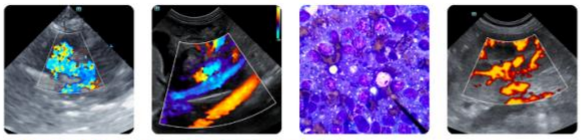


DATE

1/20/26

PATIENT

Riley Copenhaver

SPECIES

Canine

BREED

Miniature Schnauzer

SEX

Spayed Female

AGE

11/3/2024

WEIGHT

16 Pounds

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Dr. Campbell

INVOICE

35517

PRESENTING CLINICAL SIGNS

Patient History: Riley presents for evaluation of vomiting and diarrhea. Patient History: - Intermittent vomiting for the last 1.5-2 weeks. Initially vomited food, which client attributed to eating too fast. - Vomited bile yesterday morning. - Vomited early this morning after a bout of diarrhea. - Diarrhea started Wednesday night. The patient had an accident in the house. - Diarrhea worsened yesterday. - Last night, the patient had explosive, projectile diarrhea starting at 12:30 AM and had to go out 4 more times over the next 3 hours. - After the episode of vomiting and diarrhea this morning, the patient was reluctant to move. – Appetite has been picky for the last 1.5-2 weeks, requiring hand-feeding to start meals. - Patient is consuming her normal daily food volume, but at irregular times. - Diet consists of a breeder-recommended food, 1/2 cup BID. Client gave chicken and rice yesterday, which was eaten. -Client reports the patient noses around outside and chews on acorns. She also tears up tissues in the house. - The household includes two other dogs and one cat. Client states the patient does not have access to the other pets' food. -Was hosp for 1 day with apparent improvement, but vomited through cerenia and at home ondansetron so came back

Current Medications: Gabapentin, Ondansetron, Proviable.
Labwork Results: Labwork attached. Xray- Gas in the stomach, suspicious area with loss of serosal detail in the right cranial abdomen
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: STAT requested.
Imaging Performed by: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Left kidney is normal in size (4.3 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of mineral or infarcts observed. Trace pyelectasia is noted.

Right kidney is normal in size (4.6 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of mineral or infarcts observed. Trace pyelectasia is noted.

Adrenal Glands

Left adrenal gland is normal in size (0.52 cm at cranial pole and 0.59 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.7 cm at cranial pole and 0.51 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The area of the pancreas contains irregular hyperechoic pancreatic remodeling.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

The mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Significantly reactive mesenteric lymphadenopathy- infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Hyperechoic pancreas- This finding is suggestive of pancreatic fibrosis, possibly secondary to chronic pancreatitis. A TLI is recommended to rule out exocrine pancreatic insufficiency (EPI), especially if clinical signs (weight loss, diarrhea, etc.) are present.
- Moderate gallbladder debris- Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to

hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

Secondary Findings

- Trace bilateral pyelectasia

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Fine needle aspirates of the enlarged lymph nodes are recommended, if patient's coagulation status is appropriate.

A routine fecal/Giardia exam is recommended if not recently evaluated.

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

In the meantime:

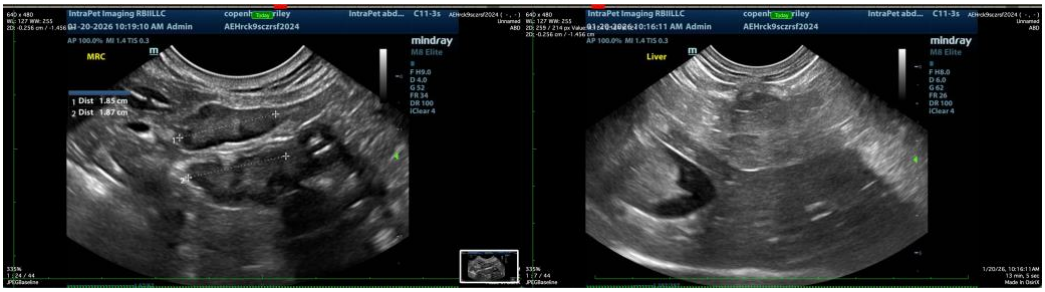
Supportive/symptomatic medical management of clinical signs is recommended, including anti-emetics, gastroprotectants (+/- sucralfate, especially with any history of hematemesis), an appetite stimulant and fluid therapy if indicated, etc.

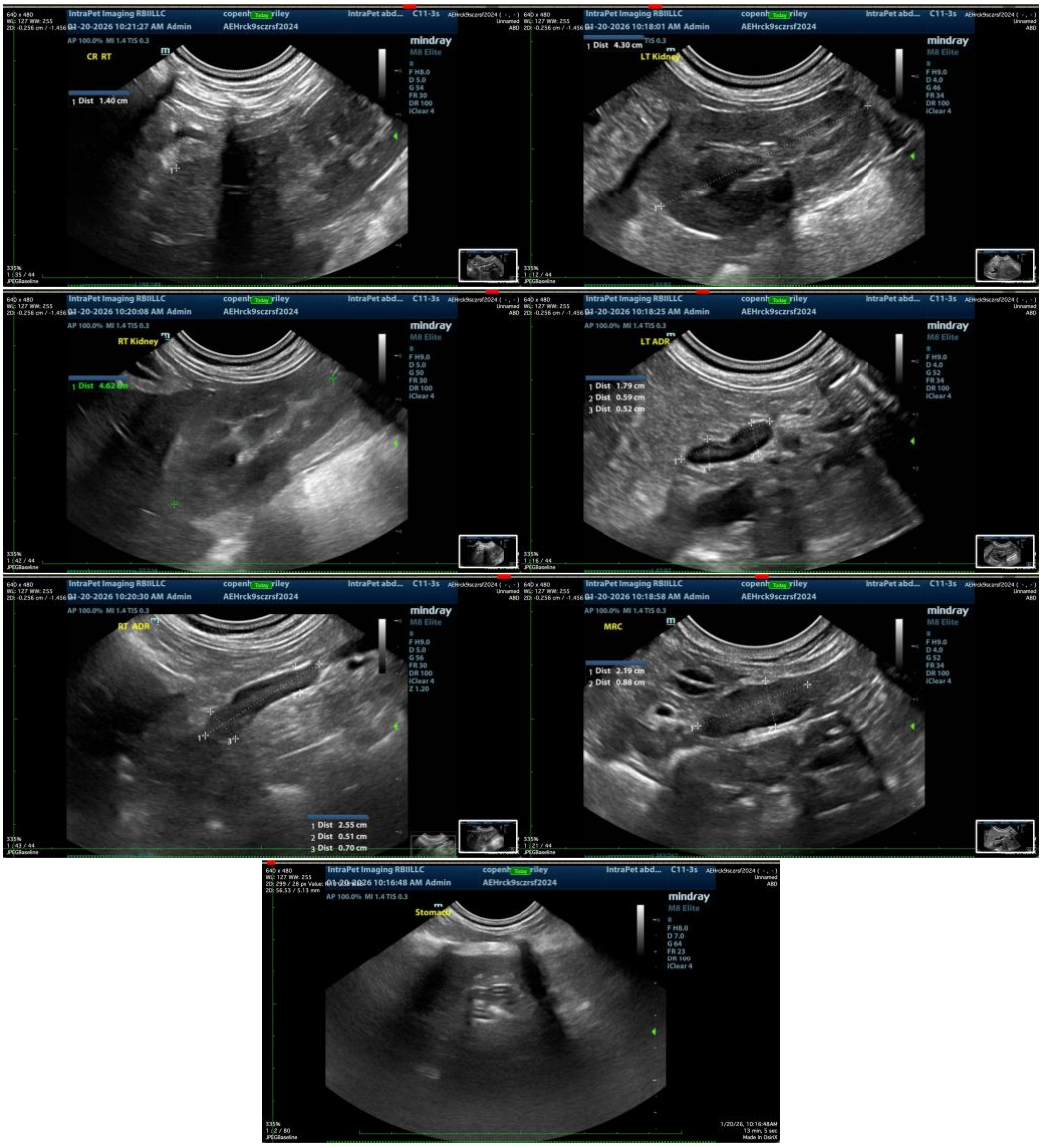
Additionally, empirical deworming with a 5-day course of Panacur is recommended.

A full course of empirical Helicobacter triple therapy could be considered.

A probiotic, such a visbiome or proviable, may be helpful.

Finally, if tolerated, a transition in diet could be considered, based on trial-and-error response with some options to consider including a gastrointestinal biome diet vs a hydrolyzed protein diet (sometimes several trials with different brands are necessary) vs an easy to digest, bland or low-fat diet vs other.





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.

Beth Johnson, DVM DACVIM

info@sonopath.com