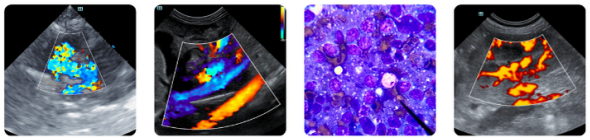


PATIENT

Maya Cover

SPECIES

Canine

BREED

Chihuahua

SEX

Spayed Female

AGE

7 years

WEIGHT

3.8 kg

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Dr. Meghan Myers

HOSPITAL NAME

Hershey Animal Emergency Center

REFERRING VET

Dr. Shally Gastelu

INVOICE

11109

DATE

1/15/2026

PRESENTING CLINICAL SIGNS

Patient presented for vomiting. Previously started with hematochezia 2-3 days ago but has since resolved. Was seen 1/10 for food bloat- was hospitalized and recovered after IVF therapy. 5-6% dehydrated Uncomfortable upon deep abdominal palpation.

Abnormal PE/Chem/CBC/UA Results: 1/10: HAEC Intake Diagnostics: Radiographs: distended stomach with ingesta type material, numerous small boney material, square foreign material versus apples that patient ingesta. Hepatomegaly with no obvious mass. Chemistry: Creat 0.3 L, ALT 139 H USG: 1.008 1/11: EPOC: pH 7.330 (L) Lactate 4.28 (H) BUN 4 (L) Repeat Radiographs: Small amount of ingesta remaining in stomach 1/15: CBC: RBC 8.76, Hgb 20.7 (H), WBC 5.82, Monos 0.06 (L), Plt >150k Chem: Glu 185 (H), Alb 4.1 (H), ALT 669 (H), GGT 12 (H) Catalyst pancreatic lipase: 70 (N) EPOC: pH 7.285 (L), Lac 6.91 (H), Glu 188 (H), HCT 56 (H) Rads: Hepatomegaly, empty stomach, no obvious obstructive pattern UA: USG >1.050, Glu 1000 mg/dL, Blood 250 Ery/uL, WBC 18/HPF, RBC >50/hpf

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The kidneys were both normal size and structure, with smooth capsule and normal corticomedullary definition and ratio. Medullary structure differed distinctly from that of the cortex. No evidence of pelvic dilation was present. Left kidney measures 4.14 cm in length, and the right kidney measures 4.32 cm in length.

Adrenal Glands

Both adrenal glands were visualized and recognized as having normal shape, size, position and echogenicity for this breed and age. The visible phrenic vasculature was unremarkable. Left adrenal measures 1.32 cm in length, 0.43 cm at the caudal pole and 0.38 cm at the cranial pole. Right adrenal measures 1.7 cm in length, 0.56 cm at the caudal pole and 0.72 cm at the cranial pole.

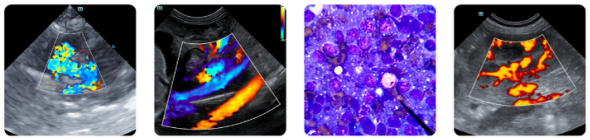
Spleen

The spleen was normal with age appropriate homogeneous parenchyma and a smooth capsule with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

Liver

The liver is subjectively normal in size with normal contours and structure. There is age appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion.

Gall bladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally.



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Gastrointestinal

The stomach contains a small volume of fluid. The gastric wall is mildly thickened with maintenance of wall layering, especially in the area of the fundus. There is no visible foreign material within the gastric lumen.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was not visualized. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The visible pancreas was observed to be largely isoechoic to surrounding omental fat.

ULTRASONOGRAPHIC FINDINGS

- Mildly thickened gastric wall consistent with gastritis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Gastric wall thickening is mild and is likely secondary to recent vomiting. Underlying gastritis of open etiology is likely. There is no definitive cause of reported GI signs in this study.

Consideration for dietary indiscretion, infectious etiologies (bacterial, viral, parasitic), food sensitivity/allergy or mild inflammatory bowel disease is reasonable. While not sonographically evident, pancreatitis cannot be completely ruled out. Empiric treatment for GI signs including anti-nausea, appetite stimulant and fluid support as clinically indicated is warranted. A diet trial with hydrolyzed protein or select protein diet could be considered if food sensitivity is suspected clinically. If signs are persistent or recurrent, additional diagnostics to be considered include baseline cortisol +/- ACTH stimulation test, GI panel (TLI/PLI/cobalamin/folate), fecal pathogen panel, thyroid testing, bile acid profile, and thoracic radiographs to rule out occult neoplasia, cardiac disease and esophageal disease as potential causes. Ultimately GI biopsy may be required for more definitive diagnosis if the patient is not responsive to medical treatment.

The liver parenchyma appears normal and there is no ultrasonographic explanation for the elevated liver enzymes in this patient. There is no significant disruption of architecture noted to suggest significant pathology. Low grade inflammatory hepatopathy/reactive hepatopathy is a likely cause of LE elevations. Fine needle aspirate is recommended and bile acid profile to assess liver function. Ultimately liver biopsy is often required for more definitive diagnosis. Empiric treatments (SAM-E, milk thistle, Vitamin E, ursodiol if bilirubin elevated or gall bladder sludge) could be tried and liver enzymes re-evaluated, especially if liver FNA does not show significant pathology before more invasive liver sampling is pursued.

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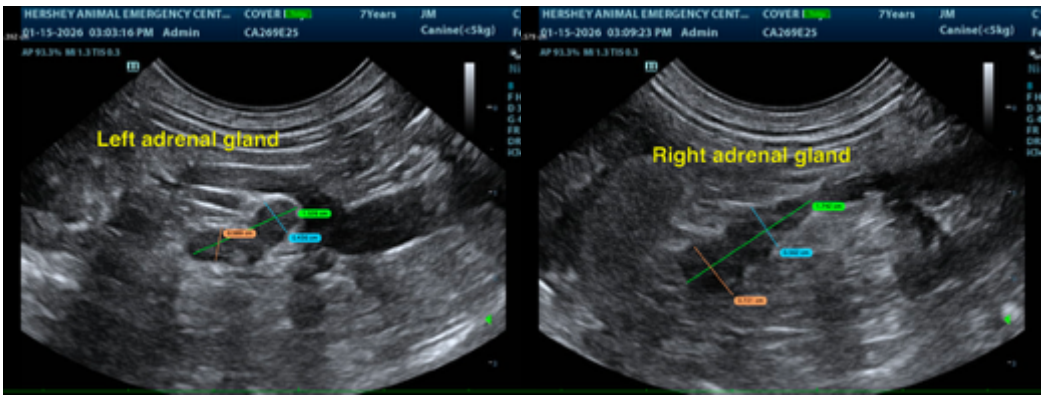

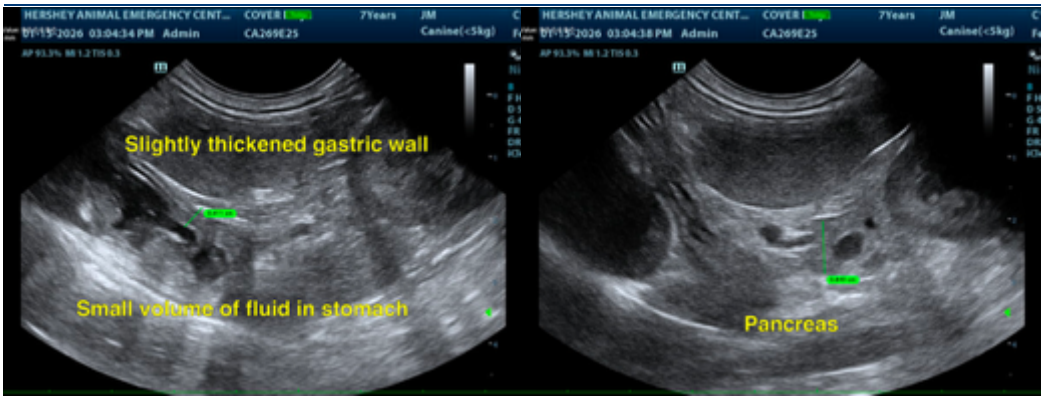

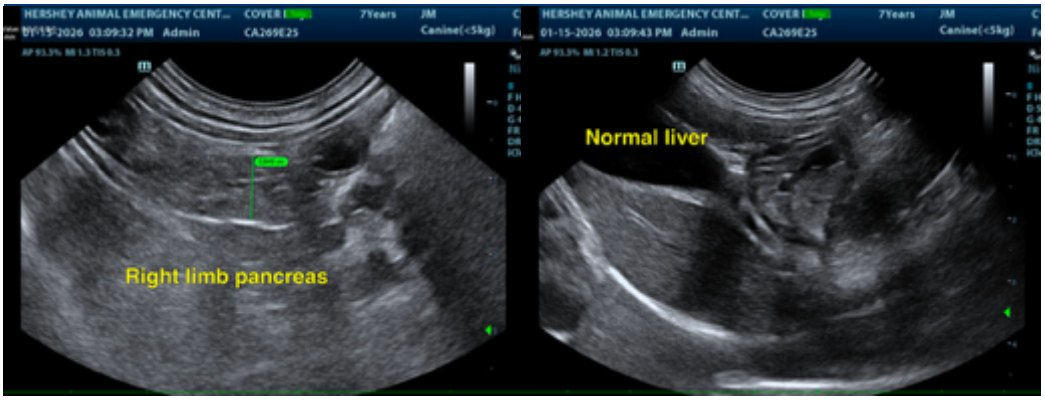

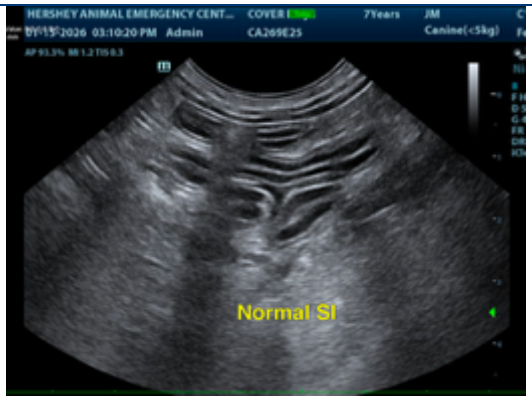

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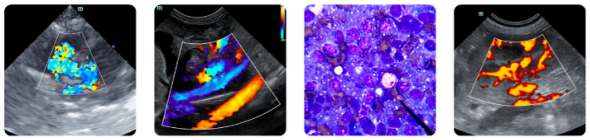

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC

info@SonoPath.com