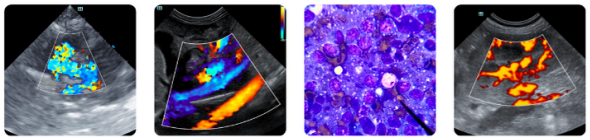


PATIENT

Rustle WEaver

SPECIES

Canine

BREED

Jack Russell

SEX

MN

AGE

11 years

WEIGHT

18.7 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Jocelyn Smith, CVT

HOSPITAL NAME

Annville-Cleona Veterinary Associates

REFERRING VET

Dr. Emily Spingler

INVOICE

12097

DATE

6/5/2026

PRESENTING CLINICAL SIGNS

Chief complaint: Daily vomiting for several months, lethargy, fever of 103.8°F yesterday (decreased to 101.3°F after medication), not eating for past 2 days.

History: Patient has seizure disorder managed with phenobarbital once daily, last dose given yesterday morning.

Physical examination findings: Abdominal discomfort/sensitivity to palpation, mild dehydration, current temperature 102.8°F.

Diagnosis: Pancreatitis, both chronic and acute components.

Additional diagnostics recommended: Abdominal ultrasound to evaluate pancreas and surrounding structures.

Abnormal PE/Chem/CBC/UA Results: Diagnostic results: - CBC: Normal white blood cell count and platelet count, hematocrit 47% (normal up to 55%), mild dehydration confirmed - Chemistry panel: Normal BUN and creatinine, slightly elevated glucose (stress-related), elevated ALP (liver enzyme, likely from phenobarbital), elevated amylase - Pancreatitis test: Positive for elevated pancreatic lipase.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is moderately distended, and the urinary bladder wall appears thin and smooth. The urine is anechoic. Normal appearance of the trigone and proximal urethra is observed. There are no calculi, and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size, measuring 4.56×2.69 cm, with a cortical thickness of 0.46 cm in the sagittal plane. The renal cortex demonstrates normal echogenicity. The corticomedullary ratio is normal, and corticomedullary distinction is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler evaluation demonstrates a normal vascular pattern.

The right kidney is normal in shape and size, measuring 4.79×2.65 cm, with a cortical thickness of 0.45 cm in the sagittal plane. The renal cortex demonstrates normal echogenicity. The corticomedullary ratio is normal, and corticomedullary distinction is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler evaluation demonstrates a normal vascular pattern.

Adrenal Glands

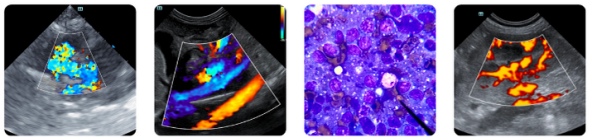
The adrenal glands could not be visualized.

Spleen

Splenic thickness is 1.62 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 edges and a regular contour. The liver parenchyma looks uniform and isoechoic compared to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.



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The gallbladder lumen is normally distended. The wall is thin and the contents are primarily anechoic. No evident dilation of the cystic duct or common bile duct is observed.

Gastrointestinal tract

The stomach is empty and folded, with a mural thickness of 2.36 mm and preserved wall layering.

The pyloric wall measures 4.52 mm.

The duodenal wall measures 4.56 mm and demonstrates mild corrugation.

The jejunal wall measures 2.83 mm with preserved wall layering.

No evidence of gastrointestinal obstruction, ileus, foreign material, or infiltrative gastrointestinal disease is identified.

The colonic wall measures 1.29 mm and contains minimal luminal contents.

Pancreas

The left pancreatic lobe measures approximately 1.74 cm in thickness, and the right pancreatic lobe measures approximately 1.71 cm in thickness. The pancreatic margins are mildly irregular. The pancreatic parenchyma is diffusely hypoechoic relative to the adjacent mesenteric fat. Marked hyperechogenicity of the surrounding mesenteric fat is present, consistent with active peripancreatic inflammation. Sonographic evidence of focal peripancreatic peritonitis is identified.

Free Abdomen

Focal peripancreatic peritonitis is present. No generalized abdominal effusion is identified. No abdominal lymphadenomegaly is observed. The iliac trifurcation region is unremarkable.

PRIMARY FINDINGS

- Pancreatic enlargement with irregular margins and diffuse hypoechogenicity.
- Marked peripancreatic fat inflammation.

SECONDARY FINDINGS

- Mild corrugation of the duodenum.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The pancreas is diffusely enlarged, hypoechoic, and irregular in contour, with marked inflammation of the surrounding mesenteric fat and associated focal peripancreatic peritonitis. In conjunction with the patient's clinical signs, abdominal discomfort, documented fever, and elevated pancreatic lipase concentration, these findings are highly supportive of clinically significant active pancreatitis.
The severity of the peripancreatic inflammatory changes and the presence of focal peritonitis indicate extension of the inflammatory process beyond the pancreatic parenchyma into the surrounding tissues.

Given the chronic history of recurrent vomiting and previously documented pancreatic disease, the findings are most consistent with an acute exacerbation of underlying chronic pancreatopathy. Once chronic pancreatic injury develops, affected dogs may become predisposed to recurrent episodes of

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pancreatic inflammation despite removal of the original inciting factor.

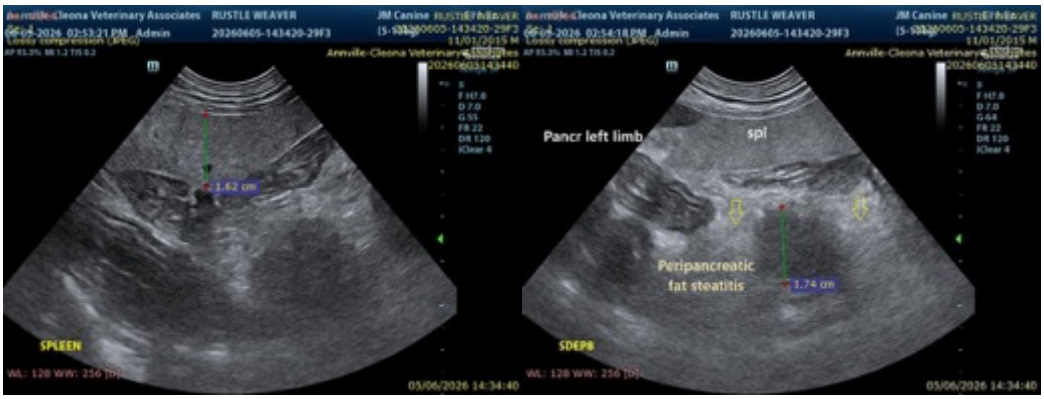
Mild duodenal corrugation is present and is considered most likely reactive to the adjacent pancreatic inflammation.

The reported elevation in alkaline phosphatase activity may reflect enzyme induction secondary to chronic phenobarbital administration. Reactive hepatopathy associated with systemic inflammatory disease, including pancreatitis, may also contribute. No sonographic evidence of clinically significant hepatobiliary disease is identified on the current examination.

Recommendations:

- Continued treatment and monitoring for pancreatitis.
- Appropriate supportive care, including fluid therapy, analgesia, antiemetic therapy, and nutritional management, should be continued as clinically indicated.
- Clinical monitoring for progression or resolution of pancreatic inflammation is recommended.

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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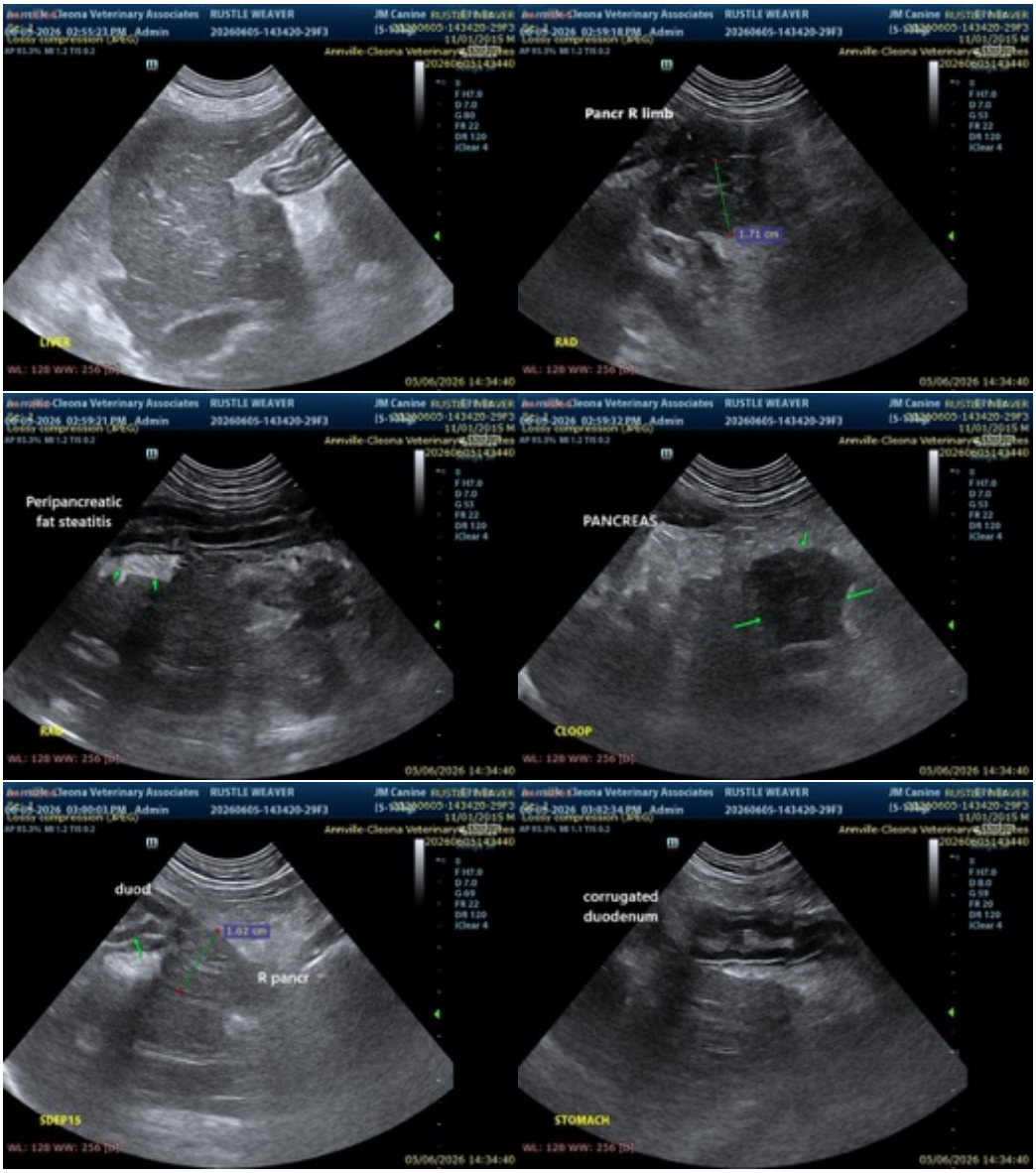

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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