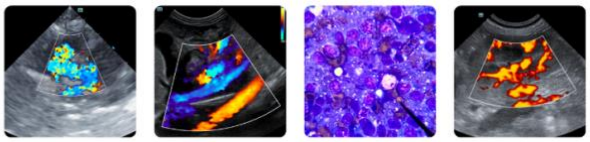


PATIENT

Bailey 2 McAlister

SPECIES

Canine

BREED

Mini Schnauzer

SEX

Female Spayed

AGE

8

WEIGHT

10.5 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Chrissy Krell, DVM

HOSPITAL NAME

Taylor EH

REFERRING VET

Chrissy Krell, DVM

INVOICE

22697

DATE

3-15-26

PRESENTING CLINICAL SIGNS

- Vomiting for 4-5 days total, not eating
- Significant weight loss: normally weighs 15 lbs, now weighs 10 lbs
- Initially seen at Ritter's on Wednesday for vomiting (symptoms started 2 days prior)
- Thursday: prescribed pills but medication compliance issue (pill found on bathroom floor)
- Friday: presented to Merced Animal Medical Center
- Currently on Cerenia
- Receiving IV fluids at 20 mls/hour
- History of sensitive stomach, previously treated at Santa Fe Pet Clinic
- Was on low-fat prescription diet (chicken and rice food) and tolerating well until recent decline
- Recent bowel movement: dark-colored, not solid, limited amounts.

-Patient has improved on fluids and supportive care overnight.
-Eating baby food and turkey.
-QAR and interactive today, still slightly distended belly but more comfortable overall.

Medications: Patient currently receiving IVF 15m/hr, offered food/water, Unasyn 30mg/kg TID, Cerenia 1mg/kg IV SID, Pantoprazole 1mg/kg SID, Buprenorphine 0.015mg/kg IV TID.

Abnormal PE/Chem/CBC/UA Results: PE: initially - very dull, recumbent, about 8% dehydrated, distended abdomen, uncomfortable on palpation. MM light pink, CRT ~1-2s. on 3/15/26 patient is QAR but interactive, starting to vocalize for owner after he left this afternoon, abdomen soft but still distended. CBC non regenerative anemia initially 29% at pDVM on 3/13, decreased to 18% by 3/15 AM and increased to 21.2% this afternoon. WBC 20K/uL, Monocytes 2.95K, suspect bands Chem: 3/13 ALP 471, 3/15: TP 5.4, ALB 1.9, Ca 7.7, ALP 431, BUN 5. 3/15: Baseline cortisol 17.1ug/dL AXR from pDVM on 3/14 and 3/15 consults reported suspected linear foreign body, notable hyperperistalsis/plication

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness. The mucosal surface is smooth. The bladder is moderately distended. A small- to moderate amount of suspended echogenic debris is observed within the lumen. No cystic calculi are observed. The region of the trigone and visible portion of the proximal urethra are normal.

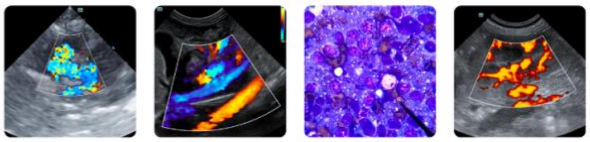
The left kidney is normal in size (4.57 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal- to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (5.22 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal- to mild 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 borderline enlarged (0.64 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.

The right adrenal gland is mildly enlarged (1.07 cm at cranial pole) (0.68 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule,



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cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.91 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 regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion.

The gallbladder lumen is moderately distended. The wall is thin and smooth. One- to two, small, polypoid-like lesions are arising from the mucosal surface. 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 and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. An at least 5.0 cm segment of small intestine in the right cranial abdomen is thickened (up to 0.54 cm) with a trend toward a loss of the normal layering pattern. The lumen in this region is mildly fluid-distended and hypomotile. The mesentery effacing the serosal surface is hyperechoic. Discreet masses are not identified. The colonic wall is normal. There is no obvious evidence of an obstructive pattern.

Pancreas

The right limb of the pancreas is visible with normal curvilinear peripheral contours. The parenchyma is slightly hyperechoic relative to surrounding omental fat and slightly heterogenous in appearance. The pancreatic duct is visible but not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Lymph Nodes

The abdominal lymph nodes are normal/not visible.

Free Abdomen

Trace free fluid is observed.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The segment of small intestinal wall thickening in the right cranial abdomen may represent an inflammatory process or emerging neoplasia. There is evidence of hypomotility in this region. Mild adjacent peritonitis is present.
- The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.

Secondary Findings

- Mild bilateral nonspecific age-related renal changes

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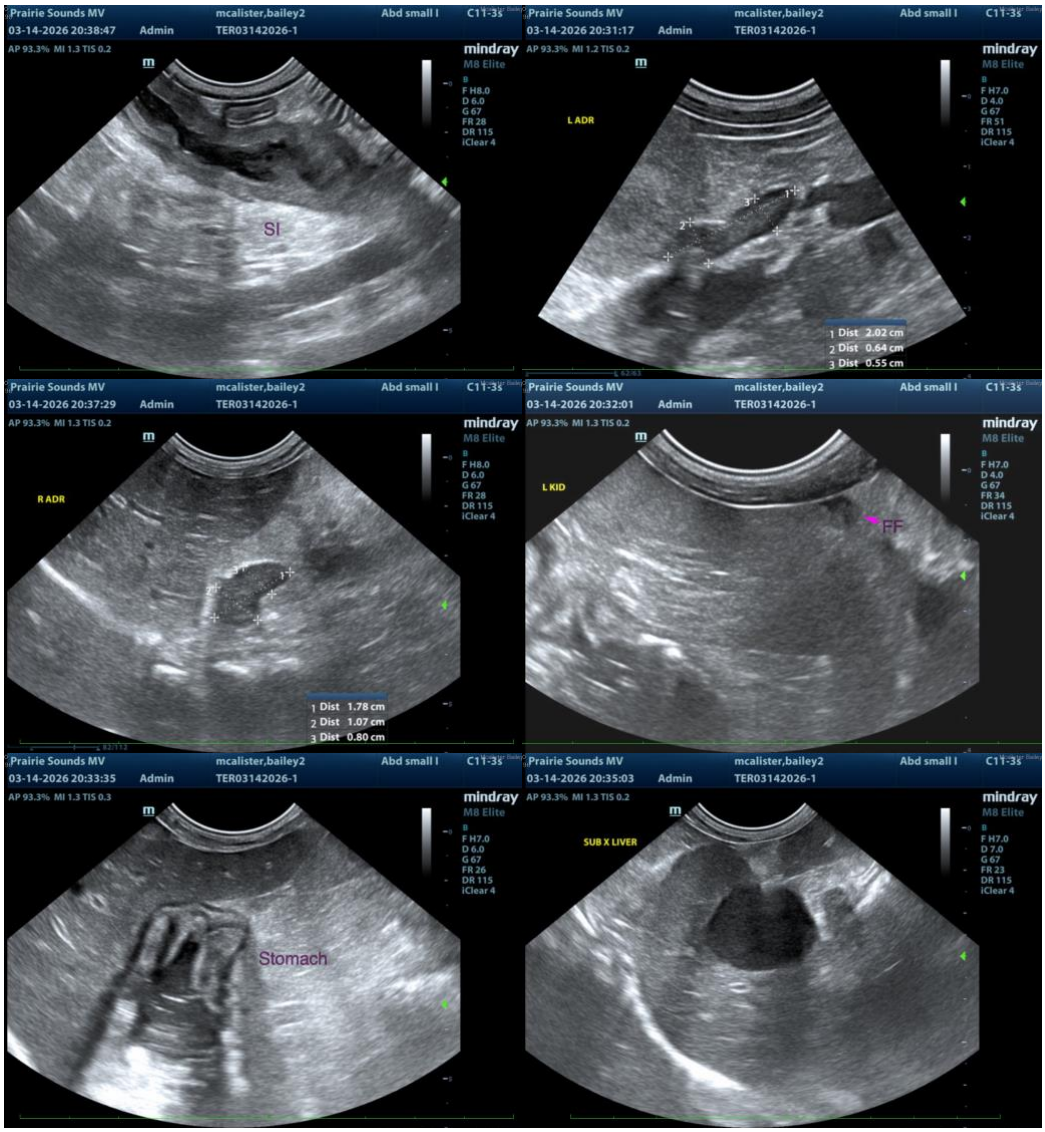
*There is no obvious evidence of a foreign body in the available images.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- If an aggressive approach is desired, consider an abdominal exploratory with GI biopsies (with particularly attention to the thickened small intestinal segment). Three-view thoracic radiographs are recommended prior to any anesthetic event. If surgery is not pursued at this time, continued supportive care is recommended.
- The patient's anemia should be close monitored and blood transfusions administered as needed.



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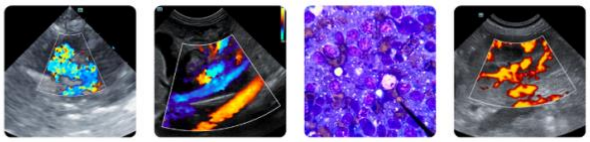

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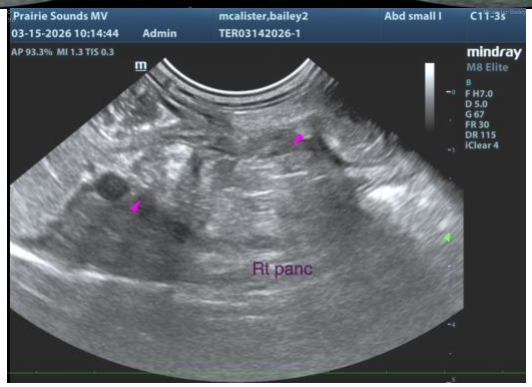

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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