



PATIENT

KC Aspandiar

SPECIES

Canine

BREED

Yorkshire Terrier

SEX

Neutered Male

AGE

8 Years

WEIGHT

8.4 Pounds

INTERPRETED BY

Eric Lindquist, DMV

DABVP, Cert. IVUSS

IMAGING PERFORMED BY

Dr. Saum Hadi

HOSPITAL NAME

Bethany Family PC

REFERRING VET

Dr. Saum Hadi

INVOICE

42944

DATE

11/23/22

PRESENTING CLINICAL SIGNS

P has a history of pancreatitis. P presented yesterday for a recent episode that may have been brought on by stress (P's O that he is close to left for vacation). P was acutely hyporexic with diarrhea and vomiting. Pain on cranial abdominal palpation. P has responded well to supportive care and is now BAR with no pain or tenseness on abdominal palpation.

Abnormal PE/Chem/CBC/UA Results: SNAP cPL: Strong positive Rest (CBC, Chem17+lytes): Mild ALKP increase (379 U/L), mild hyperglycemia (188 mg/dL), rest WNL

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized and anechoic urine was present. No evidence of inflammatory or neoplastic changes were noted. Ureteral papillae were normal.

The **kidneys** revealed largely normal size and structure, corticomedullary definition and ratio (cortex 1/3 of medulla) were essentially maintained with some age-related loss of curvilinear patterns regarding the capsule and C/M junction. The cortices presented largely uniform texture with some increased echogenicity expected for his age patient. Medullary structure differed distinctly from that of the cortex and no evidence of pelvic dilation was present. The kidneys measured 4.0 cm each.

Adrenal Glands

The **left adrenal gland** was visualized obliquely, measuring 6.0 mm. The **right adrenal gland** measured 6.0 mm.

Spleen

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes were noted.

Liver

The **liver** was swollen with minor increased portal markings. Slight hepatic enlargement present. Minor gallbladder debris noted.

Gastrointestinal

Examination of the **gastrointestinal tract** revealed an unremarkable stomach and small intestine regarding structure. There were minor areas of luminal fluid noted. There was no evidence of obstructive pattern. Excessive GI gas present. Curvilinear patterns were retained throughout the gastrointestinal tract. Fluid filled cecum noted with gas accumulation. Areas of hyperperistalsis were noted. This is consistent with response to irritation. Soft stool noted in the colon.

Pancreas

The **pancreas** revealed heterogeneous mixed echogenic changes throughout the cranial abdomen.



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ULTRASONOGRAPHIC FINDINGS

- Extensive gastroenteritis/pancreatitis/typhlitis pattern
- Age related renal changes

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Enterotoxin or similar should be considered. I recommend a fresh fecal smear and fecal floatation analysis. Anti-parasitic protocol, 24-hour NPO, GI protectants, plasma expanders, and broad-spectrum antibiotics to treat enterotoxins would be indicated in this patient. Recheck sonogram in 48 hours. No evidence of foreign body or neoplastic criteria.

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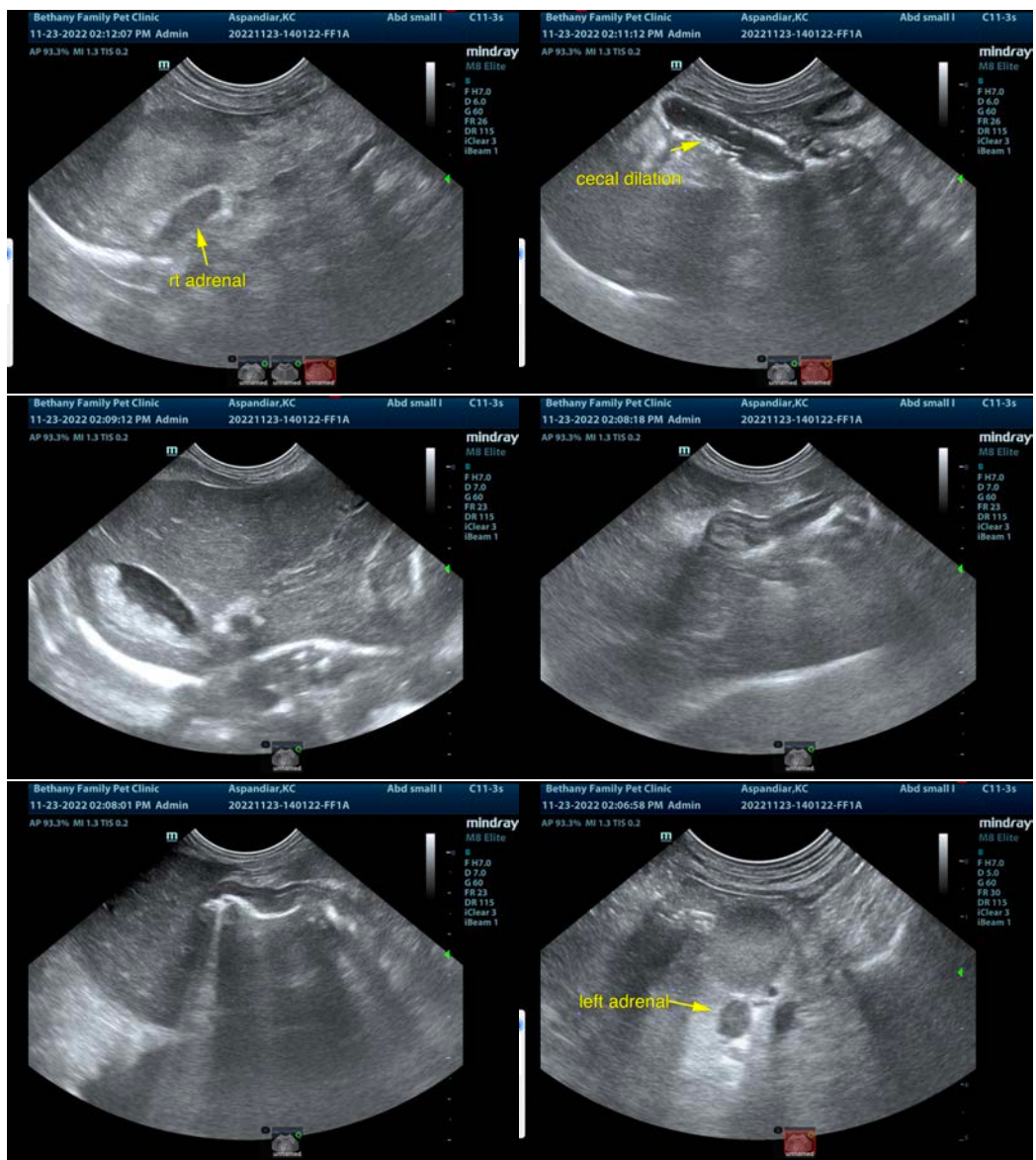
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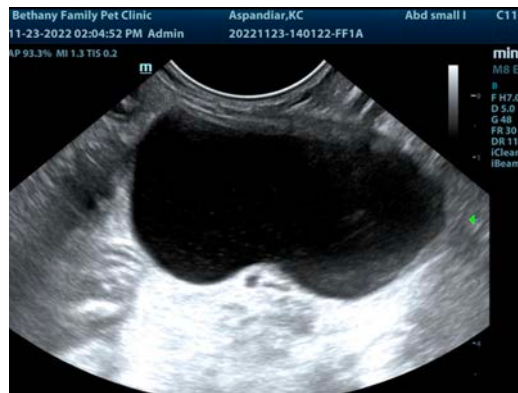
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP, Cert. IVUSS, CEO of SonoPath.com

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