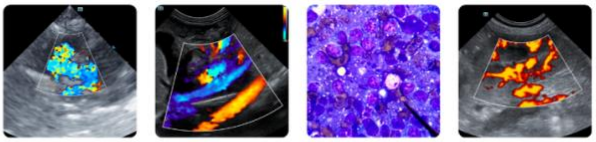



**PATIENT**

Brodie Gomora

**SPECIES**

Canine

**BREED**

Pomeranian Mix

**SEX**

Neutered Male

**AGE**

3 Years

**WEIGHT**

9.02 kg

**INTERPRETED BY**

Beth Johnson, DVM DACVIM

**IMAGING PERFORMED BY**

Melissa Randolph

**HOSPITAL NAME**

Shores Veterinary Emergency Center

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Dr. Julia Kerr

**INVOICE**

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**DATE**

04/22/26

## PRESENTING CLINICAL SIGNS

*P yesterday 12 pm noted as ADR and not playful. P last night did not eat dinner. Last night P vomited 2 times food and fluid; no vomiting overnight; today vomited two times clear fluid. P did not eat this morning. Today P is lethargic. Owner noted nausea and abdominal pain. P housemate was also vomiting today. No known toxin or ingestion of anything. P two weeks ago had annual exam and vaccines with no concerns. No prior significant health concerns. p admitted for supportive care. iv fluids, Cerenia, ondansetron, buprenorphine, Panoquel, Unasyn. *concern for severe pancreatitis - r/o idiopathic, dietary indiscretion, secondary to foreign body/obstruction; Marked liver enzyme elevation - r/o secondary to pancreatitis/biliary obstruction, primary hepatopathy

PE: dull/depressed, laying lateral in exam room; moderate pain 3/4; very tense on abd palpation--reactive, very uncomfortable; heart murmur CBC: Lymphocytes: 0.17 [L], Hematocrit: 66% [H], Hemoglobin: 22.7 [H], Red blood cells: 9.23 [H] Blood Gas [EPOC]: Lactate: 4.09 [H], Hematocrit: 67% [H], Base excess: -6.4 [L] Chemistry: Phosphorus: 7 [H], Total protein: 8.7 [H], Albumin: 4.1 [H], Globulin: 4.6 [H], Cholesterol: 324 [H], ALT: 133 [H], ALP: 385 [H], GGT: 50 [H] [ref <14], Total bilirubin: 2.4 [H], Amylase: 1,937 [H], Lipase: Too high to read cPL: Abnormal >2000 rads: Severely decreased serosal detail, concerning for peritoneal effusion. Mineral opacity ingesta in the descending colon. Significant gas in the intestines. Foreign body cannot be completely ruled out.

## 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.

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

Left kidney is normal in size (3.97 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 present.

Right 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 pyelectasia, mineral or infarcts observed.

### *Adrenal Glands*

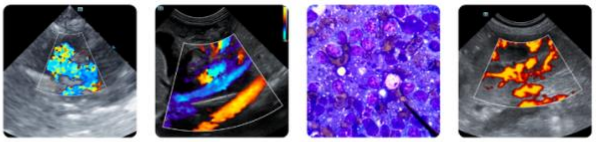
The adrenal glands are unable to be visualized in these images.

### *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





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homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

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*

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with primarily fluid as well as some echogenic non-shadowing luminal contents and gas consistent with normal chyme. There is 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*

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. Monitoring of the pancreas with power doppler is recommended to identify possible necrosis as well as other potential sequelae such as abscesses, etc.

### *Free Abdomen*

There is no apparent pathologic lymphadenopathy noted in these images.

The entire cranial abdomen is difficult to fully interpret due to pockets of free fluid, markedly enhanced hyperechoic mesentery throughout the area, some artifact from gastrointestinal gas, etc. I suspect that the largest degree of pathology and the changes associated with it are secondary to pancreatitis. Having said that, focal bowel disease in the area can't be definitively ruled out due to poor differentiation and detail of normal anatomy in the area.

## ULTRASONOGRAPHIC FINDINGS

- Suspect moderate to severe pancreatitis.
- As mentioned above, concurrent gastric or proximal small bowel disease can't be ruled out but is considered thus likely.
- Trace pyelectasia in the left kidney.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

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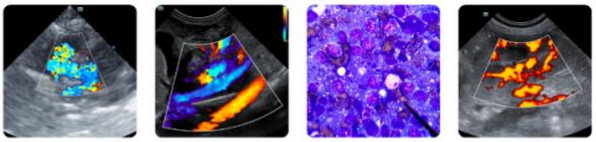

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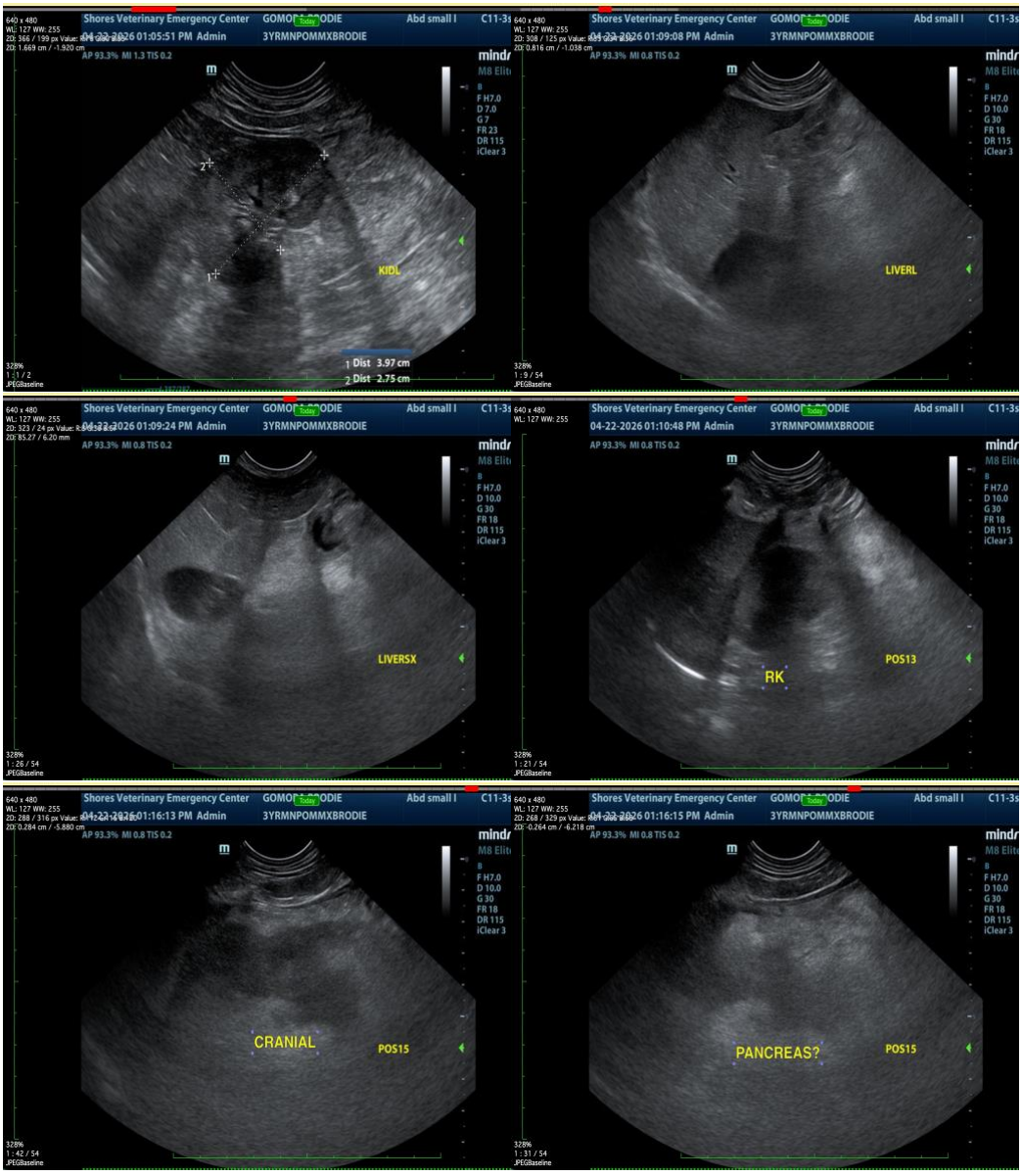

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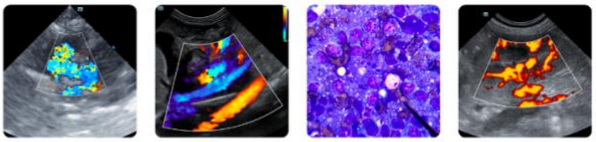

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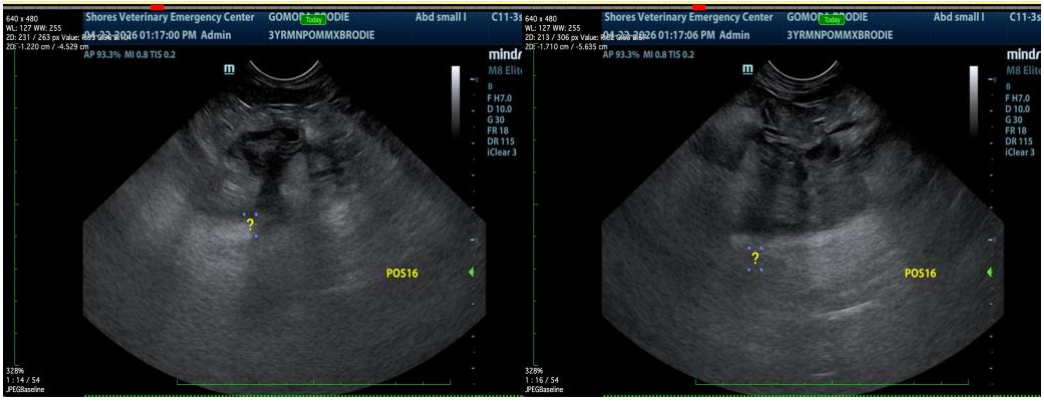


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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