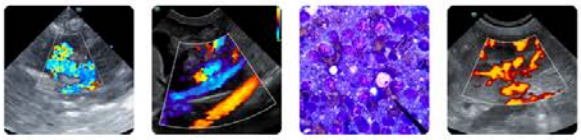


DATE

11/26/25

PATIENT

Ace Diggs

SPECIES

Canine

BREED

Yorki-Poo

SEX

Spayed Female

AGE

5/31/20

WEIGHT

6.7 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Dr. Kalwa

INVOICE

72109

PRESENTING CLINICAL SIGNS

Patient History: Potential blockage, coughing/choking, snotty nose, may have eaten plastic wrapping and paper towels found in throw up History: - Presents for: Vomiting, diarrhea, inappetence, lethargy, cough, nasal discharge, previous episode of neurologic signs. - Previous GI upset after suspected ingestion of plastic wrap and paper towels; initial presentation with vomiting and diarrhea beginning 11/24 pm. - Single episode of diarrhea; minimal water intake; persistent vomiting (progressing to clear, thick material, nasal discharge). - Defecation absent since 11/24; urination normal. - History of past foreign body ingestion, known pruritus, environmental allergies managed with allergy medication. - Sensitive GI tract; previously on prescription diets (Royal Canin), tolerates select fruits/vegetables when stable. - Significant weight loss noted; described as chronically thin and unthrifty. - Previous hospitalization for five days due to acute neurologic event: ataxia, unable to walk, possible seizures, unclear etiology. - Past diagnostics (per records): No leukocytosis on CBC; hypernatremia (sodium elevated), resolved with correction; normal ammonia and kidney values. - No confirmed diagnosis of Addison's disease. - Previous recommendations included antibiotics.

Current Medications: None listed.
Labwork Results: Labwork reported as pending…. Attached.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: IV Torb and flow by oxygen.
Stat Report: STAT requested.
Imaging Performed by: Rachel Brilhart, RDMS.

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.

The right kidney is normal is size (4.06 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 normal is size (3.8 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.

Adrenal Glands

The right adrenal gland is normal in size (0.80 cm at cranial pole and 0.50 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.50 cm at cranial pole and 0.60 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

The 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.

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

Gastrointestinal

Fundic mucosal hypertrophy with hyperechoic mucosa and some mucosal remodeling is noted. There is no loss of mural detail. Layering is normal. There is mild luminal fluid accumulation. No evidence of masses/nodules or foreign material present.

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

Pancreas is prominent (enlarged) in size and mildly irregular in shape with a slightly undulating contour. Parenchyma is coarse in echotexture and heterogenous to hypoechoic in echogenicity.

Free Abdomen

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

There is no apparent pathologic lymphadenopathy noted in these images.

Transdiaphragmatic views revealed a comet tail lung pattern, echogenic sound wave interfaces as a result of microconsolidations within the lung field. The lung field should not be visualized by sonogram unless pathology is present.

ULTRASONOGRAPHIC FINDINGS

- Chronic low-grade smoldering pancreatitis can't be ruled out and should be suspected in the face of appropriate ongoing clinical signs.

- Gastritis – Consistent with irritation secondary to dietary indiscretion or intolerance, infection (bacterial, viral, other), parasitic or protozoal disease, toxin, other metabolic disease such as pancreatitis, other. Microulceration cannot be ruled out.

- Ring downs – suggestive of lung pathology such as infiltrative neoplasia, thromboembolic disease, chronic inflammatory disease, etc.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated, three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, 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.

Differentials for patient's reported leukopenia could include infectious disease, neoplastic disease, autoimmune disease, etc. Therefore, additionally a comprehensive infectious disease evaluation could be considered, including possible gastrointestinal disease.

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, in addition to medical management of suspected (based on patient's clinical signs) possible aspiration pneumonia:

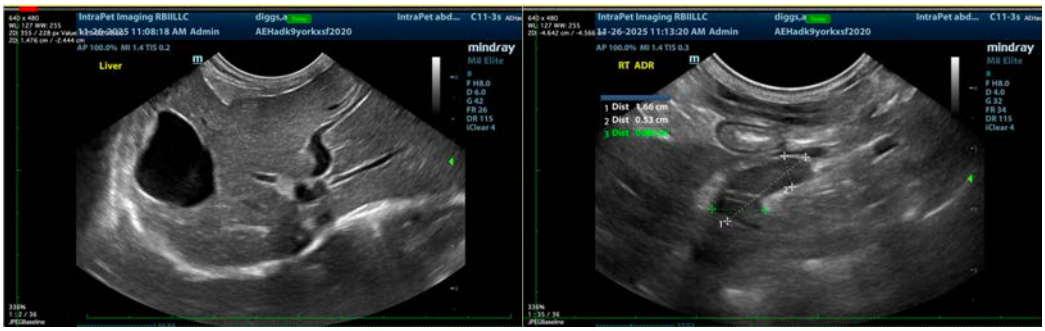
- Supportive/symptomatic medical management of clinical signs is recommended, including anti-emetics, gastroprotectants (+/- sucralfate, especially with any history of hematemesis), an appetite stimulant and fluid therapy if indicated, etc.

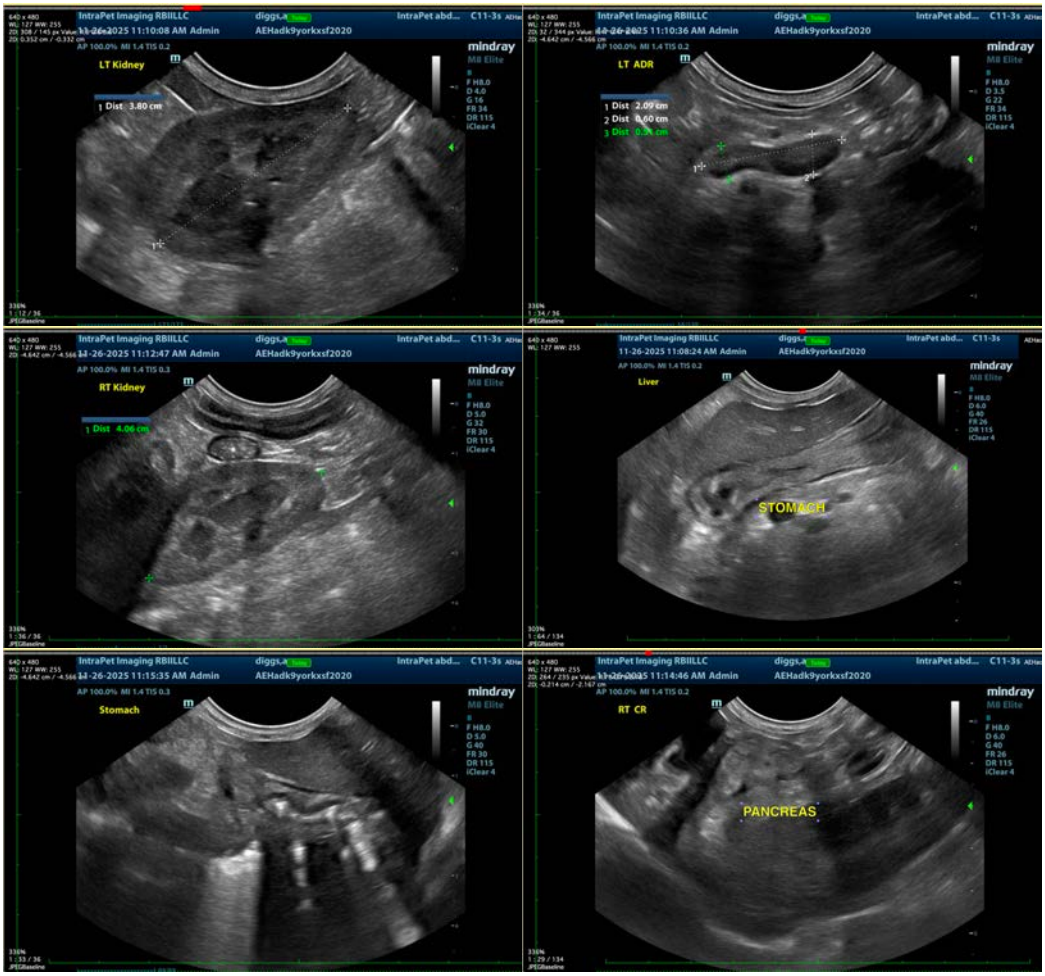
- Additionally, empirical deworming with a 5-day course of Panacur is recommended.

- A full course of empirical Helicobacter triple therapy could be considerd.

- 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