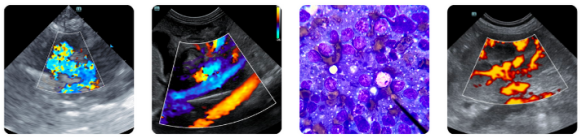


DATE

4/28/2026

PATIENT

Colby Schuler

SPECIES

Canine

BREED

Yorkshire Terrier

SEX

Intact Male

AGE

13 years

WEIGHT

6.9 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

HOSPITAL NAME

Animal Emergency Hospital

REFERRING VET

Dr. Jones

INVOICE

11804

PRESENTING CLINICAL SIGNS

Patient History: Colby presents for inappetence of 3 days duration and suspected pancreatitis flare-up. History of chronic pancreatitis; last flare-up December 2023 (hospitalized at Animal Emergency Hospital) - Maintained on low-fat diet (Pro Plan EN) due to pancreatitis history - Recent dental disease treated at outside veterinarian (Hickory Vet) with antibiotics and gabapentin; Chronic upper respiratory signs for past year - Inappetent x 4-5 days; initially ate home-cooked bland diet (boiled chicken, rice, string beans, carrots) for couple days, then switched to ground beef (fat drained) for couple days, now refusing all food x 3 days - Decreased water intake but still drinking some - Vomited once on Friday evening when picked up - Client administered Cerenia 1/2 tablet at 12:00 Friday, then 1/2 tablet at 5:00 PM Saturday; none given today - Client was giving Prevacid 1/4 tablet once daily with food (discontinued when patient stopped eating) - Currently administering Prevacid via syringe with water when not giving Cerenia - Gabapentin dose given prior to visit caused significant sedation and ataxia at hospital (more than usual).

Current Medications: Buprenorphine, Ondansetron, Metronidazole, Cerenia, Panoquell, Gabapentin.
Labwork Results: Labwork attached.

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

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 symmetrically enlarged with smooth margins that are well differentiated from surrounding tissue. Normal bilobed shape is maintained. Parenchyma is heterogenous with scattered hyperechoic foci present. No mineral or cysts are noted. The prostate measures 2.6 cm in the transverse view.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of infarcts observed. Left kidney measures 4.3 cm and contains mild pyelectasia measuring 0.3 cm in transverse view, and pinpoint non-obstructive densities. Right kidney measures 4.12 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.81 cm at cranial pole and 0.46 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.53 cm at cranial pole and 0.6 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively large 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. The spleen is folded upon itself, which is a positional non-pathologic variant.

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.

Gallbladder is mildly overdistended with a moderate amount of non-dependent, mildly aggregated/inspissated sludge. Hypo to anechoic cystic areas are noted between the gallbladder sludge and luminal wall. The wall is otherwise smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion.

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

The observed pancreas appears appropriately isoechoic to surrounding omental fat. The capsule is mildly irregular in shape. Parenchyma is mildly heterogenous and coarse. There is no visible pancreatic duct dilation. In some views there appears to be some subtly enhanced hyperechoic fat adjacent to the pancreas.

Free Abdomen

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

There is no apparent pathologic lymphadenopathy noted in these images.

Other

There's a very subtle, mildly hyperechoic approximately 0.6 cm in diameter density/nodule within the left testicle. No right testicular pathology is noted in these images at this time.

PRIMARY FINDINGS

- Pancreatic age-related remodeling/Chronic pancreatitis – Mild irregularities are consistent with benign age-related change. Low-grade smoldering chronic pancreatitis cannot be ruled out and should be suspected in the face of appropriate clinical signs. A mild acute on chronic low grade smoldering pancreatitis flare up versus potentially resolving acute pancreatitis can't be ruled out.
- 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.
- Emerging mucocele – 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. The non-dependent nature of this sludge combined with the cystic areas are suggestive, however, of possible emerging cystic mucosal hyperplasia or early gallbladder mucocele.
- Splenomegaly– can be associated with congestion caused by sedation (if sedated) but can also be associated with diffuse infiltrative disease. Both benign conditions such as extramedullary hematopoiesis, lymphoid hyperplasia, as well as infiltrative neoplastic diseases such as round cell neoplasia should be considered.

SECONDARY FINDINGS

- Age related kidney changes with mild pyelectasia and pinpoint non-obstructive nephroliths noted in the left kidney.
- Benign Prostatic Hyperplasia – Prostatic findings are most consistent with Benign Prostatic Hyperplasia (BPH) and hyperechoic foci consistent with increased vascularity and fibrosis often associated with BPH. Active prostatitis cannot be ruled out. Infiltrative neoplasia cannot be ruled out but is considered less likely.
- A small nodule in the left testicle.

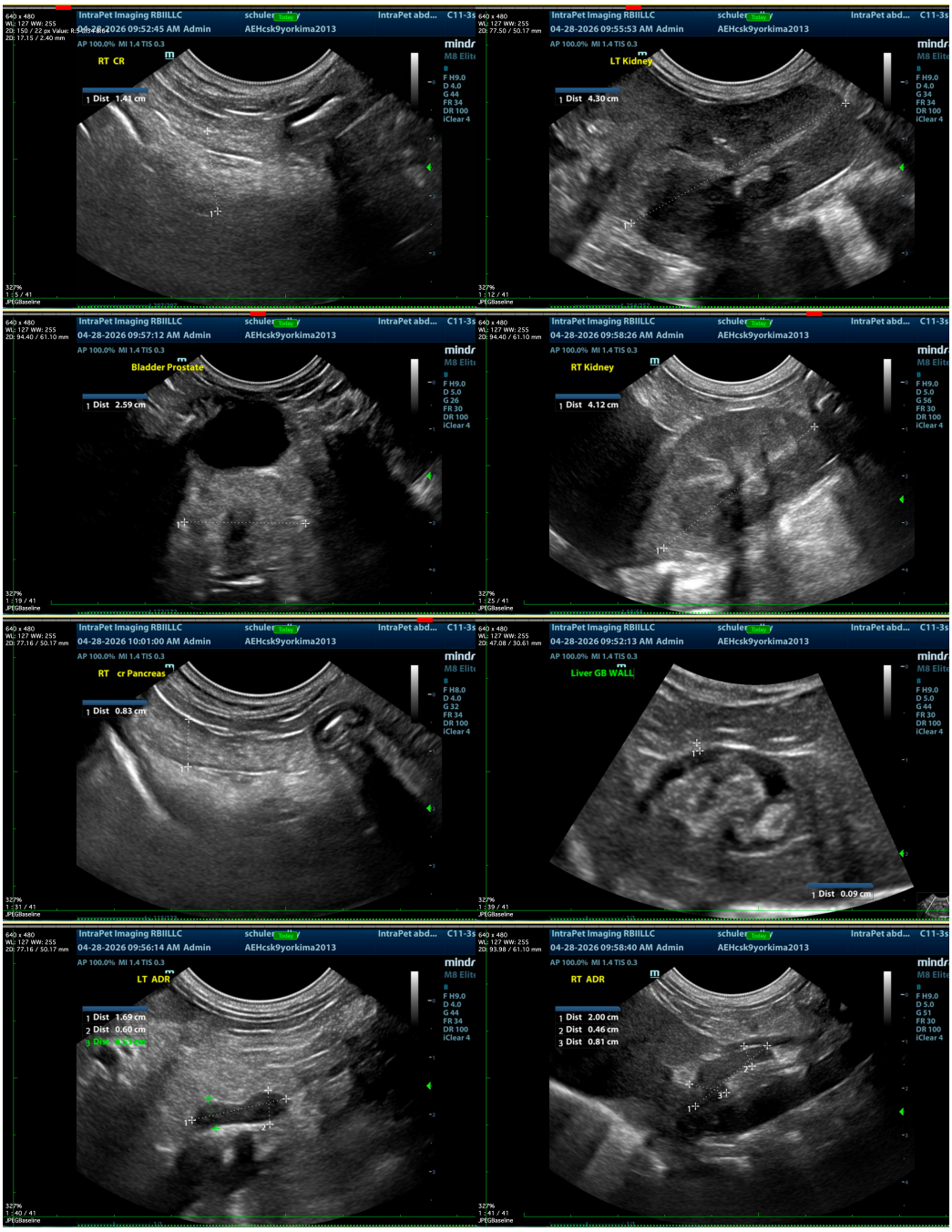
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

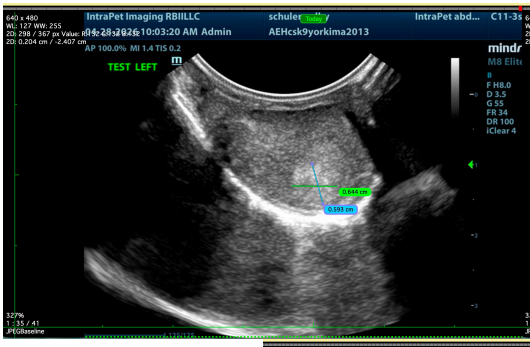
Given patient's history, combined with the changes noted above, a gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

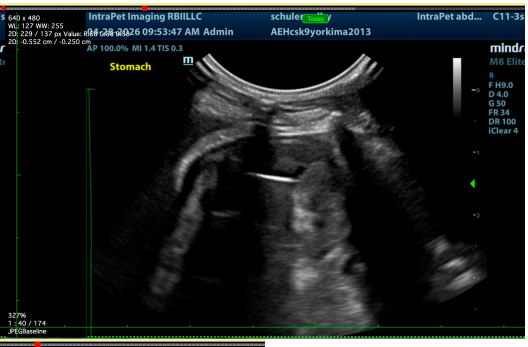
Given the reported prolonged, inappetence without very severe pancreatic changes noted in these images at this time, other contributing factors could also be considered. Therefore, a baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

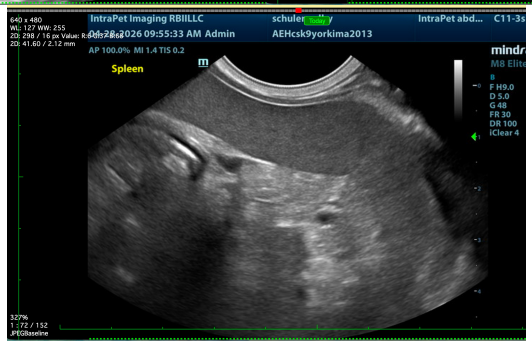
If nausea, inappetence, especially with concurrent cranial abdominal pain and/or liver enzyme changes, etc. persist beyond resolution of the suspected pancreatitis, the emerging gallbladder mucocele as a contributor could be suspected and managed, up to and including possible eventual cholecystectomy. Other options include further evaluation for possible pain (dental, orthopedic, other), upper respiratory disease or oropharyngeal disease, cardiac disease and/or neurologic disease vs other as possible causes for decreased appetite is also recommended.

Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.









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