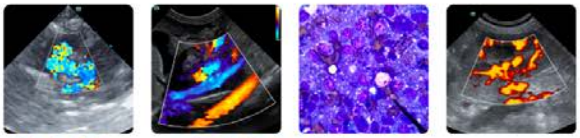


SonoPath www.thefocalzone.com info@thefocalzone.com 289.808.2608

PATIENT

Lottie Mazza

SPECIES

Canine

BREED

Jindo x

SEX

Spayed Female

AGE

3 Years

WEIGHT

9.6kg

INTERPRETED BY

Brad Harris, DVM, DACVECC, Residency trained in cardiology

IMAGING PERFORMED BY

Crystal Hill

HOSPITAL NAME

Hamilton Region Emergency Clinic

REFERRING VET

Dr. Diane Ho

INVOICE

71520

DATE

11/3/25

PRESENTING CLINICAL SIGNS

Vomiting and diarrhea for 4 days, now hematemesis and hematochezia(black tarry stools with no history of giving Pepto) Decreased interest in food although normally a picky eater, can eat foreign items in yard but overall trigger unknown. No new food fed recently. Was given Heartgard on the day before GI signs started but this is not new to her and she was given the correct dose. PE revealed QAR, mild dehydration and abdominal discomfort. Start IVF, maropitant, pantoprazole, sulcrate, entero-aid, fenbendazole.

Abnormal PE/Chem/CBC/UA Results: Mod erythrocytosis, HCT normal, very mild thrombocytopenia, RBC dot plot appears normal, BUN normal, TP mildly low, low normal albumin, pancreatic lipase normal, USG greater than 1.050 and overall quiet sediment, random cortisol pending, PT/PTT pending machine not working in clinic.

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. The bladder contains a mild amount of suspended echogenic debris. There is no urolithiasis noted. The ureteral papillae appear normal. There is no evidence of inflammatory, infiltrative, or neoplastic disease.

The kidneys are normal in size and structure, with appropriate corticomedullary definition and cortex to medulla ratio. The cortices are uniform in texture with normal echogenic relationship to liver and spleen. The medullary structure differed distinctly from the cortex and no evidence of pyelectasis is present. The capsules are uniform without significant irregularities noted. Left measures 4.19 cm. Right measures 4.28 cm.

Adrenal Glands

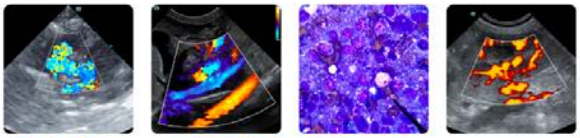
The adrenals appear slightly thin or “flattened” with an isoechoic homogeneous parenchyma. The capsule, cortex, and medullary definition were normal. The phrenic vasculature appears unremarkable. Left measures 0.51 cm x 1.68 cm. Right measures 0.42 cm x 1.21 cm.

Spleen

The spleen measures 1.6 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. 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.



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Gastrointestinal

The stomach is non-distended and free of stasis, with normal wall thickness and maintenance of normal wall layering. The pylorus and pyloroduodenal junction are patent with no evidence of mechanical outflow tract obstruction. The small intestine is multifocally minimally distended with echogenic fluid contents with a mild to-fro motion consistent with ileus. The gastrointestinal walls are normal in thickness with maintenance of normal wall layering. There are no overt macro ulcerations identified. The Ileocecocolic junction is patent, and the colon contains normal shadowing feces.

Pancreas

The base and limbs of the pancreas are isoechoic to surrounding omental fat. The pancreatic duct and capsular contour are normal. There is no overt evidence of active inflammatory or neoplastic disease.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- The urinary bladder contains echogenic, suspended debris contrasted with anechoic urine. This is often related to urinary tract infection but may represent exfoliated debris or sterile inflammation.
- There are areas of minor gastrointestinal luminal fluid noted with echogenic contents and a to-fro motion consistent with ileus. There was no evidence of an obstructive pattern, and normal wall thickness and layering is retained throughout the gastrointestinal tract. This is a consistent response to irritation or inflammation. Gastroenteritis or pancreatitis should be considered.
- Both adrenal glands are flattened and isoechoic. This may be normal for this patient or potentially secondary to hypoadrenocorticism or adrenal burnout from chronic disease.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

An ACTH stimulation test is indicated to evaluate for potential hypoadrenocorticism. A baseline/resting cortisol less than 0.52 µg/dL significantly increases the index of suspicion for hypoadrenocorticism.

Urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ratio is recommended.

Consider an acute gastroenteritis as an underlying cause for the clinical signs. However, if signs persist, consider a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory for further evaluation of GI and pancreatic function.

Pending additional diagnostics, continued supportive care, as clinically indicated, is recommended.

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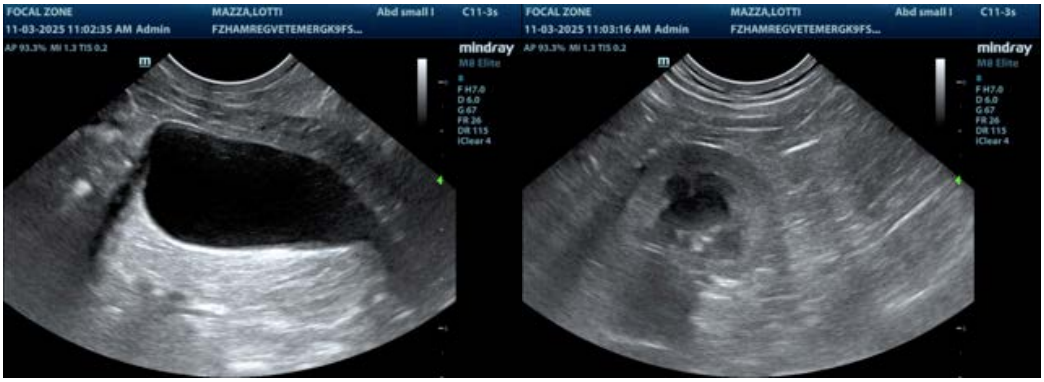

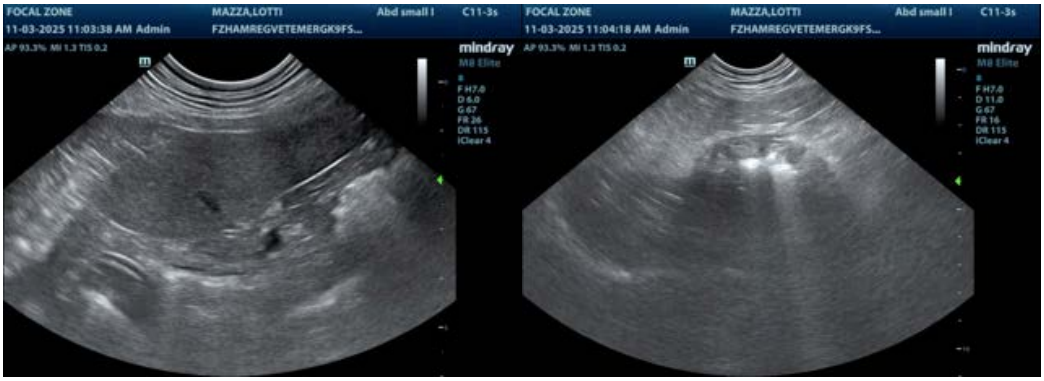

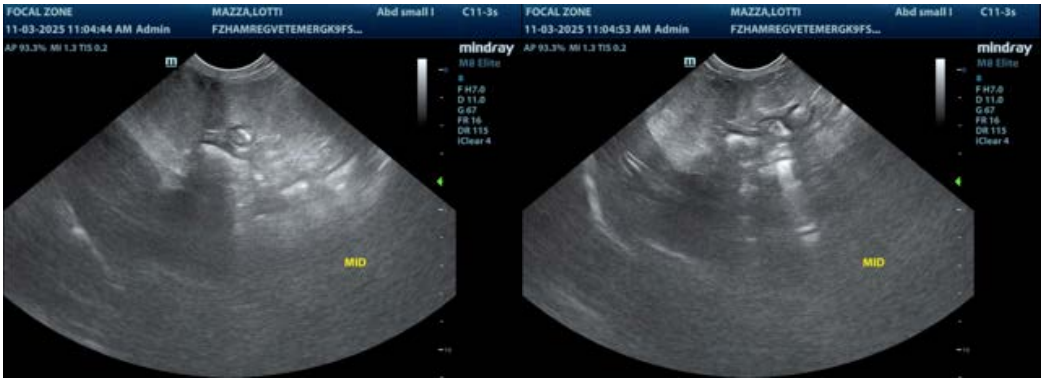

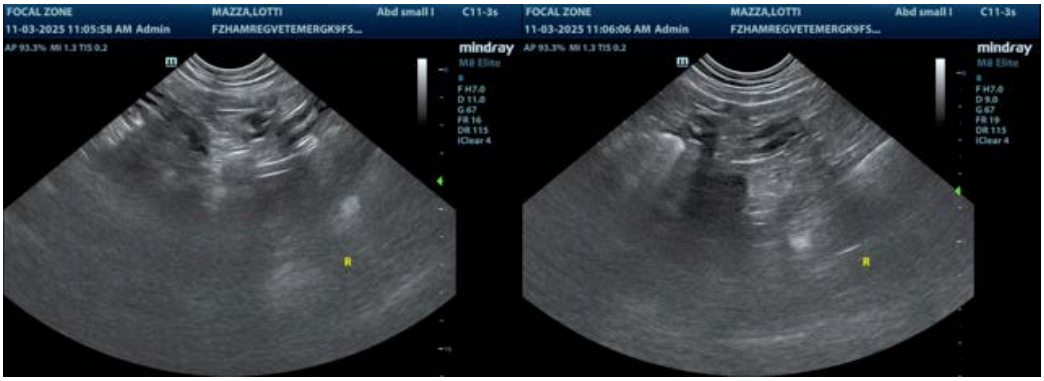

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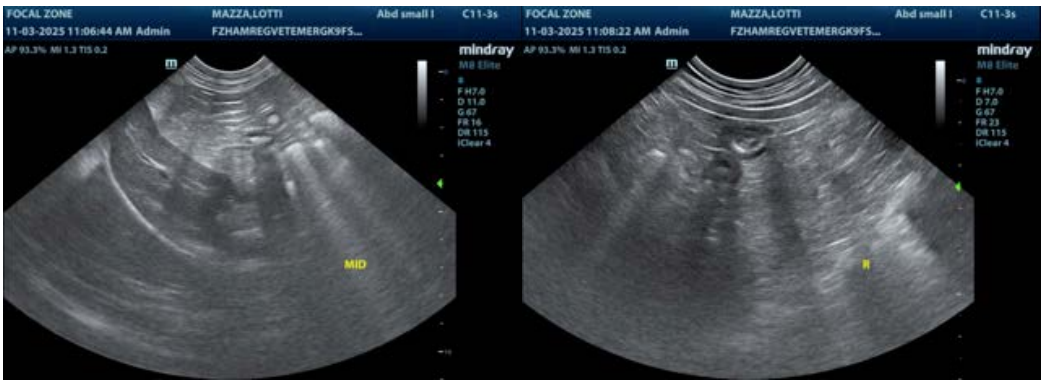

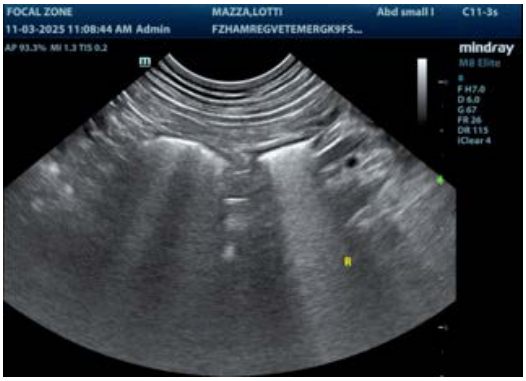

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Brad Harris, DVM, DACVECC, Residency trained in cardiology

info@SonoPath.com