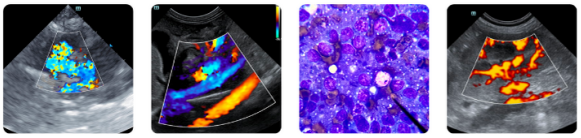


PATIENT

Honey Kiselica

SPECIES

Canine

BREED

Mixed

SEX

FS

AGE

10 years

WEIGHT

50 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Kerri Becker

HOSPITAL NAME

Harmony AH

REFERRING VET

Dr. Keefe

INVOICE

12061

DATE

6/3/2026

PRESENTING CLINICAL SIGNS

Intermittent vomiting for two weeks, dull and lethargic.

Abnormal PE/Chem/CBC/UA Results: Wbc-19.45 neut17.17.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is not fully distended, making it difficult to assess the bladder wall for pathology without further distension. Having said that, there does appear to be some mineral/sand debris and possibly small cystoliths embedded within the wall. No visible evidence of obstruction.

The right kidney is normal is size (7.56 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 (7.06 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.

Adrenal Glands

The right adrenal gland is unable to be visualized in these images.

The left adrenal gland is normal in size (0.79 cm at cranial pole and 0.99 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

The spleen appears in one view to contain a homogenous, isoechoic, rounded center measuring approximately 6.8 cm x 7.3 cm in size. Having said this, in other views the spleen has a more normal appearance. This could just be an atypical anatomical fold or positioning as the cranial abdomen is very difficult to interpret in this scan.

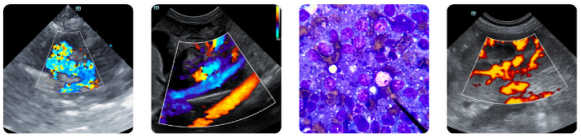
Liver

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

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is moderately overdistended with fluid. There is no definitively visible foreign material, shadowing, or cause of obstruction but partial outflow obstruction cannot be ruled out.



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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 mildly distended with very echogenic reverberation artifact from intraluminal gas. There is no evidence of obstruction, foreign material, or infiltrative disease; however, visualization is partially inhibited by gas.

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

Pancreas

The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation. *See Free Abdomen*

Free Abdomen

In the cranial abdomen, diffusely, there is free fluid noted as well as enhanced hyperechoic fat and mesentery surrounding the fluid dilated stomach, and what I believe is spleen. Pancreatic parenchyma is unable to be definitively visualized, but these suspected inflammatory changes are in the area of the pancreas. The cranial abdomen especially is very difficult to interpret in this scan with artifact from ribs, gas, poor detail between structures and interference from the fluid and enhanced clumped mesentery and fat described above.

PRIMARY FINDINGS

- Changes consistent with a cranial abdominal peritonitis, which I suspect may be due in part to acute pancreatitis, but as described above, pancreatic parenchyma is difficult to fully visualize.
- The gastric distension likely represents focal gastric ileus secondary to underlying metabolic disease such as pancreatitis versus other.
- A mechanic outflow obstruction from a mass or foreign body versus other cannot be ruled out but is considered less likely and is not visible.

SECONDARY FINDINGS

- Urinary bladder mineral/sand debris and small non-obstructive cystoliths.

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.

Fine needle aspirates of the spleen could be considered if patient's coagulation status is appropriate.

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.

If follow up imaging, while managing suspected pancreatitis, does not result in a more definitive explanation for clinical signs, should they be ongoing, advanced imaging such as an abdominal contrast CT scan may be indicated.

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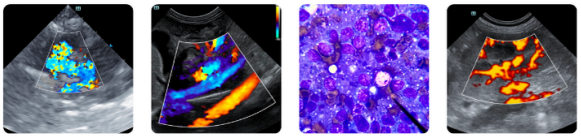

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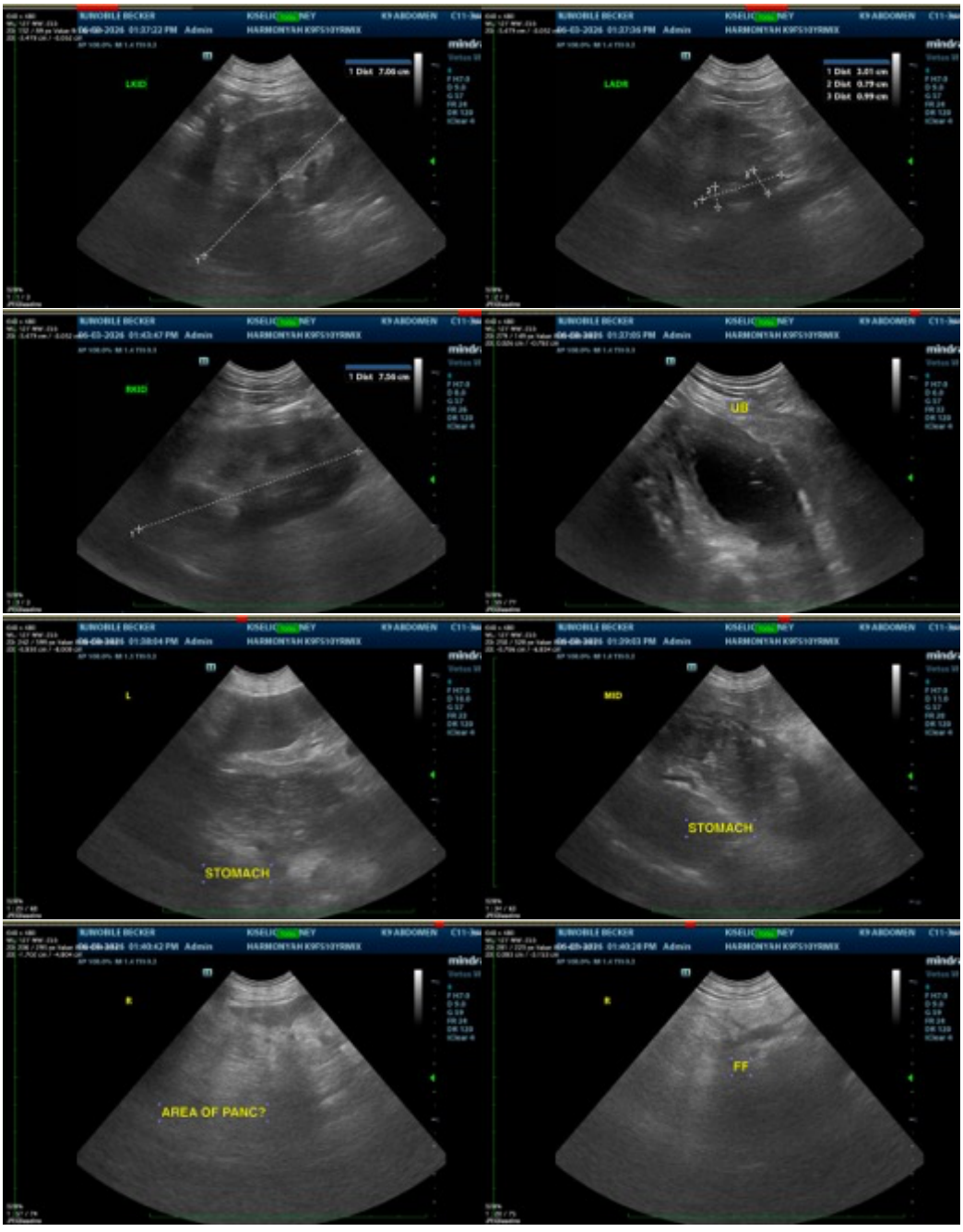

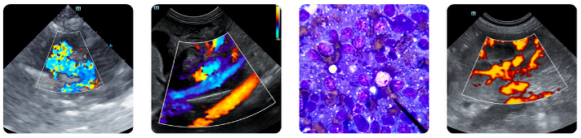

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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