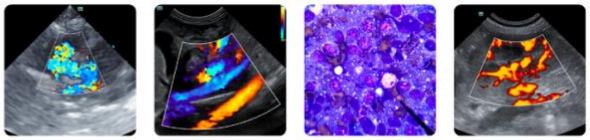


PATIENT

Sami Eisenberger

SPECIES

Canine

BREED

Doodle

SEX

Spayed Female

AGE

11 Years

WEIGHT

33 kg

INTERPRETED BY

Eric Lindquist, DMV, DABVP (Canine & Feline), Cert. IVUSS

IMAGING PERFORMED BY

Lindsay Powell, CVT

HOSPITAL NAME

Hershey AEC

REFERRING VET

Dr. Cara Sinopoli

INVOICE

37391

DATE

6/7/26

PRESENTING CLINICAL SIGNS

History: Presented Saturday 6/6 at 12p for hx eating 2 socks and diarrhea. O said she ate 2 socks last Saturday, she has been to PETS for vomiting, they did x-rays where they believe they found a FB, they gave cerenia, and was put on Omeprazole, Ondansetron and Proviable kit but today she started having diarrhea.

Abnormal PE/Chem/CBC/UA Results: EENT/oral: pink moist mm, crt 3-4s H/L: No m/a, snappy pulses, clear lung sounds, eupneic HAEC Intake Diagnostics: EPOC: Unremarkable PCV/TS: 44/7.2 CBC: Eosinophils 0.02K L Chem15: ALP 282 H Catalyst pancreatic lipase: 437 H Idexx resting cortisol: 7.17 Abdominal radiographs: mottled soft tissue opacity in moderately distended stomach, more dense material at pylorus, no obstructive pattern, mild gas diffusely in small intestines 6/6 Overnight: BP: 12a- 171/106(118), 5a- 187/89(109) PCV/TS: 42%/7.2 clear EPOC: pO2 126.9 (H) cSO2 98.8 (H) BE,ECF -5.2 (L) Repeat Radiographs: Significantly less material present within gastric lumen; still has some gas present in gastric lumen. No obvious fb or obstruction noted.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic urine. The 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. 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 loss of corticomedullary distinction, mild renal corticocystic changes, normal cortex to medulla ratio and mild dystrophic mineralization. No significant pyelectasis or obstructive disease. The capsules are mildly irregular. The left kidney measures 6.84 cm. The right kidney measures 7.50 cm.

Adrenal Glands

The adrenal glands are slightly prominent and swollen with a diffusely heterogeneous parenchyma. There's no evidence of capsular escape or vascular invasion noted. The phrenic vasculature is normal. The left adrenal gland measures 0.74 cm. The right adrenal gland measures 0.87 cm.

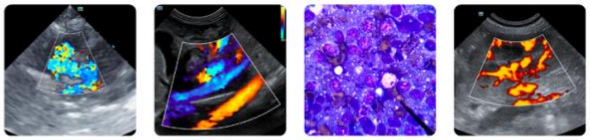
Spleen

The spleen is prominent with a diffusely heterogeneous or mottled parenchymal pattern. The vasculature is normal with no evidence of congestion. The spleen measures 2.3 cm at the hilus.

Liver

The liver is normal in size and contour with a mildly heterogeneous parenchyma. The vasculature is normal with no evidence of congestion. The gallbladder contains a mild amount of hyperechoic debris and sediment. There's no intra- or extrahepatic biliary dilation. The cystic and common bile ducts are normal.

Gastrointestinal



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The stomach is moderately distended with echogenic heterogeneous contents. There are multiple hyperechoic shadowing structures within the gastric fundus. The pylorus and pyloroduodenal junction are not completely evaluated. A pyloric outflow obstruction cannot be definitively excluded. The small intestine is nondistended with no significant dilation. The small intestinal walls are normal in thickness with maintenance of normal wall layering. The colon contains normal shadowing feces.

Pancreas

The pancreas is slightly prominent and hypoechoic with irregular margins. There's no overt hyperechoic regional mesentery or fat noted.

Free Abdomen

There is no significant lymphadenopathy or free fluid.

ULTRASONOGRAPHIC FINDINGS

- There is increased renal cortical echogenicity and thickening with a mildly irregular capsular contour. Multifocal cystic cortical changes are noted. This is secondary cystic formation consistent with degenerative changes and remodeling. There is no evidence of abscessation or suspicion of neoplasia. Dystrophic mineralization was noted and is 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 mildly enlarged spleen with a coarse/mottled reticular pattern is most consistent with a reactive spleen, or possible splenitis. Round cell neoplasia is considered less likely, but cannot be definitively excluded.
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory, immune-mediated, metabolic, or endocrine disease. Infiltrative neoplasia or acute hepatitis cannot be ruled out.
- The gallbladder contains echogenic, suspended and dependent unorganized debris. This is not yet to the level of an organized mucocele, however early/developing mucocele cannot be ruled out. This dependent sediment is often an incidental finding, or may be associated with concurrent endocrine disease such as hyperadrenocorticism or diabetes mellitus.
- The moderate amount of gastric contents is concerning given the patient's history of dietary indiscretion. Pyloric outflow obstruction can't be definitively excluded, but there's no overt evidence of small intestinal mechanical obstruction noted at this time.
- 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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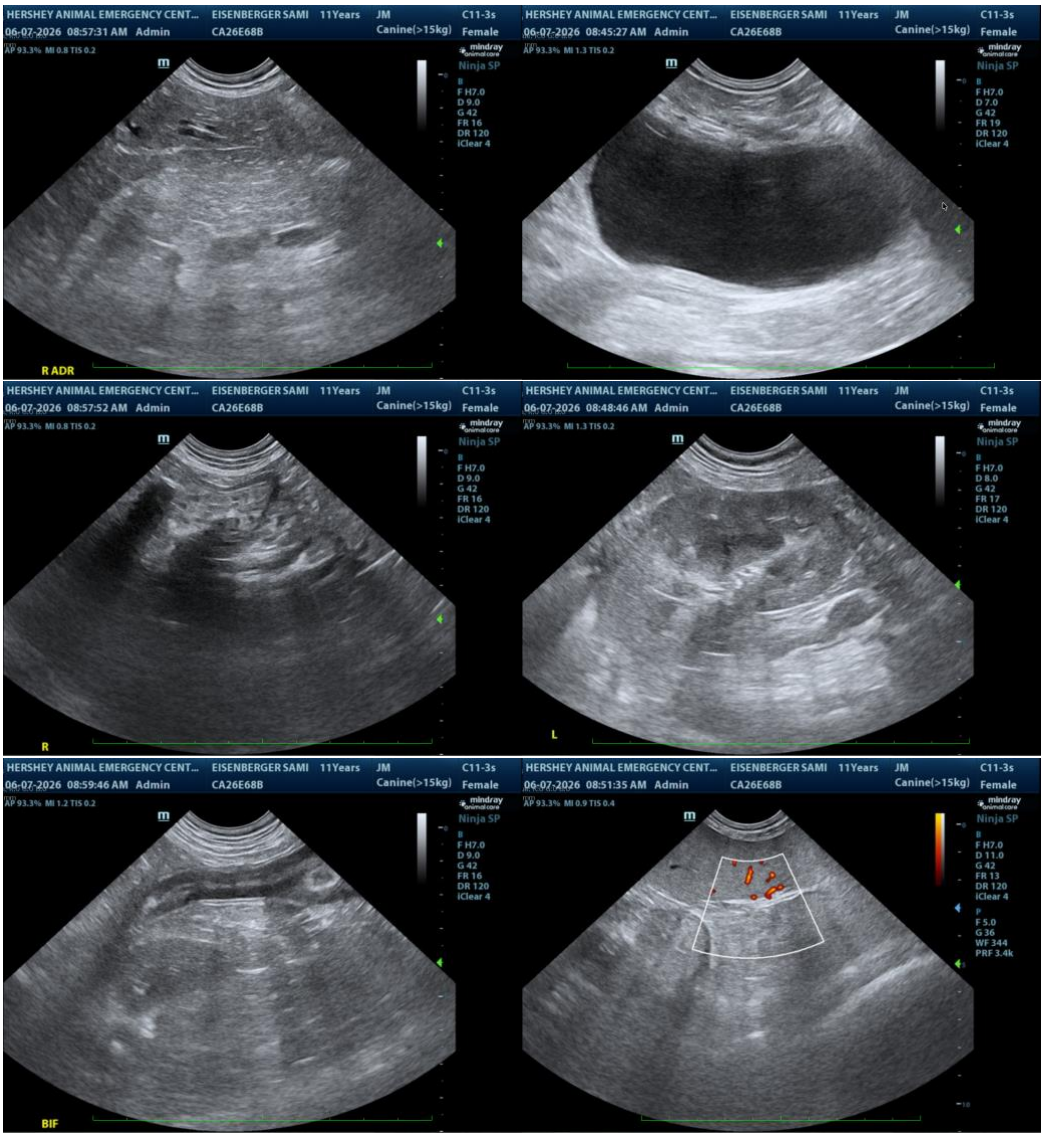
A urinalysis and urine culture via cystocentesis are recommended to evaluate the urinary tract changes for potential urinary tract infection.

Fine needle aspirates of the spleen and liver with cytology are recommended. A coagulation profile and platelet estimate prior to sampling are indicated to ensure the absence of coagulopathy. Occasionally some tissues are poorly exfoliative, or cytology is non-specific, in which case biopsy with histopathology may be required for a definitive diagnosis.

Continue supportive care for suspected pancreatitis, however, if the patient does not respond to supportive care over the next 24 hours, consider an exploratory laparotomy or endoscopy to further evaluate the pyloroduodenal junction for potential pyloric outflow obstruction.



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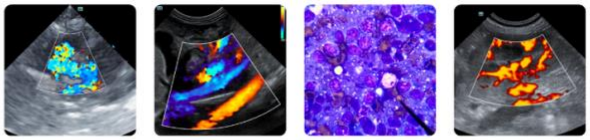

Clinical Sonography & Telecytology
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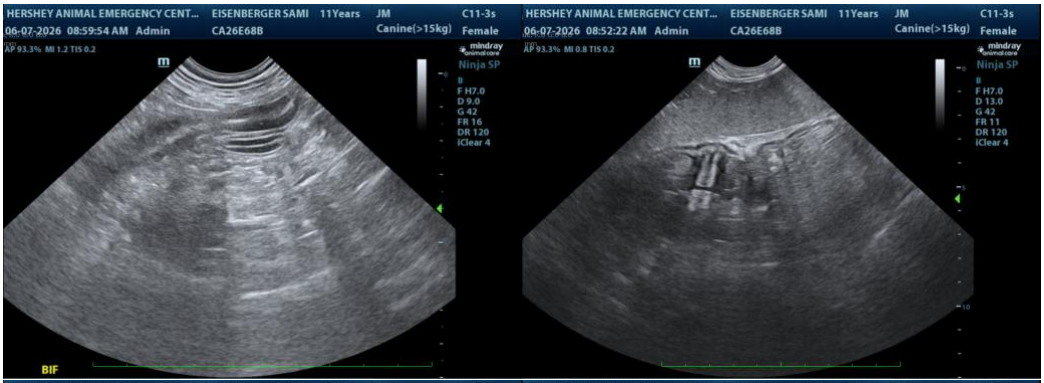

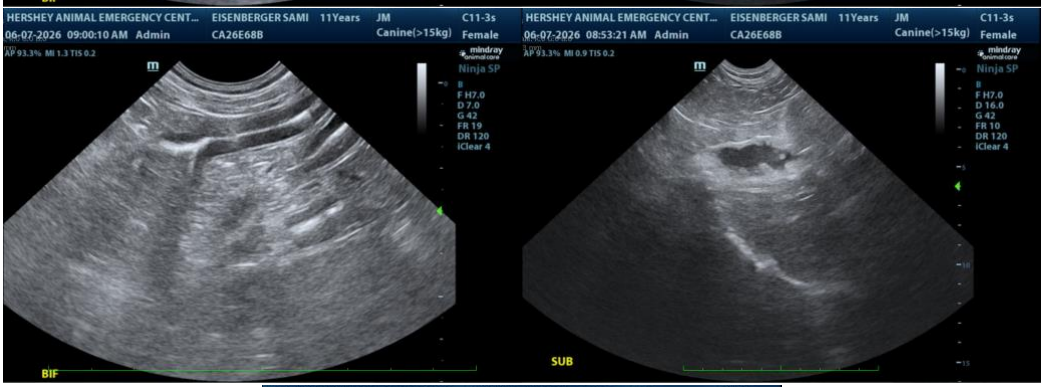

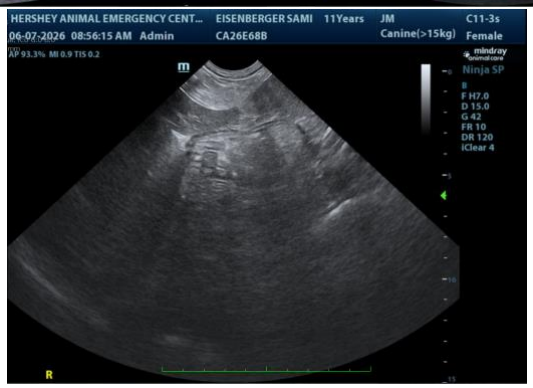

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Bradley Harris, DVM, DACVECC, DACVIM (Cardiology)

info@SonoPath.com