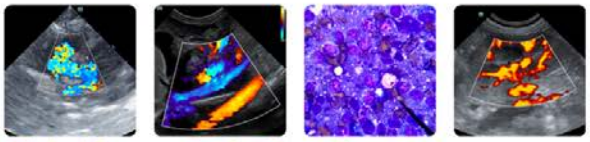


PATIENT

Zea Leister

SPECIES

Canine

BREED

Mini Schanuzer

SEX

Intact Female

AGE

7.5 Years

WEIGHT

28.8 lbs

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY

Dr. Jocelyn Hollway

HOSPITAL NAME

Valley Green Veterinary Hospital

REFERRING VET

Dr. Jocelyn Hollway

INVOICE

72228

DATE

12/1/25

PRESENTING CLINICAL SIGNS

Female INTACT. Last heat cycle in June. Had a litter April 7th 2022. Not eating, last meal was Saturday evening. Drinking more than before but sticky/discolored gums. Vomiting doam w/ yellow bile, no food other than yesterday morning she did have food she Vomited up the night before - about 5 piles yesterday and then over night blanket was wet this am the the only thing she had was water. -- no blood. Extreme lethargy since yesterday, sitting/staring off into space and not moving around. No Hx of getting in to anything. Temp (°F): 100.4 | H.R.: 120 | R.R.: 44 | C.R.T. : <2 | M.M.: light pink PE = Extremely QAR/lethargic. 5-7% dehydrated. Very tense/round ABD. Very painful, would not allow deep palpation Heart/Lungs = NSF. No obvious discharge from vulva, vulva not engorged/swollen. Slight yellow tinge to sclera. Grade 4 ddz; tacky mm. CRT <2 IDX X-ray Report CONCLUSIONS: Concern for a left caudal ventral SI gas-containing FB, but this is not obv causing SI mechanical obstruction, beyond the single dilated loop. The ABD effusion would then suggest intestinal perforation, if associated with passage of a foreign object. The abdominal effusion and the duodenal dilation is more suggestive of pancreatitis, with cranial peritonitis and duodenitis, as a cause of the clinical signs. Mild hepatomegaly is very nonspecific. Congestion from R-HF is less suspected in this P, due to normal caudal vena cava size.

Abnormal PE/Chem/CBC/UA Results: HCT 50.8 normal WBC 26.9 HIGH (50.05-16.76) Neut 24.05 HIGH (2.95-11.64) Mono 1.25 HIGH (0.16-1.12) Glob 4.8 HIGH (2.5-4.5) ALT 892 HIGH (10-125) ALP >2000 HIGH (23-212) GGT 32 HIGH (0-11) TBili 4.4 HIGH (0-0.9) Cl 100 LOW (109-122) T4 = 0.8 LOW -- r/o euthyroid sick vs true hypothyroid cPL = 32 normal

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 4.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

The visualized uterus dorsal to the urinary bladder was sonographically normal. No evidence of pyometra criteria or uterine pathology.

The left and right ovaries were not definitively visualized.

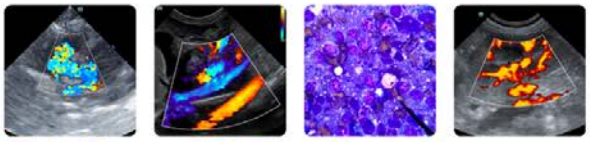
Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. Areas of mild medullary mineral noted. Left kidney measured 4.9 cm. Right kidney measured 5.2 cm.

Adrenal Glands

The adrenal glands are overtly normal in size, position and shape. The left adrenal gland measures 0.65 cm at the caudal pole. The right adrenal gland measures 0.57 cm at the caudal pole.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The



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splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver

The liver presented subjectively mildly to moderately enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was distended in size with echogenic thickening of the gallbladder wall. There was biliary sludge that appeared to be non-mobile and organized. A stellate pattern to the organized biliary sludge was present. Pericholecystic to cranial abdominal hyperechoic inflamed omentum and pericholecystic to mid/cranial abdominal peritoneal effusion noted.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

No obvious visualized significant omental lymphadenopathy.

PRIMARY FINDINGS

- Gallbladder mucocele with pericholecystic to mid/cranial abdominal peritonitis.
- Hepatopathy.
- Sonographically normal gastrointestinal tract/right pancreas.
- Normal area of the uterus.

SECONDARY FINDINGS

- Age related renal changes with mild medullary mineral.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Assuming normal clotting status, and with broad-spectrum perioperative antibiotics, gastrointestinal support and analgesia, exploratory laparotomy as soon as possible with cholecystectomy, hepatic biopsies, and abdominal flush is recommended. High concern for gallbladder leakage or rupture and bile peritonitis indicated. Correlation with pending fluid analysis recommended to assess for additional non-obvious or occult contributing factors to the effusion.

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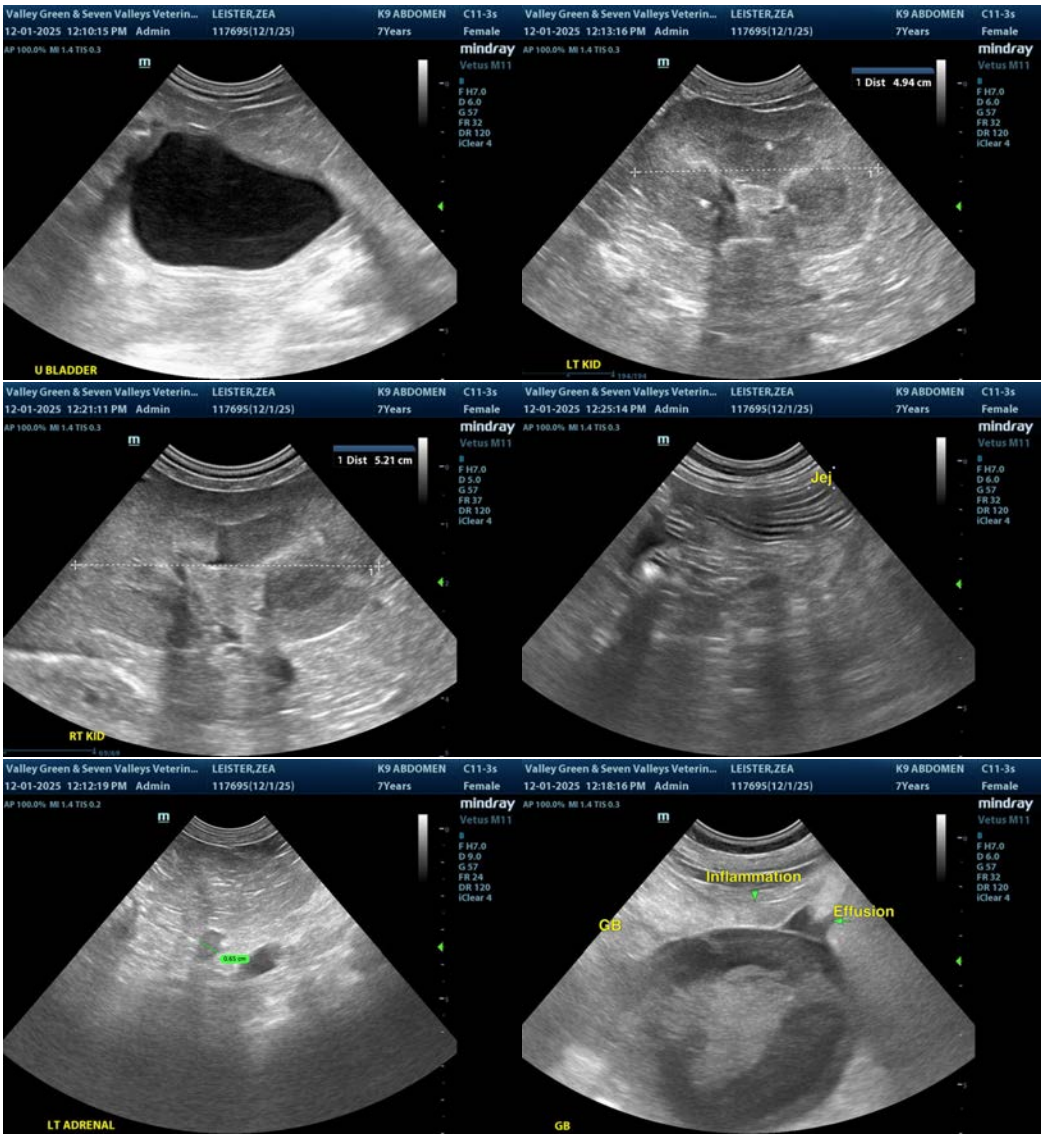
This case is considered a surgical urgency, yet even with surgical intervention, extremely guarded prognosis likely.



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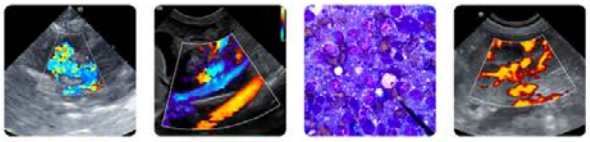

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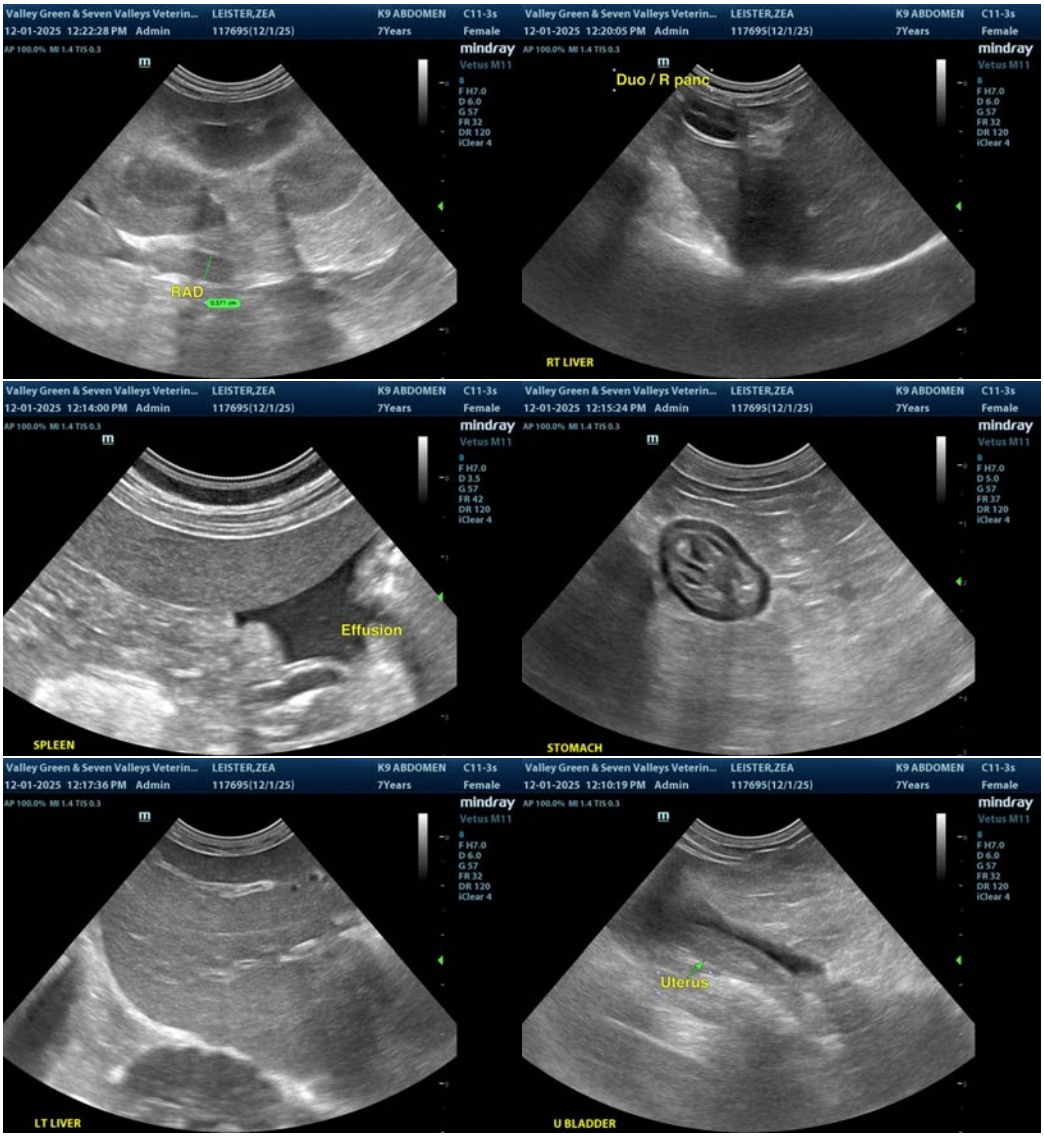

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

info@SonoPath.com