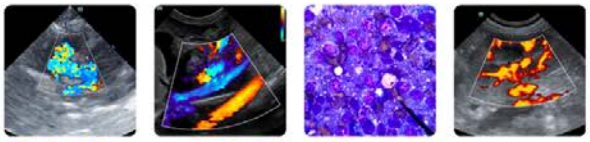


PATIENT

Bentley Cottle

SPECIES

Canine

BREED

English Bulldog

SEX

Neutered Male

AGE

9 Years

WEIGHT

22 kg

INTERPRETED BY

Brad Harris, DVM, DACVECC, Residency trained in cardiology

IMAGING PERFORMED BY

Mariusz Chmielinski, DVM

HOSPITAL NAME

Apex Veterinary Services, Ltd.

REFERRING VET

Alpine 24/7 ER

INVOICE

71855

DATE

11/16/25

PRESENTING CLINICAL SIGNS

Owners recently moved to a newly purchased older house about a week ago and started some renovation work, On Friday afternoon, Bentley ended up eating some of the drywall that was left on the floor. On Saturday 9am he vomited up grey liquid, ate breakfast (was slower to eat it) and had normal BM. Around 12:30pm he vomited a lot again (no blood). Owner took him to SAVE yesterday (Saturday) afternoon- he got bolus of SC fluids/ Maropitant and was send home for further monitoring. After that, he drank a lot of water, wasn't interested in eating anything and was stretching a lot. Owner ended up taking him back to SAVE ~9pm. Radiographs showed fluid distended stomach and large amount of small specks of radiopaque material throughout GIT. They passed NG tube under light sedation and drained ~1 cup of fluid. NG tube was removed, he was given additional dose of pain medication and was send home for further monitoring. Around 1:30am he had large bout of liquid diarrhea with red tinge, had been drooling, smacking lips, continued stretching a lot and shaking a little. No more vomiting was observed.

Abnormal PE/Chem/CBC/UA Results: T: 38.8C (aural) HR: 120/bpm RR: panting MM: pink, moist CRT: <2s. General Appearance/Attitude: QAR Abdomen: Tense and uncomfortable on palpation. BW CBC= elevated Reticulocyte Hgb (30.2; 22.3-29.6), monocytosis (1.19; 0.16-1.12x10^9/L), eosinopenia (0.01; 0.06-1.23x10^9/L) CHEM= hypokalemia (3.1; 3.5-5.8mmol/L), hypochloremia (108; 109-122 mmol/L), elevated Lipase (1817; 200-1800 U/L)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are unremarkable with normal wall thicknesses and normal tone. The ureters were not visualized, which is a normal finding. There are no uroliths or sediment noted, and anechoic urine is present. The ureteral papillae appear normal. There is no evidence of inflammatory, infiltrative, or neoplastic disease.

The kidneys are normal in size. The cortices are hyperechoic with a decrease in normal corticomedullary distinction. There are multifocal pinpoint dystrophic mineralizations with a normal cortex to medulla ratio. No significant pyelectasis or renal pelvic dilation. The renal capsules are mildly irregular bilaterally. Left kidney measures 6.58 cm. Right kidney measures 6.54 cm.

Adrenal Glands

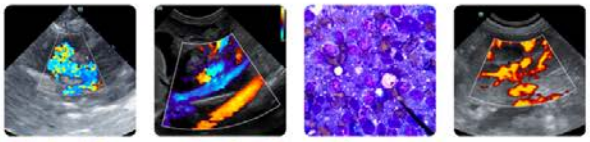
Both adrenal glands are prominent with no overt capsular expansion or evidence for vascular invasion. The phrenic vasculature is normal and the parenchymal detail is within normal limits. Left measures 0.95 cm at the caudal pole. Right measures 0.93 cm at the caudal pole.

Spleen

The spleen measures 1.5 cm at the hilus. It is smooth with homogeneous parenchyma and hyperechoic to liver and renal cortical parenchyma. The capsule is without noticeable irregularity or deformation. The splenic vasculature is normal without signs of congestion, spontaneous echo contrast, or thrombosis. No evidence of acute or chronic inflammatory, neoplastic, or infarct are documented.

Liver

The liver is subjectively normal liver size, contour, and structure. Parenchymal echogenicity is naturally coarse and hypoechoic to the spleen. Vasculature is within normal limits with no evidence of congestion.



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The gallbladder has thin walls which contain anechoic bile. There is no evidence of intra- or extra-hepatic biliary dilation. The cystic and common bile ducts were normal. No hepatic lymphadenopathy is documented. There is no overt structural evidence of inflammatory, infiltrative or regenerative pathology evident.

Gastrointestinal

The stomach is moderately distended with echogenic fluid and suspended shadowing debris. There are several linear angular shadowing materials within the stomach that is concerning for potential foreign material. The pyloroduodenal junction is patent with no evidence of outflow obstruction. There are regions of small intestine with moderate luminal distention and echogenic fluid. There is no overt shadowing foreign body obstruction noted, but a mechanical obstruction can't be ruled out, given the degree of luminal distention and presence of gastric shadowing material. There is a mild diffuse prominent of the small intestinal muscularis layer with normal overall wall thickness, and a focal segment of small intestine that is thickened with slight loss of normal wall detail.

Pancreas

The pancreas is prominent and diffusely hypoechoic with nodular hyper- and hypoechoic parenchymal changes. The capsule is irregular, and there is regional hyperechoic mesentery consistent with local steatitis.

ULTRASONOGRAPHIC FINDINGS

- The kidneys are relatively normal in size and structure, and cortex:medulla ratio (cortex 1/3 of medulla) is essentially maintained. There is age-related loss of the normal smooth capsular contour and C/M junction definition. The cortices are largely uniform in texture with mild hyperechogenicity expected for this patient's age. Dystrophic mineralization was noted and appears non-obstructive at this time, with no evidence of pylectasis.

- The adrenal glands are mildly enlarged with no evidence of focal capsular expansion or vascular invasion noted. The parenchyma is uniform and there is no overt suspicion of neoplasia. This is considered likely a hyperplastic change associated with stress or adrenal endocrinopathy (PDH).

- The gastrointestinal distention with shadowing material is concerning for potential mechanical gastrointestinal obstruction, although a definitive obstruction is not visualized on this study.

- The mild prominence of the gastrointestinal muscularis layer may be secondary to inflammatory changes given the likelihood of a concurrent gastroenteritis with the history of dietary indiscretion. However, infiltrative disease such as inflammatory bowel disease or other chronic enteropathy or infiltrative round cell neoplasia can't be definitively excluded.

- The focal segment of small intestine that is thickened with loss of normal wall layering likely represents a secondary inflammatory change, but again infiltrative disease, as mentioned above, can't be definitively ruled out.

- The prominent, hypoechoic pancreas with an irregular contour and mixed ill-defined hyper and hypoechoic changes is most consistent with pancreatic remodeling and nodular hyperplasia. This may be secondary to active or acute-on chronic inflammatory disease or pancreatitis.

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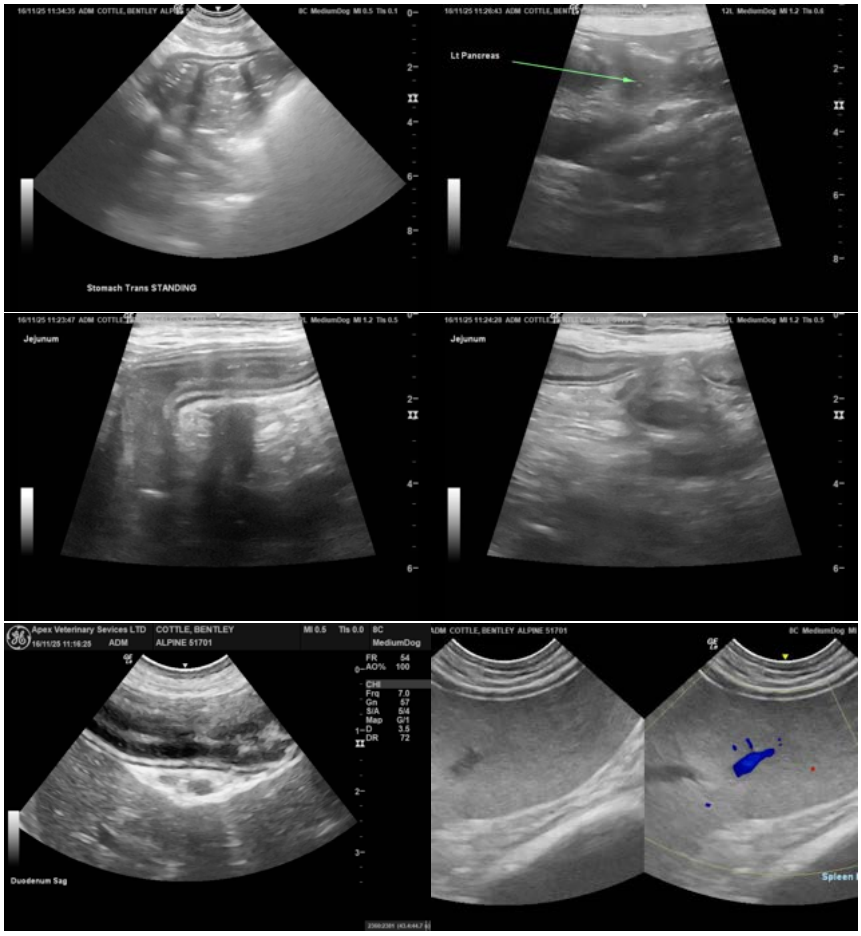
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A urinalysis and urine culture via cystocentesis are recommended to evaluate the urinary tract changes for potential urinary tract infection.

A spec cPLI is recommended to further evaluate the pancreas for active pancreatitis.

A gastrointestinal panel (TLI, PLI, B12, folate) via Texas A&M gastrointestinal laboratory is indicated to further evaluate for potential chronic enteropathy. Ultimately, gastrointestinal biopsies may be required for a definitive diagnosis.

Hospitalization with conservative management and serial imaging is reasonable at this time, given the lack of overt evidence for a mechanical gastrointestinal obstruction. However, consideration should be given to an exploratory laparotomy with the potential for gastrointestinal biopsies if the explore is negative for a mechanical obstruction. When clinical signs have resolved, consider an ACTH stimulation test and low dose dexamethasone suppression test to evaluate for potential pituitary dependent hyperadrenocorticism.



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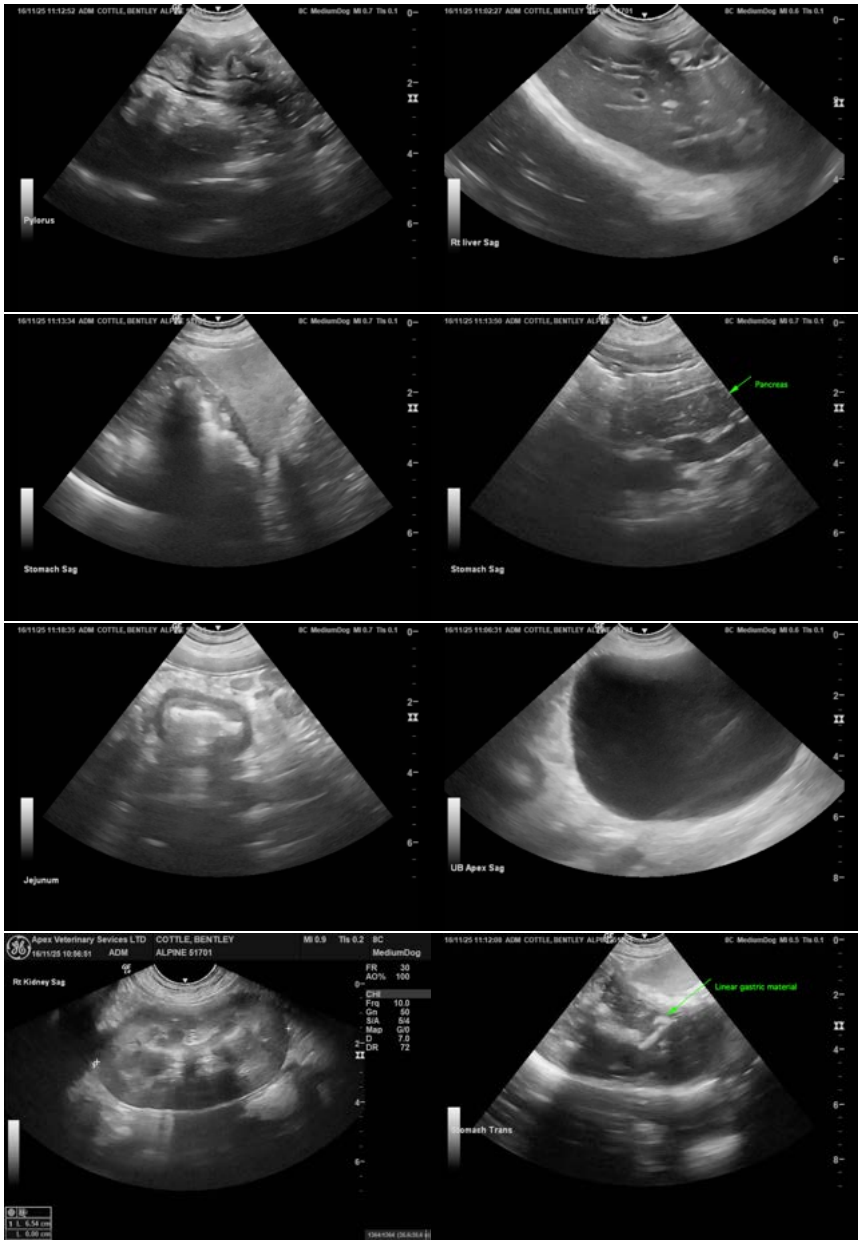

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Brad Harris, DVM, DACVECC, Residency trained in cardiology

info@SonoPath.com