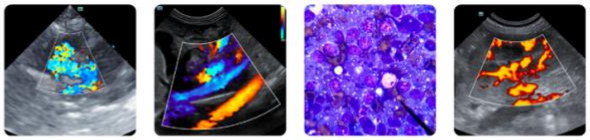

PATIENT

Gunner Ertner

SPECIES

Canine

BREED

Rat Terrier

SEX

Neutered Male

AGE

11 Years 7 Months

WEIGHT

17.4

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Kaitlyn Rudie DVM

HOSPITAL NAME

Sherwood Family Pet Clinic

REFERRING VET

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INVOICE

15201

DATE

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PRESENTING CLINICAL SIGNS

Gunner presented 4/4 for vomiting 5x in 24 hrs with blood present, he has a history of pancreatitis and had been having some loose stool so O transitioned from Solid Gold to Royal Canin GI Low Fat, but he wasn't improving with this. Gunner is on occasional gabapentin. No hx of NSAIDs or toxic exposure (heavy metal, mushrooms, plants, etc). Given Cerenia and famotidine SQ. Sent home on Sucralfate and Omeprazole. He was feeling better 4/7 with good appetite but his diarrhea hadn't resolved so he was started on Proviable and Propectalin. Came back in 4/11 for poor appetite again.

Abnormal PE/Chem/CBC/UA Results: Pancreatitis negative 4/4. See BW results from 4/4 attached. On exam, Gunner has lost a small amount weight and was uncomfortable on palpation of his abdomen.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended, and the wall appears thin and smooth. The urine is anechoic. The bladder neck and proximal urethra appear normal. No uroliths are identified, and there is no ultrasonographic evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size, measuring 4.44×2.64 cm in the sagittal plane, with a cortical thickness of 0.43 cm. The cortex is mildly hypoechoic relative to the liver parenchyma. The corticomedullary ratio and definition are preserved. No pyelectasia, nephroliths, or hydronephrosis are observed. Color Doppler demonstrates a normal vascular pattern.

The right kidney is normal in shape and size, measuring 4.53×2.57 cm in the sagittal plane, with a cortical thickness of 0.40 cm. The cortex is isoechoic relative to the liver parenchyma. The corticomedullary ratio and definition are preserved. No pyelectasia, nephroliths, or hydronephrosis are observed. Color Doppler demonstrates a normal vascular pattern.

Prostate

The prostate is small and hypoechoic, consistent with post-castration atrophy.

Adrenal Glands

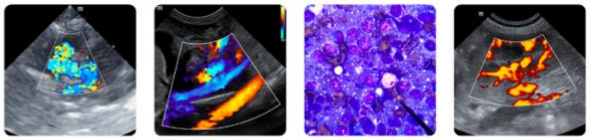
Both adrenal glands are mildly enlarged and have a rounded (globose) shape. Dorsoventral diameters measured in the sagittal plane: the left adrenal gland measures 0.79 cm cranially and 0.82 cm caudally; the right adrenal gland measures 0.98 cm cranially and 0.90 cm caudally. These values exceed typical reference ranges for a dog of this size (generally <0.6–0.7 cm).

Spleen

Splenic thickness is 0.99 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver

The liver is subjectively normal in size, with sharp margins and a regular contour. The parenchyma is homogeneous and isoechoic relative to the falciform fat. A small hypoechoic focus measuring 4.08×5.56 mm is identified, of uncertain clinical significance. No hepatic lymphadenopathy is observed.



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The gallbladder is normally distended. The wall shows changes consistent with mucosal gland hyperplasia, and the lumen contains a moderate amount of biliary sludge. No dilation of the cystic duct or common bile duct is observed.

Gastrointestinal

The stomach is is empty and folded, with a mural thickness of 2.08 mm and preserved wall layering. The pylorus measures 4.56 mm.
Duodenum: 4.42 mm.
Jejunum: 4.26 mm.

Multiple small intestinal segments demonstrate prominent hyperechoic linear striations within the mucosa, in some areas diffuse, giving the mucosa a markedly hyperechoic appearance. Wall layering is otherwise preserved.

Colon: 1.19-1.54 mm and is empty.

Pancreas

The evaluated pancreatic areas do not show evidence of overt inflammation or neoplastic disease.

Free Abdomen

No sonographic evidence of abdominal effusion, peritonitis, or lymphadenomegaly is identified. The iliac trifurcation is normal.

PRIMARY FINDINGS

- Diffuse hyperechoic mucosal striations in the small intestine.
- Bilateral adrenomegaly.
- Gallbladder mucosal hyperplasia with moderate sludge.

SECONDARY FINDINGS

- Small hepatic hypoechoic focus (incidental vs nonspecific).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The presence of diffuse hyperechoic mucosal striations within the small intestine is a well-described ultrasonographic pattern most commonly associated with intestinal lacteal dilation, and is strongly suggestive of intestinal lymphangiectasia. This finding may occur as a primary disorder or, more commonly, secondary to chronic inflammatory enteropathy (IBD), neoplastic infiltration (lymphoma), or other causes of impaired lymphatic drainage. Given the clinical history (chronic gastrointestinal signs, weight loss), this pattern is highly consistent with an underlying chronic enteropathy, potentially associated with protein-losing enteropathy.

Despite the absence of overt ultrasonographic pancreatic abnormalities, the clinical presentation (acute vomiting, abdominal discomfort, and prior history of pancreatitis), together with the marked elevation in liver enzymes (particularly ALT), is consistent with pancreatic or hepatobiliary disease, most likely pancreatitis with secondary reactive hepatopathy. It is important to recognize that ultrasonography has limited sensitivity for detecting early or mild pancreatitis, and a normal pancreatic appearance does not exclude clinically significant disease.

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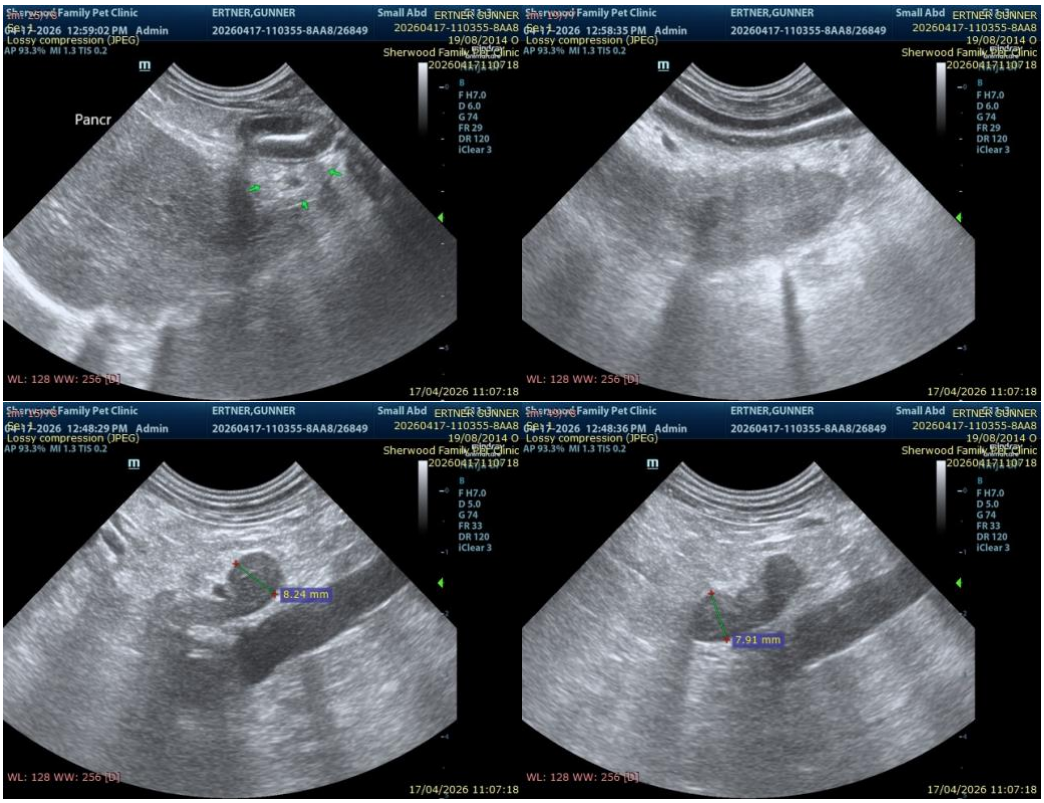
Hepatobiliary findings, including gallbladder mucosal hyperplasia and biliary sludge, are present and may be associated with chronic or hormonally influenced changes, but can also occur secondary to systemic or pancreatic disease. There is no evidence of biliary obstruction.

Bilateral adrenomegaly is noted and may reflect adrenal hyperplasia (pituitary-dependent hyperadrenocorticism) or incidental age-related change. In the absence of supportive clinical signs, this finding should be interpreted with caution and correlated clinically.

Recommendations

- Continue supportive management for suspected pancreatitis or hepatobiliary disease.
- Pancreatic-specific lipase testing to further assess pancreatic inflammation.
- Consider endocrine testing (ACTH stim or LDDS) only if clinical suspicion for hyperadrenocorticism is present.
- Monitor serum albumin and measure cobalamin/folate (if not already assessed).
- Consider intestinal biopsy for definitive diagnosis.

Final diagnostic and therapeutic decisions should be made by the attending veterinarian, who can best integrate these findings with the patient's clinical status.



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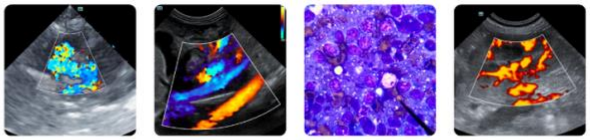

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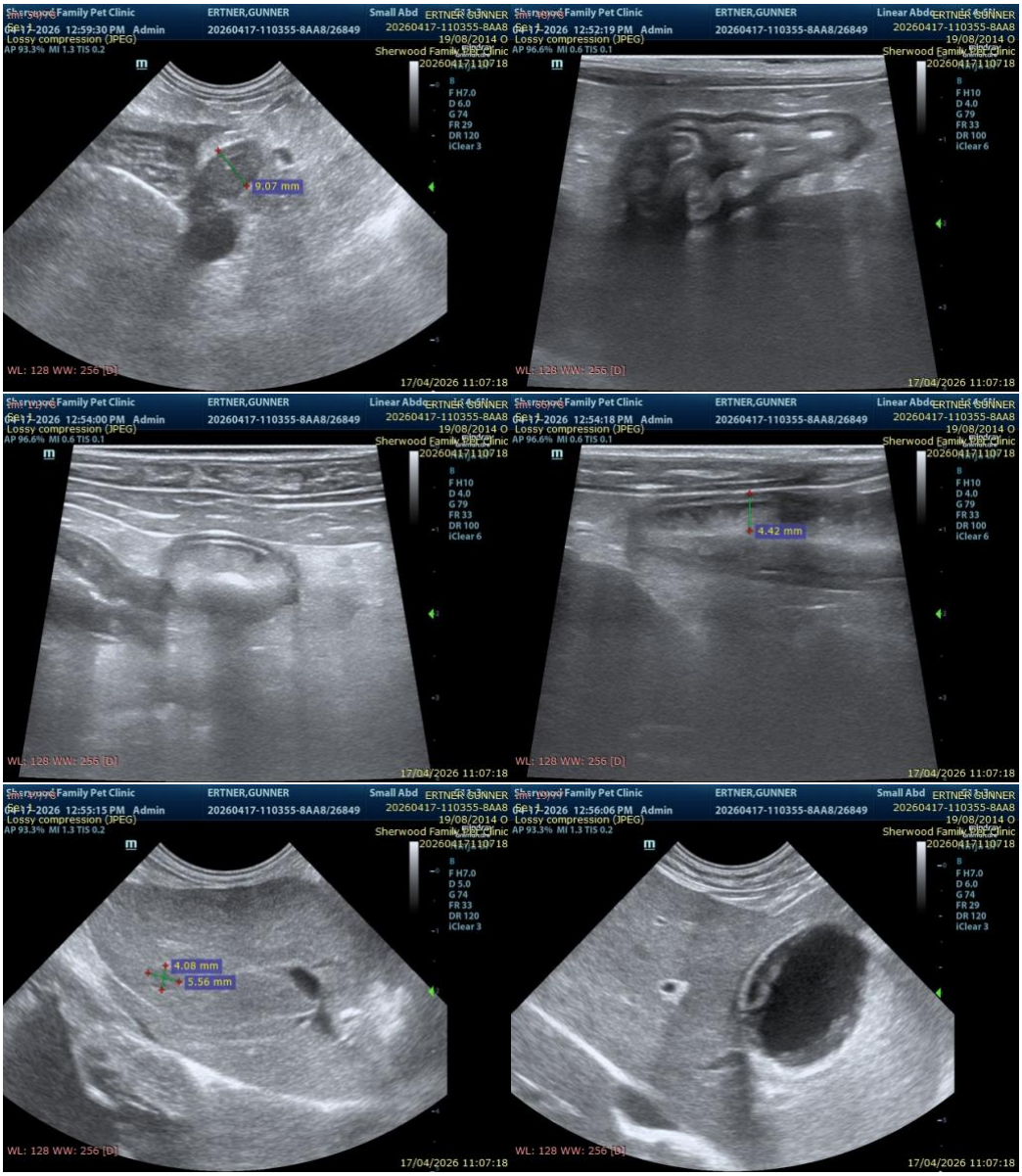

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

info@SonoPath.com