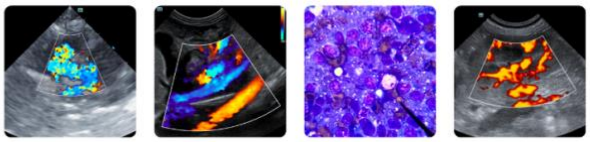


PATIENT

Rhodey Brice

SPECIES

Canine

BREED

Frenchie

SEX

Neutered Male

AGE

5

WEIGHT

32 lbs

INTERPRETED BY

Andrea Nicastro, DVM, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Nicole Hession

HOSPITAL NAME

VEC of Casselberry

REFERRING VET

Dr Edmister

INVOICE

22313

DATE

11-24-25

PRESENTING CLINICAL SIGNS

History: P presented for acute vomiting and an episode of soft stool. Rhodey has a history of a mechanical obstruction, (~1yr ago), during surgery approximately 10 inches of intestines were resected. Continuing to regurgitate through Cerenia, Ondansetron, Pantoprazole after no findings on endoscopy last night.

Abnormal PE/Chem/CBC/UA Results: BW ~24hrs ago: Cl 106 (109-121), GLU 128, MCH 26.3 (21.2-25.9), WBC 17.4 (5.05-16.76), NEU 15.16 (2.95-11.64), AMYL 454 (500-1500). Rest WNL.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness. The mucosal surface in the region of the apex is slightly irregular. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (0.65 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal in size (5.30 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (5.03 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size (0.47 cm at cranial pole) (0.51 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is mildly enlarged (0.89 cm at cranial pole) (0.81 cm at caudal pole) with slightly swollen peripheral contours. Glandular echogenicity and detail are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

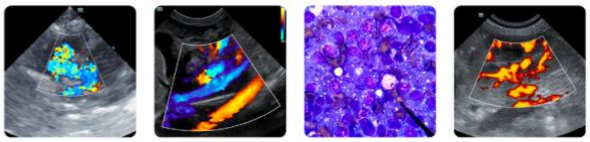
Spleen

The spleen is prominent in size (1.91 cm in width at the level of the hilus) with smooth peripheral contours. The parenchyma is subtly mottled in appearance. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively normal in size with normal peripheral contours. The parenchyma is hypoechoic relative to the spleen and homogenous in appearance. There is an increase in portal markings. Hepatic vasculature is of normal volume with no evidence of congestion.

The gallbladder lumen is moderately distended. The wall is normal to borderline thickened (up to 0.14 cm and hyperechoic). A small to moderate amount of gravity-dependent, echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.



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Gastrointestinal
The gastric lumen is mildly distended with ingesta. The gastric wall is normal to moderately thickened (up to 0.79 cm) with retention of the normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

Pancreas
The base and limbs of the pancreas are visible with normal curvilinear peripheral contours. The parenchyma is slightly hypoechoic relative to surrounding omental fat and slightly mottled in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Lymph Nodes
At least two prominent mesenteric lymph nodes are visualized (one measuring 2.08 x 0.52 cm).

Free Abdomen
There is no obvious evidence of free fluid.

Other
A brief echocardiogram reveals no obvious evidence of pericardial or pleural effusion in the visible window.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The gastric wall changes are most consistent with gastritis, with a lower possibility of emerging neoplasia. There is mild retained gastric ingesta, which could suggest delayed gastric emptying (if the patient was fasted for this study).
- The pancreatic changes could be consistent with mild acute or chronic pancreatitis, with minor parenchymal remodeling.

Secondary Findings

- The splenic parenchymal changes are most consistent with a benign process such as lymphoid hyperplasia, extramedullary hematopoiesis, splenitis or antigenic stimulation with a lower possibility of infiltrative neoplasia (i.e., lymphoma, mast cell neoplasia).
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The borderline gallbladder wall thickening may be a normal variant for this patient or could suggest mild cholecystitis.
- The increase in hepatic portal markings may also be a normal variant for this patient, or could suggest a mild hepatopathy. Correlation with the patient's liver values is recommended.
- Right adrenomegaly

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Three-view thoracic radiographs are recommended to assess for occult esophageal disease.

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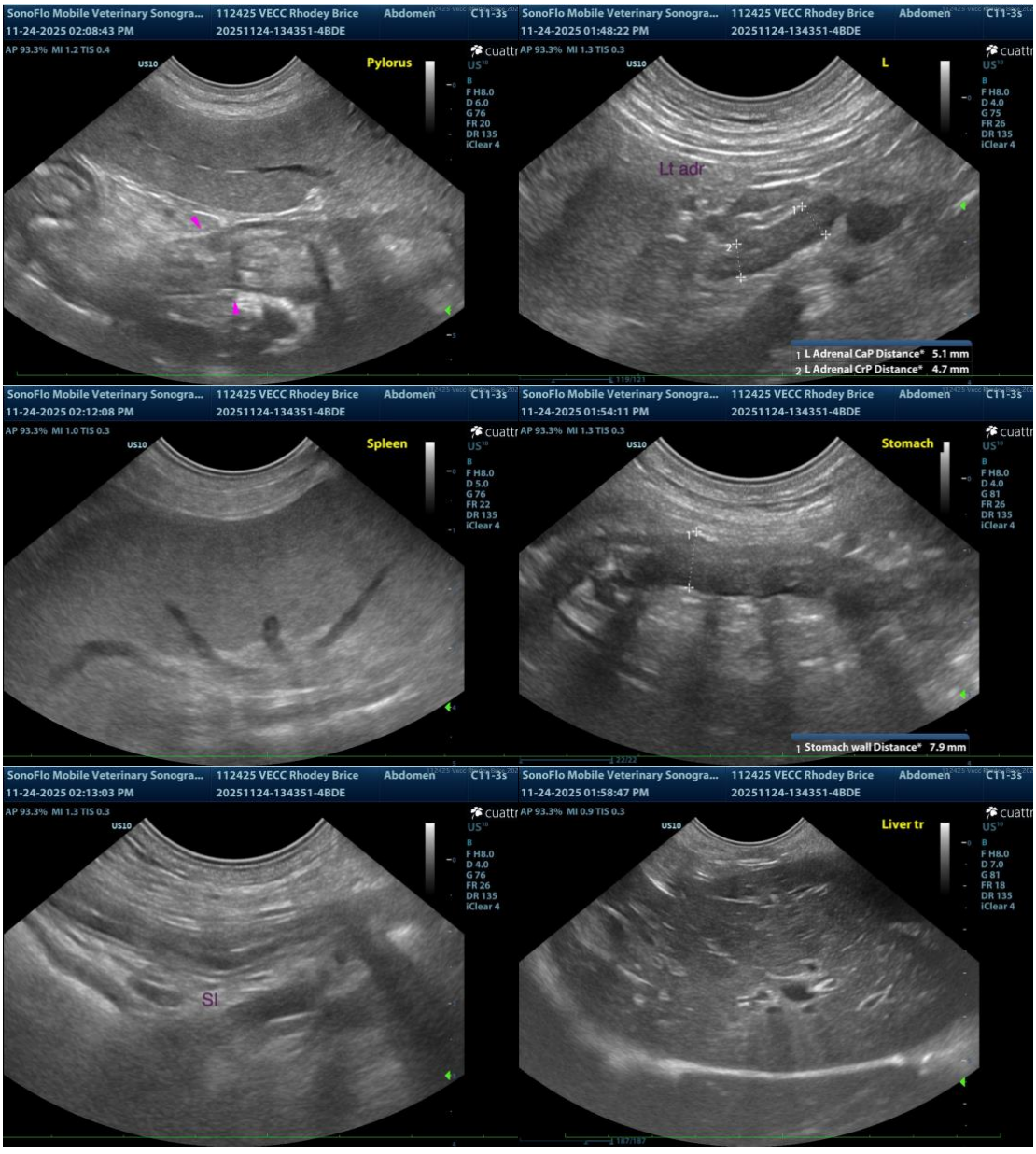
- Other diagnostics consideration include the following:

1. Fecal evaluation for ova and Giardia
2. GI panel including serum cobalamin and folate, TLI, PLI and resting cortisol level
3. Supportive care for gastroenteritis and possible esophagitis, including a proton pump inhibitor, sucralfate, antiemetics, fluid therapy, a probiotic, +/- a temporary feeding tube.
4. If clinical signs persist despite medical management, GI biopsies may be indicated.



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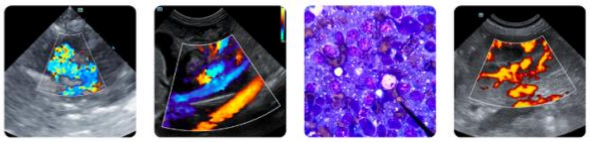

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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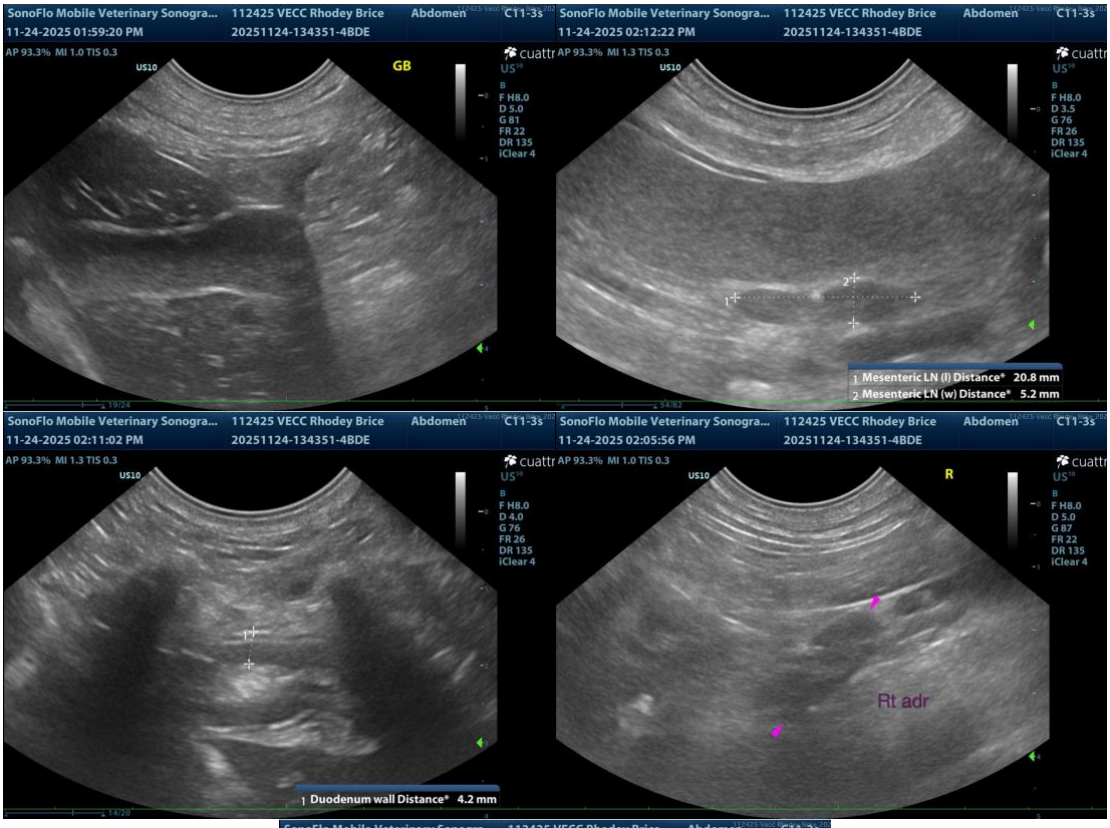

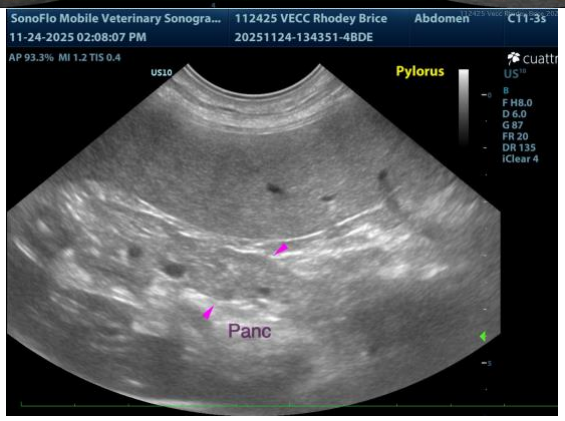

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com