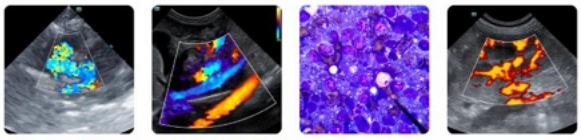


DATE

12/30/25

PATIENT

Juniper Hudson

SPECIES

Canine

BREED

Labrador Retriever

SEX

Female, spayed

AGE

12/4/2019

WEIGHT

80.1 lbs.

INTERPRETED BY

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

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Dr. Campbell

INVOICE

13363

PRESENTING CLINICAL SIGNS

Patient History: Juniper presents for acute vomiting and abdominal discomfort Patient History: - Onset yesterday afternoon with vomiting and general discomfort - Vomiting throughout last night - Ate this morning but immediately vomited food back up - Unable to keep down food or water for last 12 hours - Last bowel movement 12 hours ago: mucous only - Last full meal kept down: yesterday morning (normally fed twice daily at 7am and 7pm) - History of eating grass regularly, typically vomits it up without issue; ate grass on walk a few days ago - Known to get into things she shouldn't – Seizure disorder: - Maintained on phenobarbital - Seizures occur approximately every 6 months upon waking from sleep - Last seizure: evening before Thanksgiving (prior episode in July) - Current medications: - Phenobarbital for seizure control - Apoquel available PRN for pruritus (not currently taking) - Monthly heartworm preventative (given around first of month, no adverse reactions) - Sensitive to topical flea medications(causes pruritus) - Environmental concern: mice/rats in shed with rodenticide present. Date: 12-29-2025 Notes: O reveled to technician while doing estimate that p got into a whole prime rib - that was not told during triage or during doctor conversation.

Current Medications: Proviable, phenobarbital, ondansetron, maropitant, omeprazole, gabapentin, midazolam
Labwork Results: Globulins 4.9, elevated amylase and lipase, elevated cPL, suspected band, neutrophilia
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Requested. Heart check declined at this time.
Imaging Performed by: Stephanie Warga RDCS, RVT.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. A scant amount of suspended echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The left kidney is normal in size (6.10 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 (6.69 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 (0.52 cm at cranial pole) (0.62 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 normal in size (0.78 cm at cranial pole) (0.70 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.

Spleen

The spleen is overall normal in size (1.42 cm in width at the level of the hilus. A 3 cm irregular isoechoic swelling is observed at the cranial aspect. In the remainder of the spleen, the margins are curvilinear and the parenchyma is homogeneous. Splenic vasculature is normal with no evidence of thrombosis.

Liver

The liver is subjectively normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative, or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion.

The gall bladder lumen is moderately distended. The wall is mildly thickened (up to 0.33 cm) and hyperechoic. A small amount of suspended echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is mildly fluid distended. The gastric wall is normal in thickness with a normal layering pattern. The proximal duodenal wall is thickened (up to 0.85 cm) with retention of the normal layering pattern. The remaining small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. The small intestinal lumen is empty. Discreet masses are not identified. The colonic wall is normal. There is no obvious evidence of an obstructive pattern.

Pancreas

The pancreas is diffusely enlarged with irregular peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and edematous with subcapsular fluid present. The pancreatic duct is not overtly dilated. Surrounding mesentery is hyperechoic. Peripancreatic effusion Is noted.

Lymph nodes

A 0.95 cm lymph node is observed in the left cranial to mid-abdomen.

Free Abdomen

The mesentery throughout the abdomen is hyperechoic. A small amount of free fluid is present.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- The pancreatic changes are most consistent with severe pancreatitis. However, pancreatic neoplasia with concurrent pancreatitis cannot be excluded. There is diffuse peritonitis, likely secondary to pancreatic pathology.

Secondary Findings:

- The gallbladder wall changes are suggestive of cholecystitis.
- The proximal duodenal wall thickening is likely due to an inflammatory process likely secondary to pancreatitis.
- The prominent lymph node in the left cranial to mid-abdomen is likely reactive with a lower possibility of emerging neoplasia.
- The swelling at the cranial aspect of the spleen trends toward the benign (i.e., focus of lymphoid hyperplasia or similar). However, emerging neoplasia cannot be completely excluded.

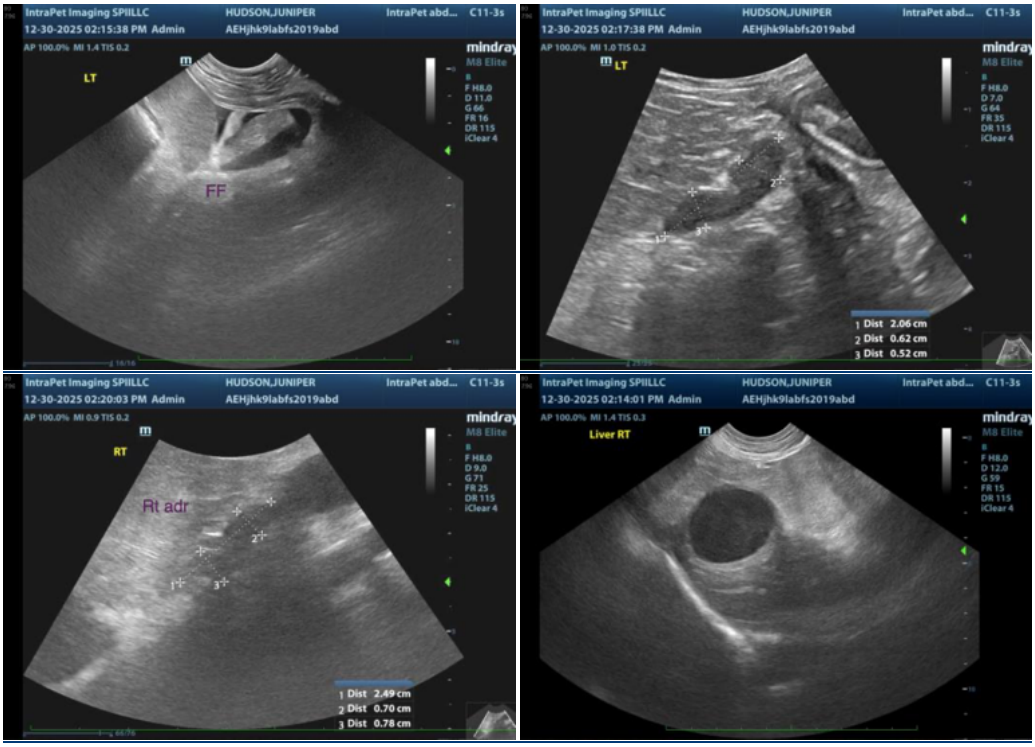
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

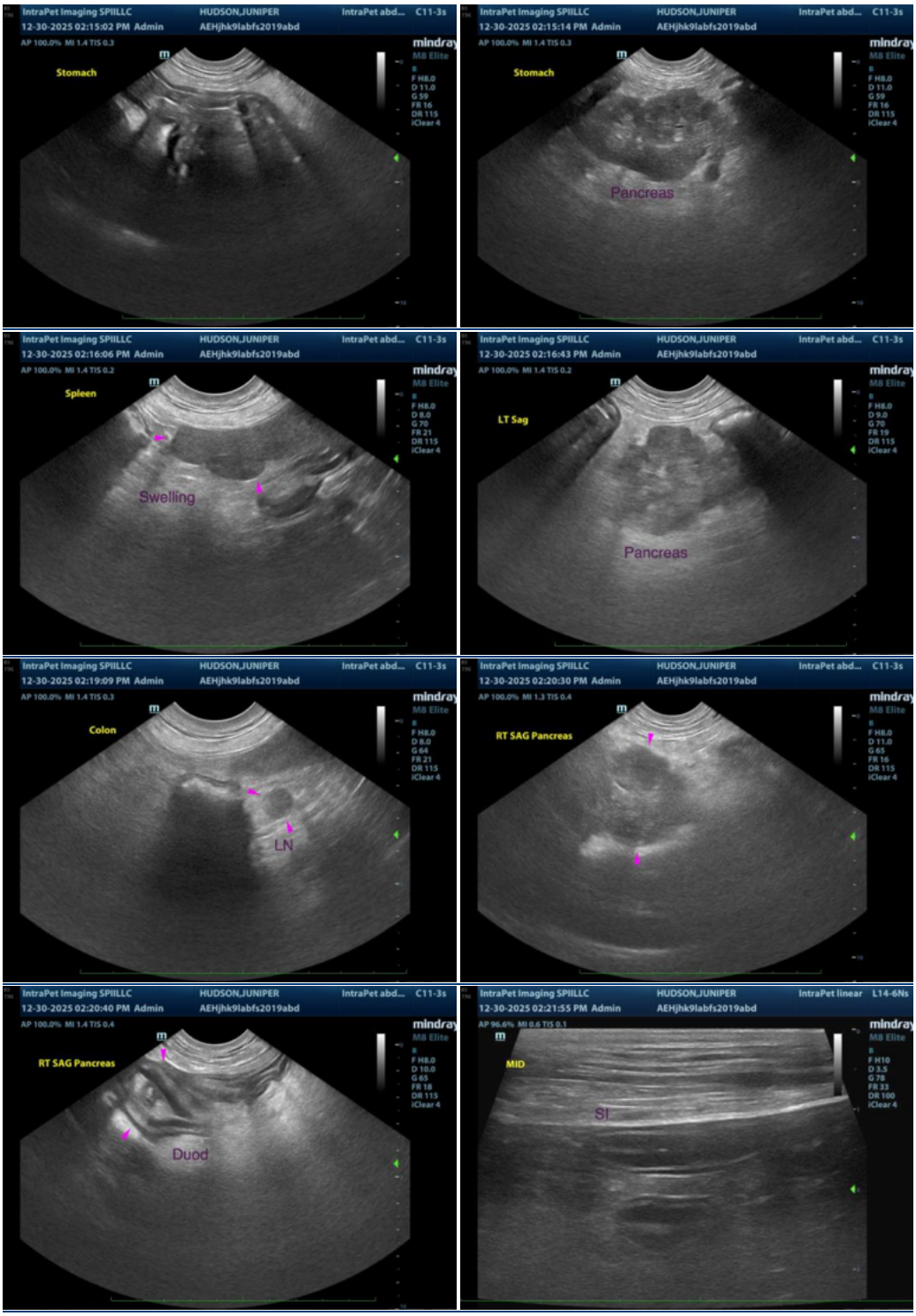
1. Three-view thoracic radiographs are recommended to assess cardiopulmonary status.

2. Consider fine needle aspiration of the pancreas, assuming normal clotting status. A 25 gauge needle should be used.

3. Supportive care for pancreatitis is recommended including IV fluid therapy, gastric protectants, antiemetics, pain medication as needed, +/- fresh frozen plasma +/- Fuzapladib. Nutritional support should also be initiated as soon as the patient will tolerate it.

4. Close monitoring of the patient's organ functions is also recommended due to potential systemic effects of pancreatitis. Serial (i.e., daily) sonographic monitoring is also recommended to assess progression of the pancreatitis particularly due to the potential for abscess formation in severe cases.




IntraPet Imaging SPIILLC
HUDSON,JUNIPER
12-30-2025 02:15:02 PM Admin
AEHjhk9labfs2019abd
Stomach
IntraPet Imaging SPIILLC
HUDSON,JUNIPER
12-30-2025 02:15:14 PM Admin
AEHjhk9labfs2019abd
Stomach
Pancreas
IntraPet Imaging SPIILLC
HUDSON,JUNIPER
12-30-2025 02:16:06 PM Admin
AEHjhk9labfs2019abd
Spleen
Swelling
IntraPet Imaging SPIILLC
HUDSON,JUNIPER
12-30-2025 02:16:43 PM Admin
AEHjhk9labfs2019abd
LT Sag
Pancreas
IntraPet Imaging SPIILLC
HUDSON,JUNIPER
12-30-2025 02:19:09 PM Admin
AEHjhk9labfs2019abd
Colon
LN
IntraPet Imaging SPIILLC
HUDSON,JUNIPER
12-30-2025 02:20:30 PM Admin
AEHjhk9labfs2019abd
RT SAG Pancreas
IntraPet Imaging SPIILLC
HUDSON,JUNIPER
12-30-2025 02:20:40 PM Admin
AEHjhk9labfs2019abd
RT SAG Pancreas
Duod
IntraPet Imaging SPIILLC
HUDSON,JUNIPER
12-30-2025 02:21:55 PM Admin
AEHjhk9labfs2019abd
MID
SI

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