

PATIENT

Priscilla Corro

SPECIES

Canine

BREED

Morkie

SEX

Spayed Female

AGE

7 Years

WEIGHT

7 kg

INTERPRETED BY

Greg Kuhlman, DVM,
 DACVIM (SAIM)

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Hamilton Region EVC

REFERRING VET

Dr. Colangelo

INVOICE

37433

DATE

6/9/26

PRESENTING CLINICAL SIGNS

History: 2-3 day history pancreatitis, inpatient treatment initiated at Er setting over past 12h Severe gastric dilation with predominantly fluid-filled gastric contents and clotted blood. NG tube placed temp; >150 mL gastric fluid removed. Large amount of dark red clotted blood present within gastric contents. Findings consistent with delayed gastric emptying/gastric ileus. Markedly elevated pancreatic lipase. Severe hyperglycemia. Ketonuria. Metabolic acidosis. Moderate hypokalemia. Bacteriuria present on urinalysis. Patient dull and intermittently restless. Current Medications: KCL, Plasmalyte, Emavert, Methadone, Ketamine, Ampicillin

Abnormal PE/Chem/CBC/UA Results: Primary Question to Be Answered in This Exam Obstruction - mechanical vs functional ? Cause of gastric bleeding (coffee grounds) and distension with gastric contents mixed with clotted blood Pancreatitis vs neoplasm? If possible, prognosis of etiology to guide whether referral to ICU is indicated or if poor prognosis likely. BW attached.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder is moderately distended with anechoic urine. No uroliths are seen. The bladder wall is normal in appearance and thickness. No masses are seen.

The right kidney presents normal size (5.3 cm length) with normal shape and architecture. Normal corticomedullary distinction. No pyelectasia, ureteral dilation or nephrolithiasis. Mild medullary rim sign was noted.

The left kidney presents normal size (5.1 cm length) with normal shape and architecture. Normal corticomedullary distinction. No pyelectasia, ureteral dilation or nephrolithiasis. Mild medullary rim sign was noted.

Adrenal Glands

The right adrenal gland is diffusely enlarged for a patient of this size. The cranial pole measures 10.5 mm and the caudal pole measures 7.1 mm.

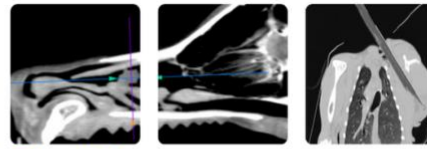
The left adrenal gland is mildly enlarged for a patient of this size. The cranial pole measures 6.4 mm and the caudal pole measures 6.1 mm.

Spleen

The spleen is normal in size, shape, margination and echogenicity. No masses are seen.

Liver

Liver is subjectively enlarged (swollen contour) without disruption of architecture. It has a normal homogenous echotexture. Parenchyma is diffusely hyperechoic characterized by less prominent than normal portal vein walls and increased echogenicity relative to the spleen and falciform fat. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.



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Gallbladder is moderately distended with anechoic bile as well as mild suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

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Gastrointestinal

The stomach is markedly dilated with hypoechoic fluid. The fluid contains a marked amount of echogenic debris. The gastric wall has loss of normal layering and is mildly thickened (4.1 mm in width).

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The intestines have normal wall layering and thickness. Colon contains normal contents with normal wall thickness.

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Pancreas

The visible pancreas is diffusely hypoechoic and enlarged with mild to moderate surrounding hyperechoic fat.

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Free Abdomen

There are no enlarged abdominal lymph nodes seen on this exam. No free abdominal fluid is seen.

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ULTRASONOGRAPHIC FINDINGS

- The patient appears to have functional gastritis, most likely due to pancreatitis.
- Mild medullary rim sign bilaterally - most likely clinically insignificant.
- Bilateral adrenomegaly
- Patient appears to have acute pancreatitis.
- Hyperechoic hepatomegaly – This is most likely due to either diabetes mellitus causing a vacuolar hepatopathy, or in this case additionally the patient may have hyperadrenocorticism, which would also be causing a vacuolar hepatopathy. Infiltrative neoplasia, such as lymphoma or mast cell, seems unlikely at this time. Patient most likely has a benign vacuolar hepatopathy.
- Mild gallbladder debris - No obvious evidence of a mucocele is seen at this time.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the bilateral adrenomegaly, consider pituitary dependent hyperadrenocorticism as a possibility. When patient is more clinically stable, recommend performing low dose dexamethasone suppression test.

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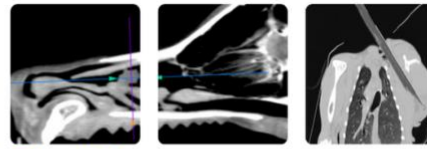
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A cause for the patient's fluid dilated stomach is most likely functional gastritis. No mechanical lesion is seen within the gastric lumen or within the small bowel. An obstructive lesion is not suspected at this time. Functional gastritis is suspected to be due to patient's pancreatitis and electrolyte derangements. Electrolyte derangements appear to be due to a new diagnosis of diabetes mellitus, and with the reported lab work, the patient most likely has diabetic ketoacidosis at this time.

Prognosis is guarded at this time.



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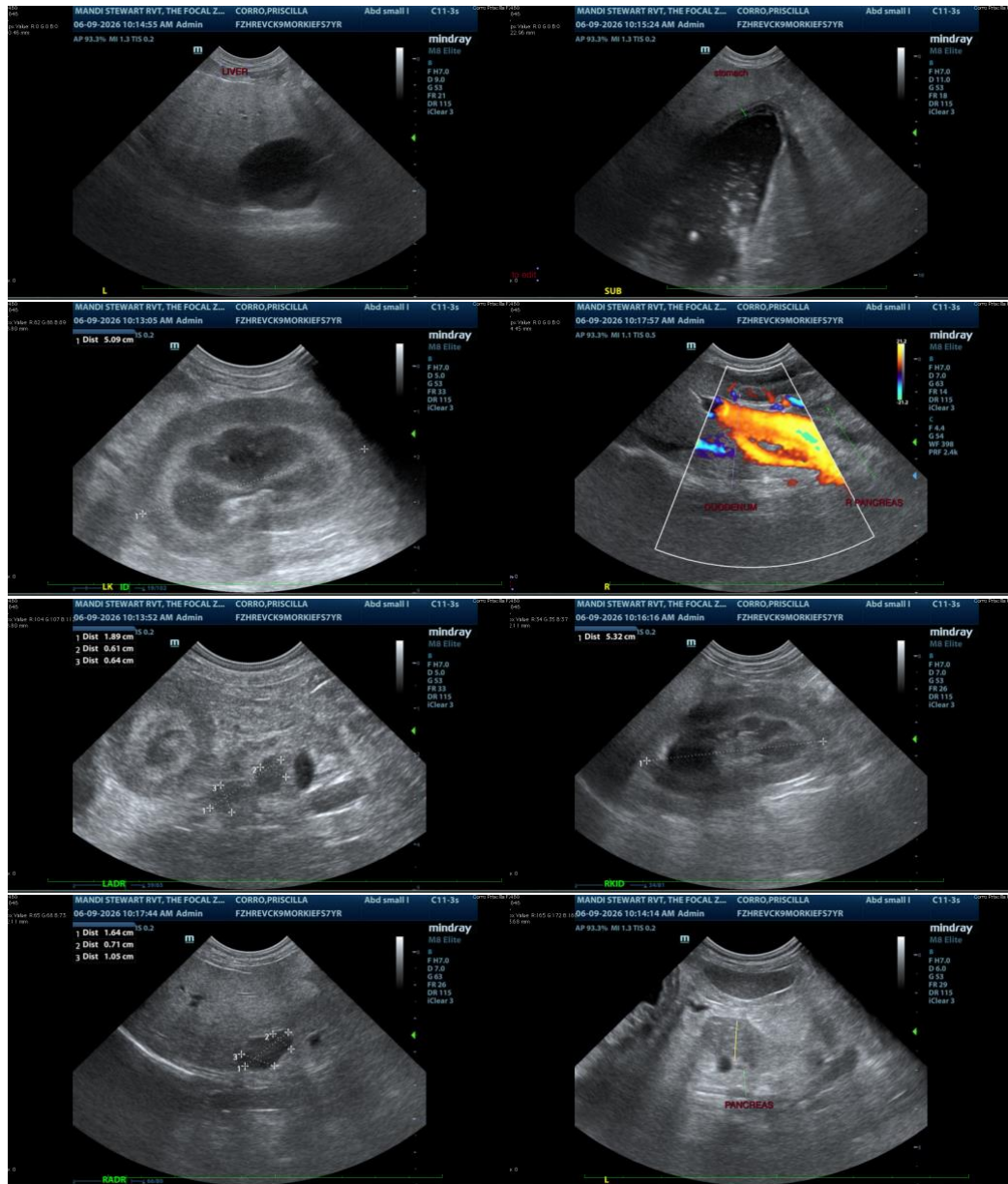
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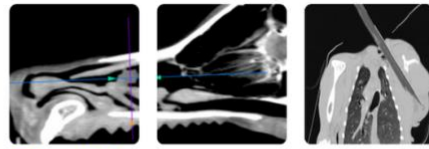
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Recommend aggressive supportive care, including fluid diuresis and supportive care with antiemetics and prokinetic. For the patient's pancreatitis, recommend Panoquell at a dose of 0.4 mg/kg, given IV, once per day for 3 days.



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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Greg Kuhlman, DVM, DACVIM (SAIM)

Priscilla Corro

Veterinary Internal Medicine Specialist
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