



DATE PRESENTING CLINICAL SIGNS

05/19/26 Patient History: Started vomiting on 5/5/26 seen at another hospital and started on outpatient supportive care. NSF on BW/imaging done at other hospital. No change in symptoms, unable to keep down food or water.

PATIENT

Rex Weichert

QAR on PE, tense on abdominal palpation. Otherwise, NSF.

SPECIES

Canine

Current Medications: Maropitant 1.2 mg/kg IV SID started 5/18, Methadone 0.2mg/kg IV prn started 5/18 Panoquel 0.4mg/kg IV SID started 5/18.

Labwork Results: Labwork attached, reported as CPL >2000, Hyperglobulinemia 4.8, BUN 5, Leukocytosis 20.86K/uL with neutrophilia 16.38 K/uL and suspected bands. Thrombocytosis 535 K/uL.

Date of Previous IntraPet Ultrasound: No previous.

BREED

Yorkie Mix

Sedation: Torb and Propofol required to complete full diagnostic ultrasound.

Stat Report: Requested.

Imaging Performed by: Andi Parkinson, BS, RDMS.

SEX

Neutered Male

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with a large amount of echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The prostate is unable to be well visualized in these images.

AGE

02/10/17

Left kidney is normal in size (6.35 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.

WEIGHT

19.4 lbs

Right kidney is normal in size (6.5 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.

INTERPRETED BY

Beth Johnson, DVM
DACVIM

Adrenal Glands

Left adrenal gland is normal in size (0.7 cm at cranial pole and 0.8 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

HOSPITAL NAME

Eastern Animal
Hospital

Right adrenal gland is normal in size (0.5 cm at cranial pole and 0.5 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

REFERRING VET

Dr. Ashland

Spleen

INVOICE

16336

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 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. Common bile duct dilation is noted to the level of the duodenal papilla measuring 0.63 cm dilated with no duodenal papilla abnormalities appreciated. A very subjective irregular shape to the gallbladder is noted characterized by almost a second smaller thick-walled fluid-filled density adhered to or adjacent to the gallbladder/inside the gallbladder that may just represent a pocket of fluid and mucus consistent with a mucocele but previous sealed off leak cannot be definitively ruled out. There is no evidence of free fluid adjacent to the gallbladder in these images at this time although enhanced hyperechoic fat is present.

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 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 no trace free fluid present.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- Suspect moderate acute pancreatitis.
- Gallbladder mucocele- the enhanced hyperechoic tissue in the cranial abdomen is likely in part related to the pancreatitis although ongoing or previous cholangitis associated with the mucocele and/or even previous leakage are unable to 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.

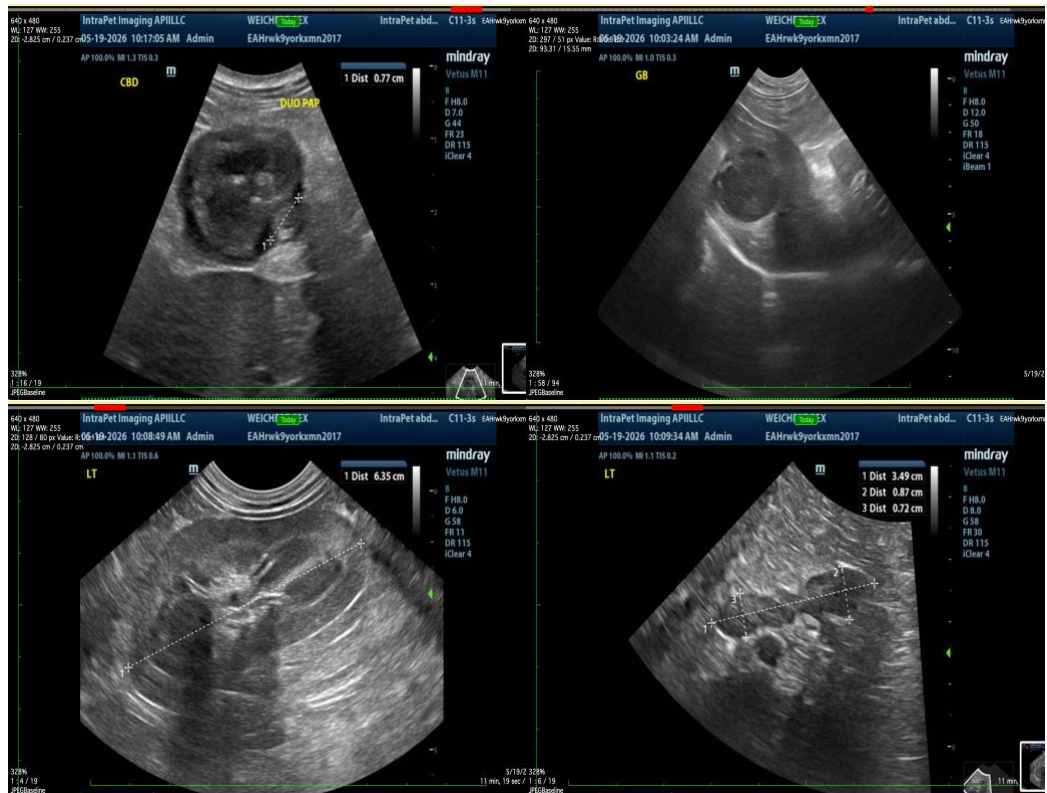
- A large amount of echogenic urinary bladder debris.

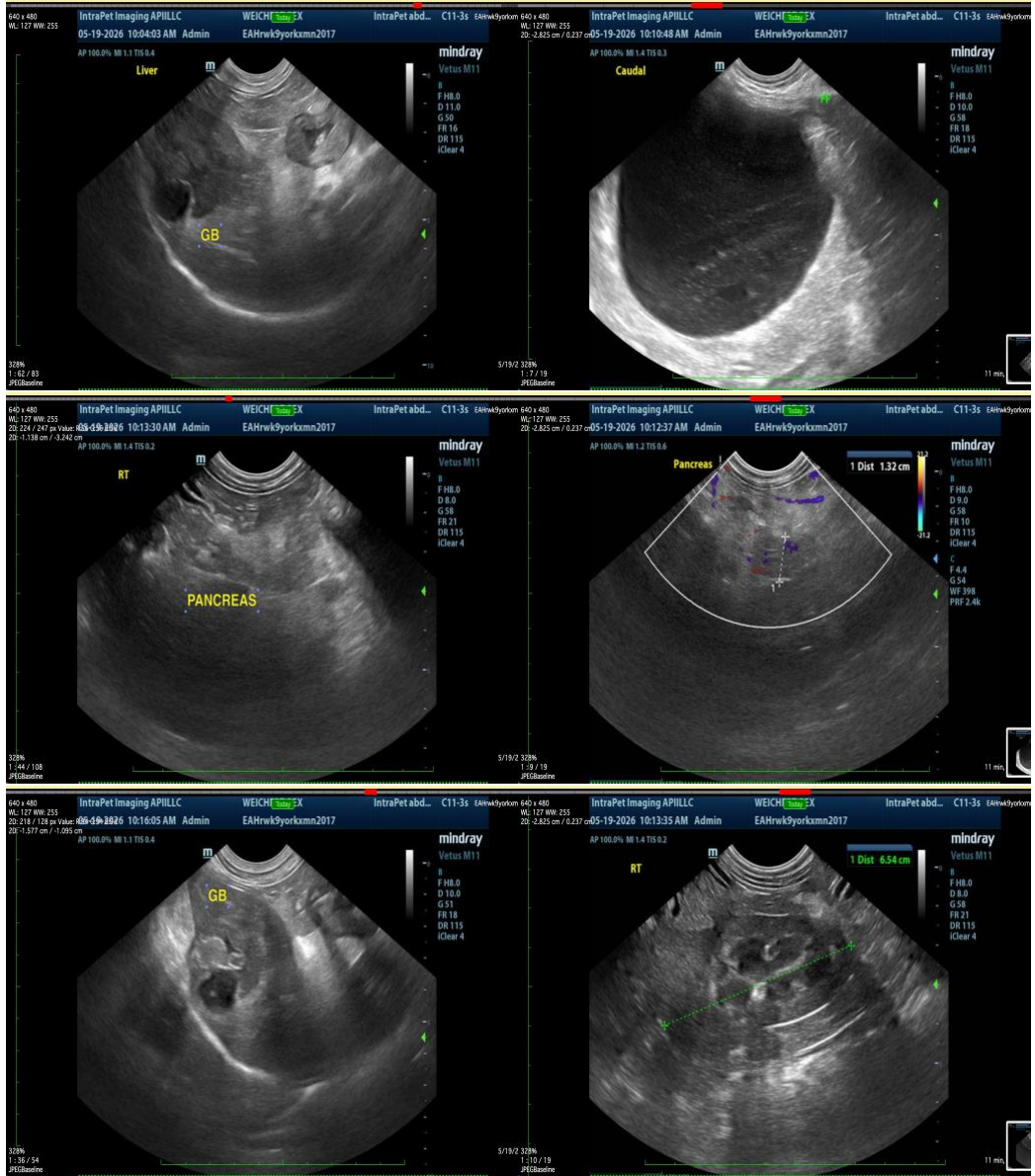
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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.

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

Further evaluation/intervention for possible concurrent gallbladder disease/mucocele is dependent on patient's clinical resolution versus progression, ongoing ultrasound monitoring, laboratory changes, etc. as ultimately, or if a more aggressive empirical approach is elected, an exploratory laparotomy of the abdomen for planned cholecystectomy may be indicated.







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.

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