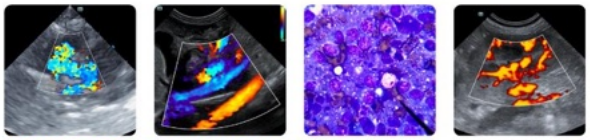


PATIENT
Bella Williams

SPECIES
Canine

BREED
Yorkie

SEX
Female, intact

AGE
7 yrs.

WEIGHT
1.3 kg.

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

IMAGING PERFORMED BY
Dr. Myers

HOSPITAL NAME
Hershey Animal Emergency Center

REFERRING VET
Dr. Davidson

INVOICE
13597

DATE
3/10/26

PRESENTING CLINICAL SIGNS

- O went away over the weekend, O's friend was watching them. P did not eat at all yesterday, did have d+, was drinking water and then v+, did not eat this morning either. Lethargic since yesterday. Went to rDVM with hypothermia, hypoglycemia and hypovolemic shock this morning.
- Mucous membranes pink/very tacky, CRT <2s, severe tartar/gingival erythema
- pulses snappy
- Uncomfortable on cranial abdominal palpation
- intact female, no vulvar swelling or discharge noted.

Abnormal PE/Chem/CBC/UA Results: At HAEC: - BG: 103 on triage At rDVM (3/10/26, 10am) - BG 39 on presentation, given 1 ml dextrose with 3 mls saline which increased BG to 128. Maintained on 2.5% dextrose - cPL abnormal - Chem: hypoglycemia (18), SDMA (18, H), BUN (64, H), Creatinine (1.3), hypocalcemia (7.4, L), ALP (349,H), hyponatremia (141, L), hypochloremia (100, L) - CBC: leukophillia (23.58k), neutrophilia (22.2k),eosinopenia (0.02k), basophilia (0.15), thrombocytosis (plt 816), HCT 42.7%, RBC (9.21 H), MCV (46.4 L) - Radiographs: unremarkable thorax and abdomen

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. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone is normal.

The left kidney is normal in size (3.20 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 (3.90 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with normal corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is enlarged (0.67 cm at cranial pole) (0.57 cm at caudal pole) with swollen peripheral contours. The glandular echogenicity and detail are unremarkable. The phrenicoabdominal vein and surrounding vasculature are normal.

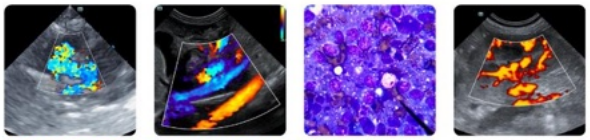
The right adrenal gland is mildly enlarged (0.59 cm at cranial pole) (0.55 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.54 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

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



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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 thin and smooth. A small to moderate amount of aggregated, echogenic mostly gravity-dependent debris/sludge is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal
The gastric lumen is not distended. The gastric wall is normal in thickness with a normal layering pattern. The small intestinal lumen is not dilated. The small intestinal wall thickness is normal 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 right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is hyperechoic 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
1-2 prominent mesenteric lymph nodes are visualized, one of the nodes measuring 0.94 x 0.46 cm. Surrounding mesentery is slightly hyperechoic. See *Other.*

Free Abdomen
There is no obvious evidence of free fluid.

Other
The uterine body is visible and measures 0.51 cm in width. The lumen is not overtly dilated.

In the mid-abdominal cavity, a 0.64 x 0.43 cm hypoechoic structure is visualized. Surrounding mesentery is hyperechoic.

ULTRASONOGRAPHIC FINDINGS

- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.
- The small intestinal changes are suggestive of enteritis.
- Mild bilateral adrenomegaly

*An obvious cause for the patient's hypoglycemia is not identified in this study. Considerations include sepsis, insulinoma, hepatic dysfunction, hypoadrenocorticism (less likely given the mildly enlarged adrenal glands), paraneoplastic disease, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- To further evaluate for causes of hypoglycemia, consider the following:
  1. Insulin: glucose ratio

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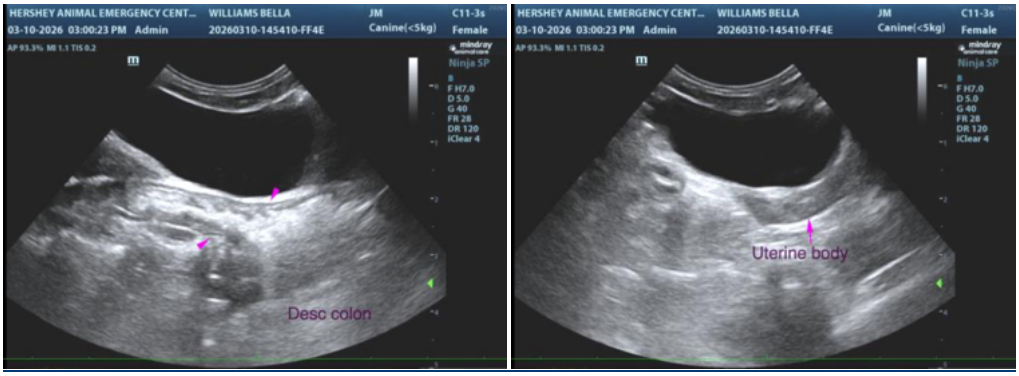
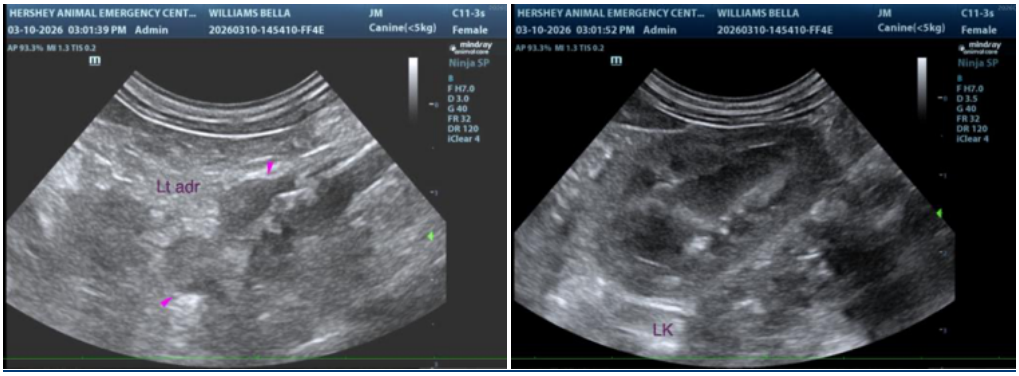
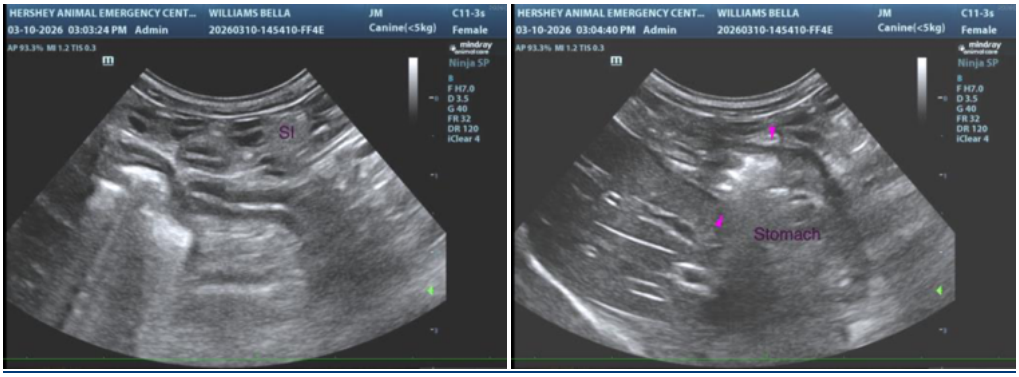
2. Pre and post-prandial serum bile acids
3. +/- resting cortisol level

- While awaiting test results, aggressive supportive care is recommended. Depending on the results of the above diagnostics, further workup may be indicated.







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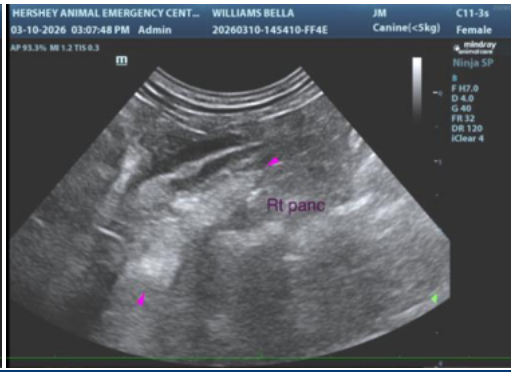

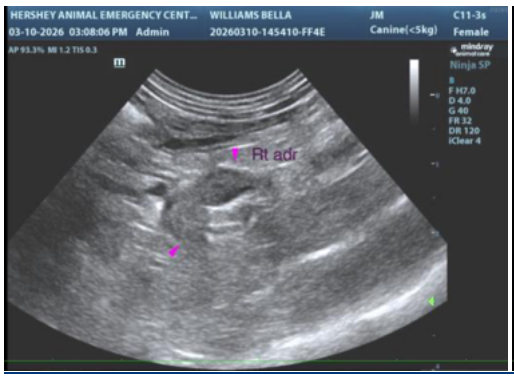

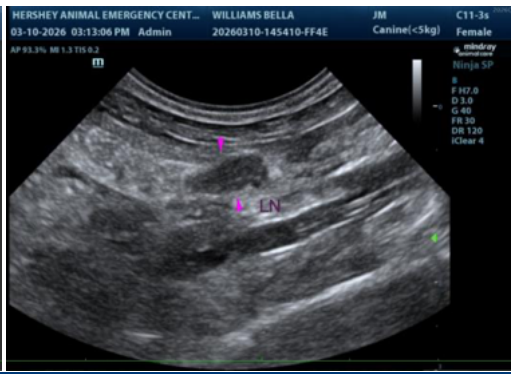

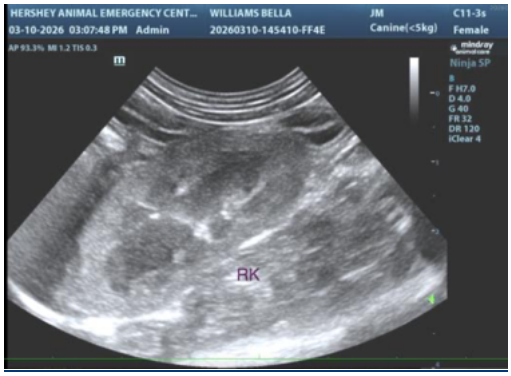

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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