PATIENT

Max Wayland

SPECIES

Canine

BREED

Bichon Frise

SEX

MN

AGE

10 years

WEIGHT

4 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Brighton Greens Veterinary Hospital

REFERRING VET

Dr. Robin Janeway

INVOICE

11066

DATE

1/7/2026

PRESENTING CLINICAL SIGNS

12/23/25 pt was evaluated for vomiting and diarrhea of several weeks- o felt symptoms started after he used some freeze dried food a friend gave them, both dogs developed diarrhea but the other dog improved after diet change. pt was also found to have a waxing and waning of his appetite. On exam Pt resented abdominal palpation and was found to have a fever of 103.4 Blood work revealed regenerative anemia, leukocytosis elevated bilirubin and mild elevation in ALT and ALP. hypoglycemia on in house panel but spot glucose was 83mg/dl. Radiographs to radiologist revealed hepatomegaly and signs of gastroenteritis. Brief in house ultrasound revealed possible gall bladder mucocele and renal cortex was found to have some hyperechoic areas. NOSF, no free fluid or mass lesions found. Lepto PCR blood and urine negative Pt was Tx with cerenia, sc fluids and rx Doxycycline, denamarin, ursodiol, visbiome and cerenia. Pt was back for recheck 12/29 - o noted pt shaking at home, was unsure if cold or stress or? NSF on physical exam. Normothermic. 1/5/26 pt came in after being unable to get up o was concerned possible stroke, o thought pt unable to use the left side of his body, but recovered within 30 minutes. Mentation was normal and neuro exam normal in hospital. O states lethargic and decreased appetite at home, no weight loss. MEDS_ Denamarin 90mg PO SID, doxycycline 20mg PO BID, Cerenia 30mg PO SID, ursodiol 62.5mg PO SID.

Abnormal PE/Chem/CBC/UA Results: Blood work revealed Hct 34%, TP 4.0, Alb 1.5, A/G 0.6, ALP 182 BUN/Creat 38, glu 67, Ca 7.9 (corrected Ca 9.9), Amyl 1950 Bilirubin and ALT now both WNL (TP prev 6.4 and Alb 2.5) 1/6/26 in house blood glucose 88mg/dl. Sent out UA and UPC Noted ascites on brief in house u/s- fluid is cloudy to clear grossly. Gall bladder continues to appear abnormal- concern for GB rupture. UPC <0.2 (WNL), UA NSF Working diagnosis GB rupture, bile peritonitis, lymphangiectasia, IBD, other cause of gi protein loss or decreased production by liver. * See above. Most recent 1/5/26- Hct 34%, TP 4.0, Alb 1.5, A/G 0.6, ALP 182 BUN/Creat 38, glu 67, Ca 7.9 (corrected Ca 9.9), Amyl 1950 Bilirubin and ALT now both WNL TP prev 6.4 and Alb 2.5 In house BG 88mg/dl UPC WNL.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The 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.

Prostate is normal in size, echotexture, and echogenicity for a neutered male.

The right kidney is normal is size (4.28 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 pyelectasia, mineral or infarcts observed.

The left kidney is mildly small (3.5 cm), irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. There is no mineral observed. Mild pyelectasia is present. Additionally, multiple chronic infarcts appear noted.

Adrenal Glands

The right adrenal gland is normal in size (0.55 cm at cranial pole and 0.47 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

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The left adrenal gland is normal in size (0.45 cm at cranial pole and 0.47 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

The 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 enlarged with mildly irregular margins. Parenchyma is mildly heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately overdistended with organized, aggregated and centralized non-gravity dependent sludge. Striations of sludge separated by anechoic areas are noted extending from the lumen to the luminal wall. The wall is mildly thick, irregular and hyperechoic. There is no evidence of CBD dilation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with a small to moderate amount of echogenic non-shadowing luminal content and gas consistent with normal ingesta. As well as some visibly shadowing contents. This shadow could still represent gas and ingesta, although non obstructive foreign material can't be ruled out.

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

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

Pancreas

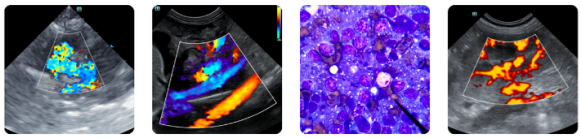
The observed pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and irregular in shape with a swollen undulating contour. Enhanced hyperechoic ill-defined surrounding fat is noted.

Free Abdomen

There is a moderate amount of free fluid noted in these images as well as diffusely enhanced/almost clumped appearing hyperechoic fat and mesentery, largely in the cranial abdomen.

Cranial abdominal/pancreaticoduodenal and portal 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.

*Upon further review after additional history, in the area of the portal lymph nodes adjacent to the portal vein, there are some views where there is a subtly more elongated echogenic appearance adjacent to and over the portal vessel that could represent early or portal thrombus of the portal vein. Definitive obstruction with doppler is difficult to assess but this finding warrants monitoring pending



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patient response, as well as potentially consideration of anti-thrombotic therapy, given patient's reported hypoalbuminemia, if coagulation status is otherwise appropriate.

Other

Cardiac images are non-diagnostic owing to interfering artifact.

ULTRASONOGRAPHIC FINDINGS

- Suspect moderate to severe acute pancreatitis.
- Gallbladder mucocele.
- Moderate mucosal speckling – Mucosal speckling is often present with inflammatory bowel disease (IBD). It is not specific for type or severity of disease. Mild speckling change can occur as a normal patient variant in the post-prandial state.
- Mild to moderate chronic kidney disease changes and pyelectasia primarily noted in the left kidney.
- A moderate amount of free fluid is of unknown origin. Differentials (unless already ruled out) could include increased hydrostatic pressure (cardiac disease and/or vascular or lymph blockage), decreased oncotic pressure (low albumin), vasculitis, paraneoplastic fluid, rupture/leakage of/from an organ (GI, GB, UB, other), blood (hemoabdomen), other.
- Mildly heterogenous Liver – These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.
- Moderately reactive cranial abdominal (portal and pancreaticoduodenal lymph nodes) – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Non-obstructive gastric material can't be definitively ruled out. As stated above, however, normal ingesta and gas can mimic the appearance. Reassessment following an additional 12-24 hours of fasting could be considered.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a significant amount of pathology in this study involving the pancreas, gallbladder, and bowel. Any of which or a combination could be contributing to patient's reported clinical signs as well as the free abdominal fluid, etc. There's no definitive evidence of gallbladder rupture, but gallbladder leakage/rupture contributing to the free fluid can't be definitively ruled out.

Having said that, Based on imaging. My suspicion is that the primary diagnosis is moderate to severe acute pancreatitis. With the free fluid exacerbated by patient's reported hypoalbuminemia. Concurrent protein losing enteropathy is possible with the gallbladder mucocele of unknown contribution to patient's reported clinical signs especially in the face of resolved liver enzymes.

Therefore, further diagnostics are indicated, beginning with:

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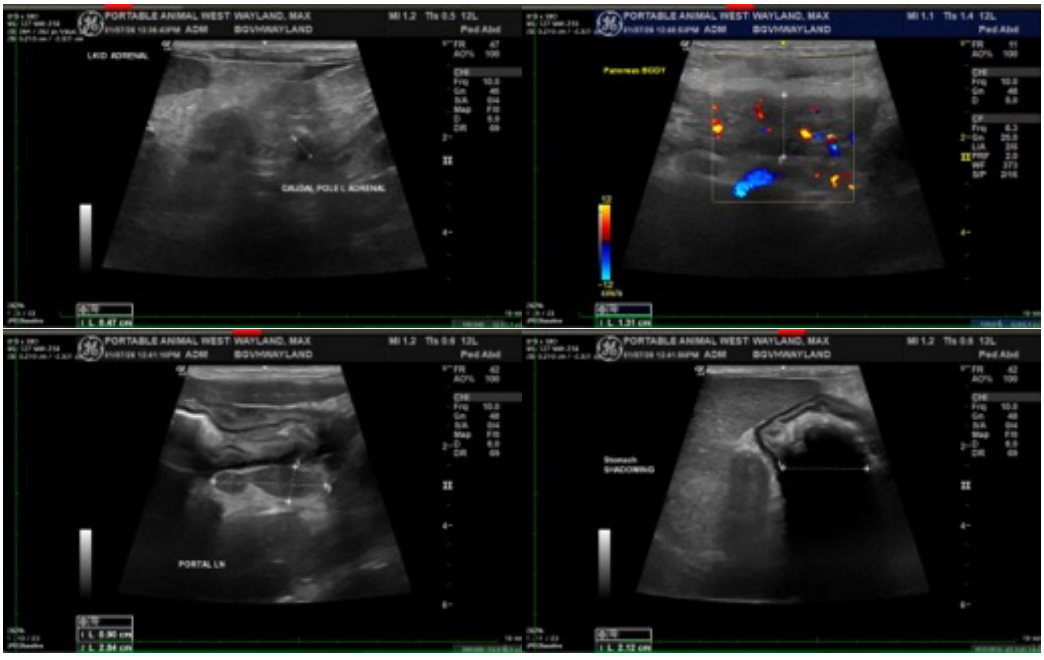
- Sampling of the free abdominal fluid for analysis and cytology.
- A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.
- A fecal enteropathogen PCR panel to Texas A&M GI Laboratory 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.

In the meantime, medical management of pancreatitis with anti-emetics, gastroprotectants, appetite stimulants or nutritional support as needed, pain management, broad spectrum antibiotics, and fluid therapy is recommended. If possible, a fresh frozen plasma transfusion and hyperbaric oxygen therapy (HBOT) could be beneficial. Monitoring of the pancreas with power doppler is recommended to identify possible necrosis as well as other potential sequelae such as abscesses, etc.

Further/more aggressive intervention, up to and including, a possible exploratory laparotomy for further evaluation and potentially removal of the gallbladder, potentially biopsies of the GI tract +/- pancreas, etc., may be warranted pending patient's ongoing clinical status as well as results of the above.



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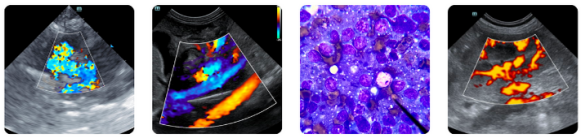

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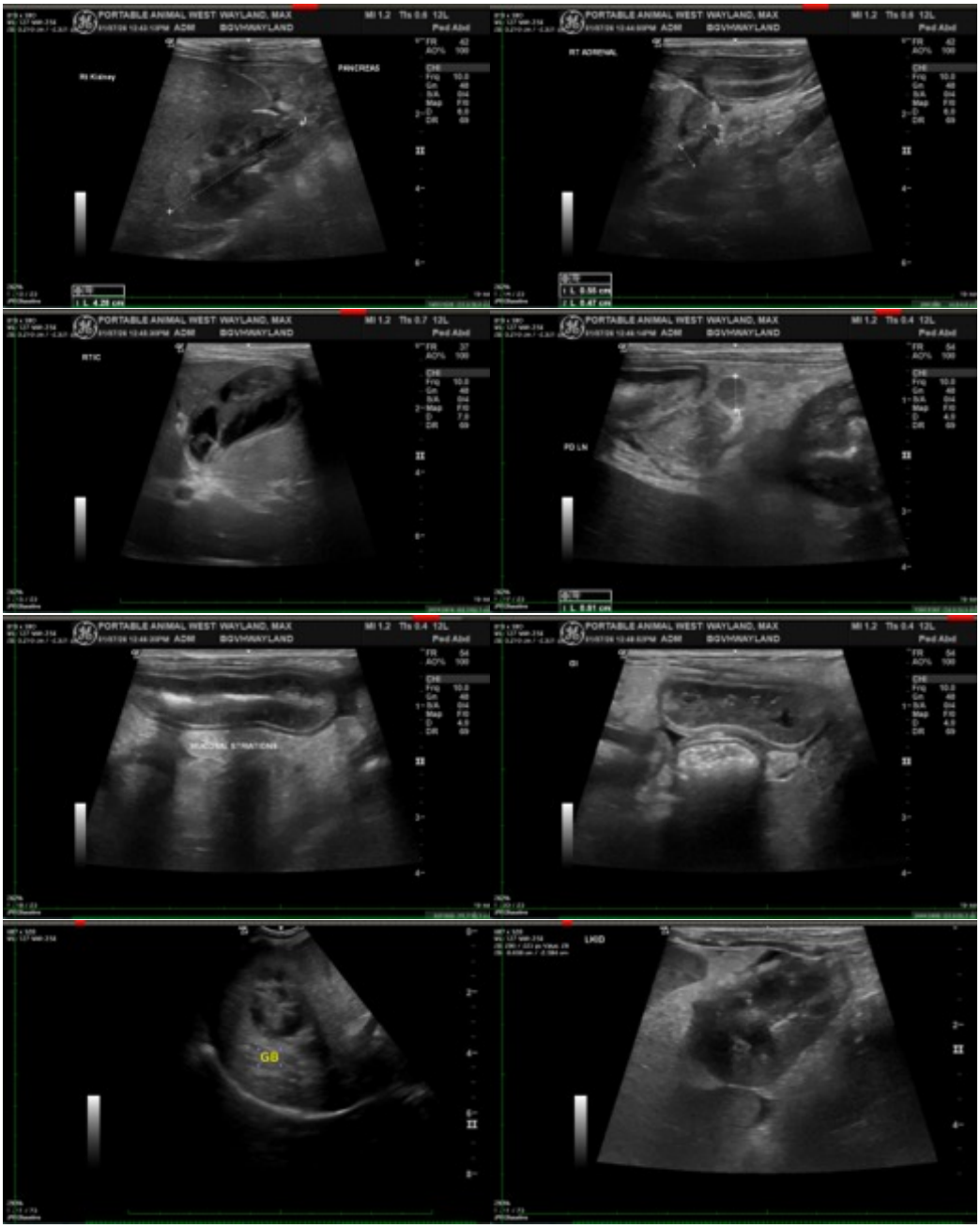

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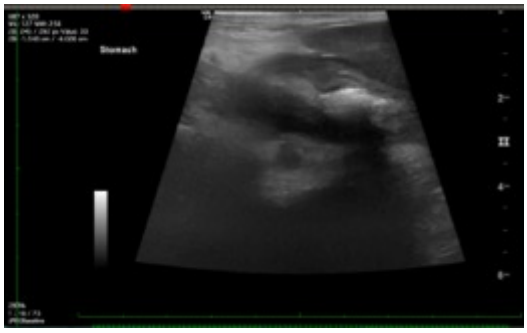

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM info@sonopath.com