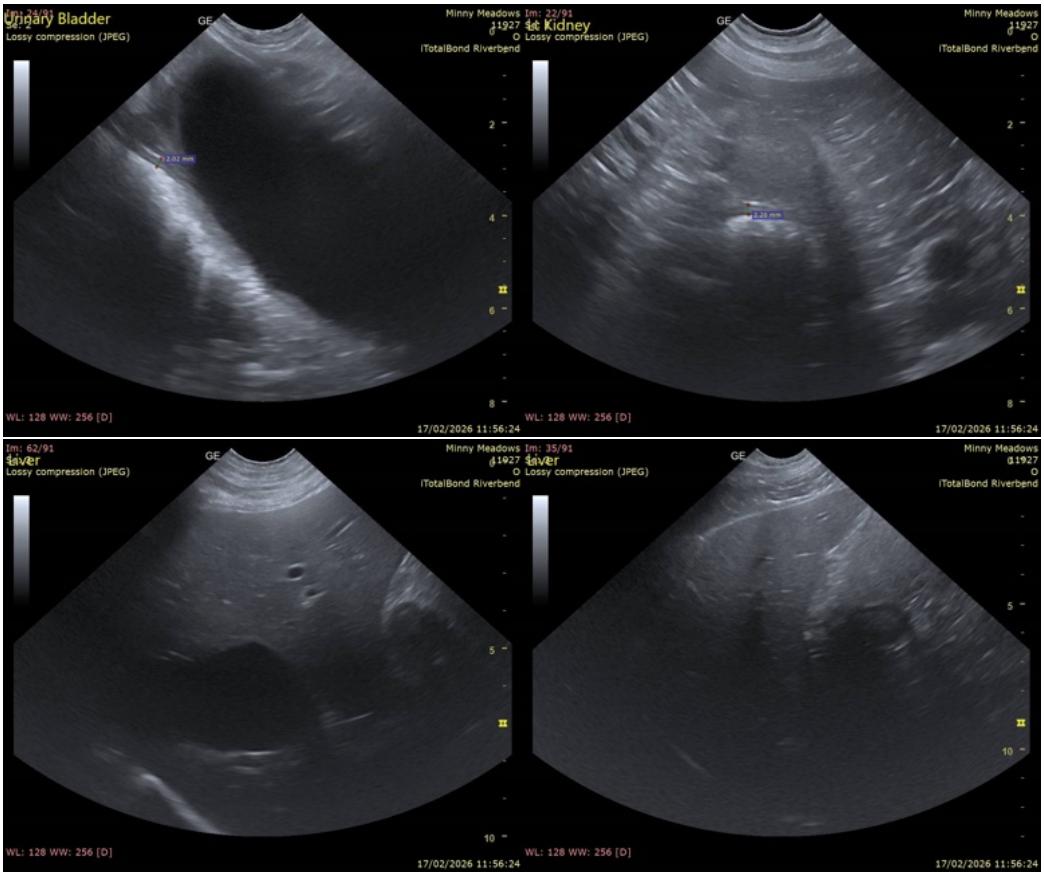
Overall, this case is most consistent with chronic relapsing pancreatitis in the absence of structural abdominal disease. The underlying driver: dietary, metabolic, inflammatory, or (less commonly but possible) immune-mediated, remains to be determined.

Recommendations

- Repeat full biochemistry during a stable period, including fasting triglycerides and cholesterol, to identify potential metabolic triggers.
- Maintain strict low-fat diet with no dietary indiscretion; consider omega-3 supplementation.
- Manage flares early with antiemetics, analgesia, and supportive care.
- If recurrent episodes continue despite appropriate management and no trigger is identified, consider a controlled trial of anti-inflammatory corticosteroids for suspected chronic inflammatory pancreatitis.



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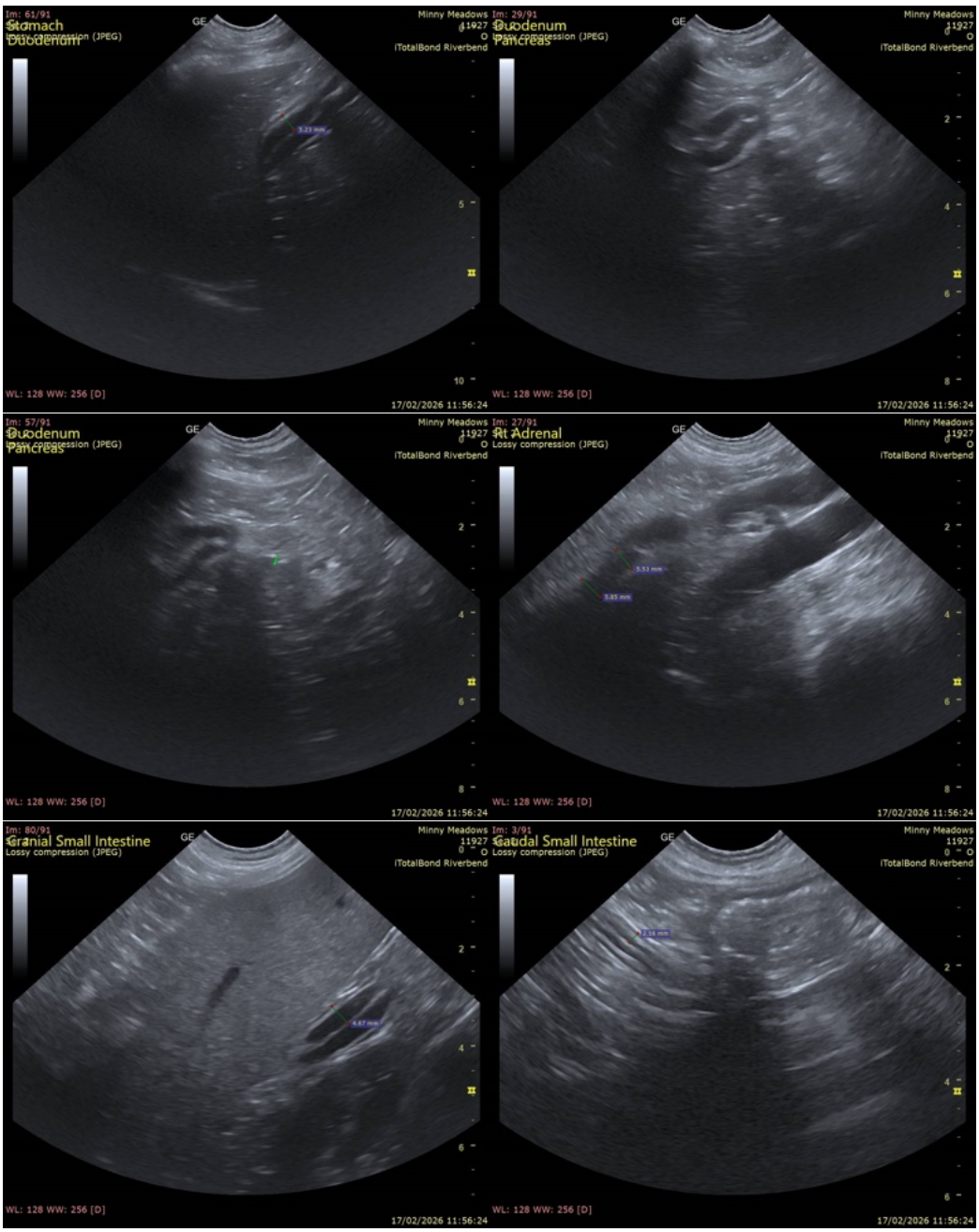

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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