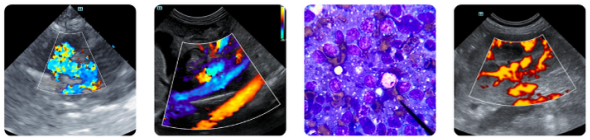


PATIENT

Moxy Castillo

SPECIES

Canine

BREED

Shih Tzu Mix

SEX

Spayed Female

AGE

11 years

WEIGHT

19.92

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Dr. Celia Galanti

HOSPITAL NAME

Craig Road Animal Hospital

REFERRING VET

Dr. Celia Galanti

INVOICE

11491

DATE

3/13/2026

PRESENTING CLINICAL SIGNS

- Patient is an 11yr FS shih tzu mix presented for vomiting and not eating. Last night P ate dinner and also stole some of another dog's food. Within a few hours P began vomiting. P has since vomited about 5 times. This morning P began straining to defecate and producing very small amounts of liquid stool. P has been lethargic, shaking and showing no interest in treats. In the last month P has been drinking and urinating excessively. O reports P typically weights 5-6 lbs more.

Abnormal PE/Chem/CBC/UA Results: pH 7.34.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is markedly distended, and the urinary bladder wall appears thin and smooth. The urine is anechoic. The bladder neck and proximal urethra have a normal appearance. No calculi are identified, and there is no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size (5.19 × 2.26 cm). The cortical thickness measures 0.48 cm in the sagittal plane.

The right kidney is normal in shape and size (5.72 × 2.82 cm). The cortical thickness measures 0.45 cm in the sagittal plane.

Both kidneys: The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is normal and corticomedullary definition is preserved. A mild medullary rim sign is present. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. Dorsoventral diameters measured in the sagittal plane:

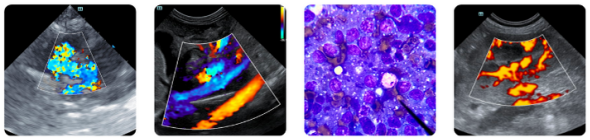
- Left adrenal gland: 0.58 cm at the cranial pole and 0.61 cm at the caudal pole.
- Right adrenal gland: 0.51 cm at the cranial pole and 0.56 cm at the caudal pole.

Spleen

Splenic thickness measures 1.25 cm. The parenchyma demonstrates normal echogenicity and a fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver

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



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The gallbladder lumen is moderately 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 markedly distended with fluid. Mural thickness measures 2.84 mm with preserved wall layering.

Duodenum: 7.21 mm; very thickened and mildly corrugated, with preserved wall layering.

Jejunum: 2.36–2.63 mm; some segments appear mildly corrugated with fluid content. Wall layering is preserved.

Colon: 0.96 cm; empty.

Pancreas

Pancreatic thickness ranges from 1.14–1.47 cm with an irregular contour. The pancreatic parenchyma is markedly hypoechoic compared to the adjacent omental fat. Peripancreatic fat demonstrates increased echogenicity and edema. A minimal amount of free fluid is also observed.

Free Abdomen

Mild abdominal effusion is present with focal peritonitis.
No lymphadenomegaly is identified.
The iliac trifurcation appears normal.

PRIMARY FINDINGS

- Severe acute pancreatitis with secondary regional peritonitis and systemic inflammatory response.

SECONDARY FINDINGS

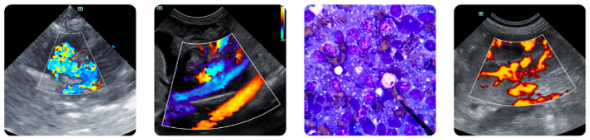
- Reactive hepatopathy.
- Dehydration/hemoconcentration.
- Hyperlipidemia.
- Possible pancreatitis-associated diabetes mellitus or stress hyperglycemia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The ultrasonographic findings are most consistent with severe acute pancreatitis with associated regional peritonitis. Ultrasonographic findings are characteristic of severe inflammatory pancreatic disease and correlate strongly with the patient's clinical presentation and laboratory findings.

The gastrointestinal tract shows mild fluid distension and duodenal corrugation, which may reflect reactive enteritis or localized ileus associated with pancreatic inflammation.

Mild abdominal effusion and focal peritonitis are compatible with regional inflammatory peritonitis secondary to pancreatitis.



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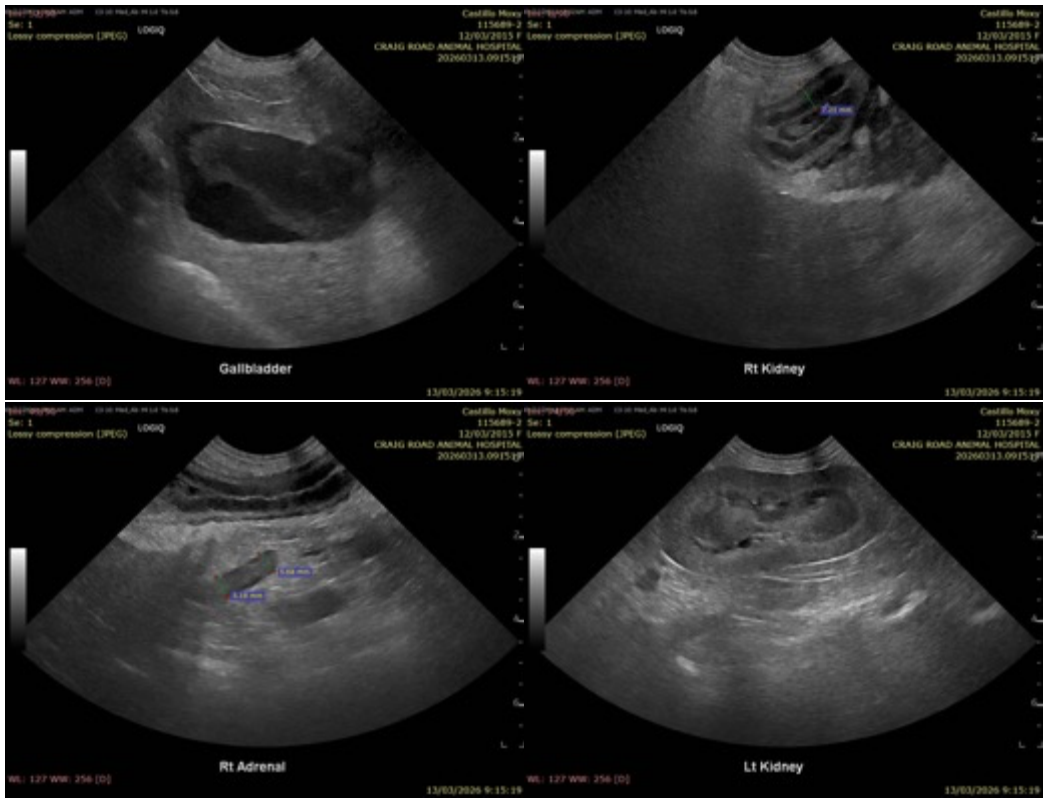
The liver appears structurally normal on ultrasound; however, mild ALT elevation and marked ALP elevation likely represent reactive hepatopathy secondary to systemic inflammation and pancreatic disease, which is commonly observed in severe pancreatitis.

Marked hyperglycemia with glucosuria and ketonuria raises concern for diabetes mellitus or stress-induced hyperglycemia secondary to pancreatitis, and pancreatic endocrine dysfunction should be considered.

Evidence of hemoconcentration and elevated BUN with normal creatinine is most consistent with dehydration, likely secondary to vomiting and reduced intake.

Recommendations

- Aggressive supportive therapy and fluid resuscitation.
- Analgesia and antiemetic therapy.
- Monitoring for systemic complications (SIRS, DIC, pancreatic necrosis).
- Monitoring of glucose levels for possible diabetes mellitus.
- Follow-up abdominal ultrasound.



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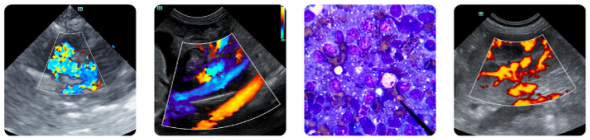

Clinical Sonography & Telecytology
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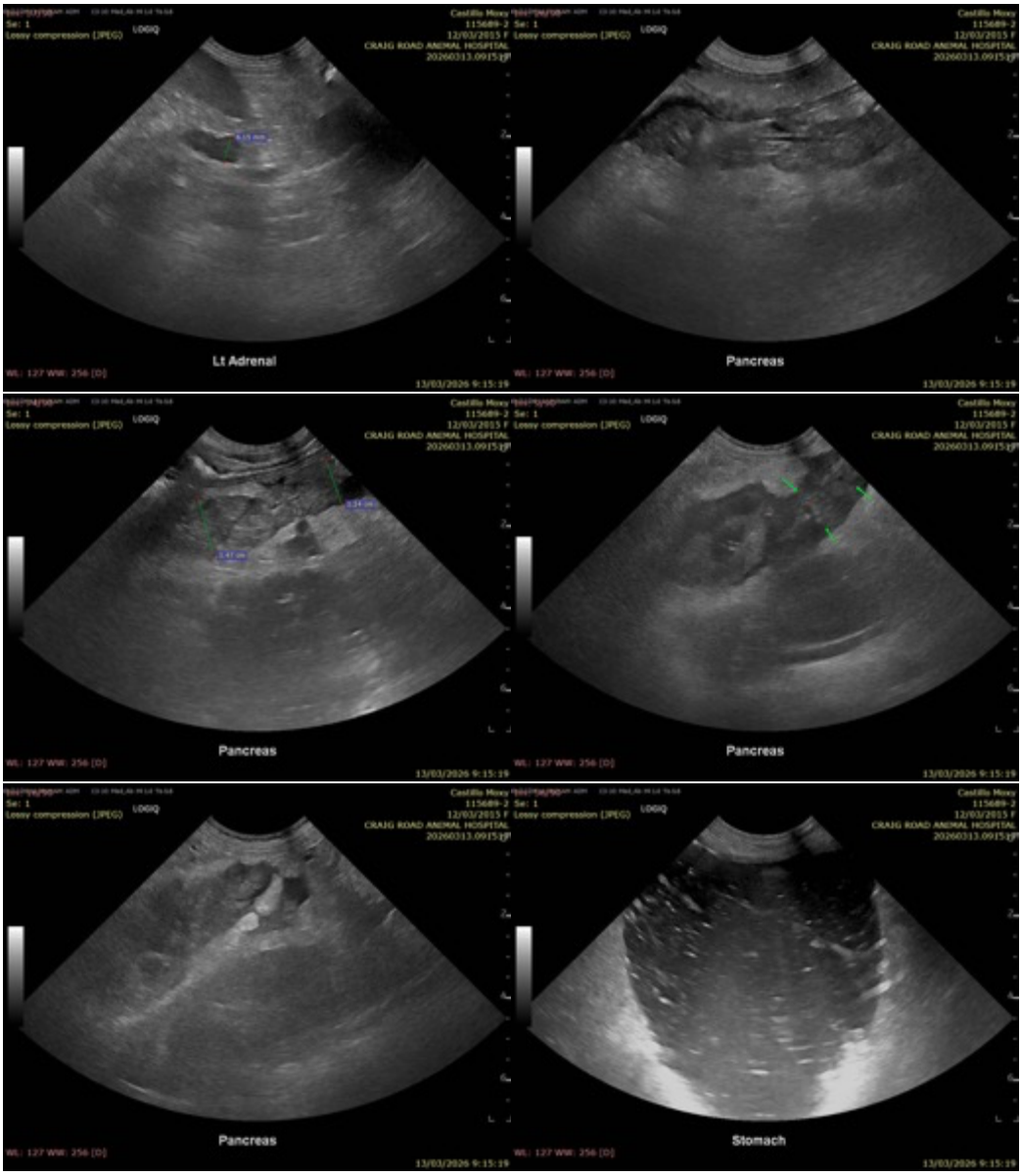

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

info@SonoPath.com