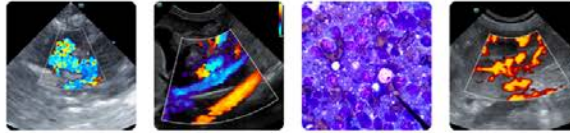


DATE
1/2/26

PATIENT
Hobbes Carroll

SPECIES
Canine

BREED
Cavalier King Charles

SEX
Neutered Male

AGE
12/30/22

WEIGHT
19.9 lbs

INTERPRETED BY
Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

HOSPITAL NAME
Animal Emergency Hospital

REFERRING VET
Dr. Ruby

INVOICE
72926

PRESENTING CLINICAL SIGNS

Patient History: Hobbes Carroll presents for acute anorexia and lethargy following escape episode. Patient History: - Escaped with another dog three days ago; returned exhausted at noon Saturday. - Marked anorexia since return; not interested in food despite attempts to tempt. - One episode of regurgitation (small volume, hair present; unclear if deer hair). - Two normal bowel movements; no straining. - No vomiting (other than regurgitation) or diarrhea - No medications administered since onset. - No prior significant medical history; previously healthy.

Current Medications: Buprenorphine, gabapentin, maropitant, ondansetron, omeprazole
Labwork Results: Labwork attached Xray Abdomen 2 View- No obvious FB or obstructive pattern. Diffuse loss of detail
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Not required to complete full diagnostic ultrasound.
Stat Report: Not requested.
Imaging Performed by: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System
The urinary bladder is moderately distended with urine. There is a small amount of hyperechoic suspended debris and some dependent sandy debris. The Bladder wall appears of normal thickness with a smooth mucosal surface. The region of the trigone, ureteral papillae and proximal urethra appear free of any mass lesions or calculi.

The prostate is normal in size (0.84 cm) and shape for this neutered male dog. The parenchyma is homogenous and the external margins are smooth. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (4.8 cm) with mild pyelectasia at 0.39 cm. Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.37 cm) with pyelectasia at 0.19 cm. Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands
The left adrenal gland is normal in size measuring 0.49 cm at the cranial pole and 0.58 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.64 cm at the cranial pole and 0.63 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen
The spleen is subjectively normal in size (0.99 cm), echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver
The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and likely incidental at this time. The cystic and common bile ducts are normal/not visible.

Gastrointestinal
The stomach contains moderate fluid/shadowing ingesta. It measures at a normal thickness of <0.7cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. On some views, the shadowing ingesta interferes with full evaluation of the stomach. Definitive obstruction is not fully visualized.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. Jejunum wall measures 0.25 cm. Duodenum wall measures 0.37 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. The descending colon appears moderately distended with non-formed fecal material, and the colon wall appears prominent measuring 0.28 cm, with intact wall layering.

Pancreas
The pancreas is large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with mild/moderate pancreatitis.

Free Abdomen
Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There is a mild/moderate mesenteric lymphadenopathy with isoechoic lymph nodes measuring 0.55 cm x 1.29 cm and 0.63 cm x 1.45 cm. The omentum is hyperechoic around both limbs of the pancreas.

PRIMARY FINDINGS

- Pancreatic changes consistent with mild/moderate pancreatitis in both limbs.
- Mild bilateral pyelectasia – Pyelectasia of the kidneys could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.
- Fluid and shadowing ingesta visualized within the gastric lumen – Correlate with the feeding history. If the patient has truly been NPO for several days, this could represent delayed gastric emptying or ingested foreign material. A definitive obstruction is not visualized.

- Mildly thickened small intestine with some areas exhibiting mild intraluminal fluid – Findings are most consistent with inflammatory/enteritis type change.

- Thickened distal colon – Findings could be consistent with impending diarrhea/colitis.

- Lymph node changes most consistent with reactive lymphadenopathy.

SECONDARY FINDINGS

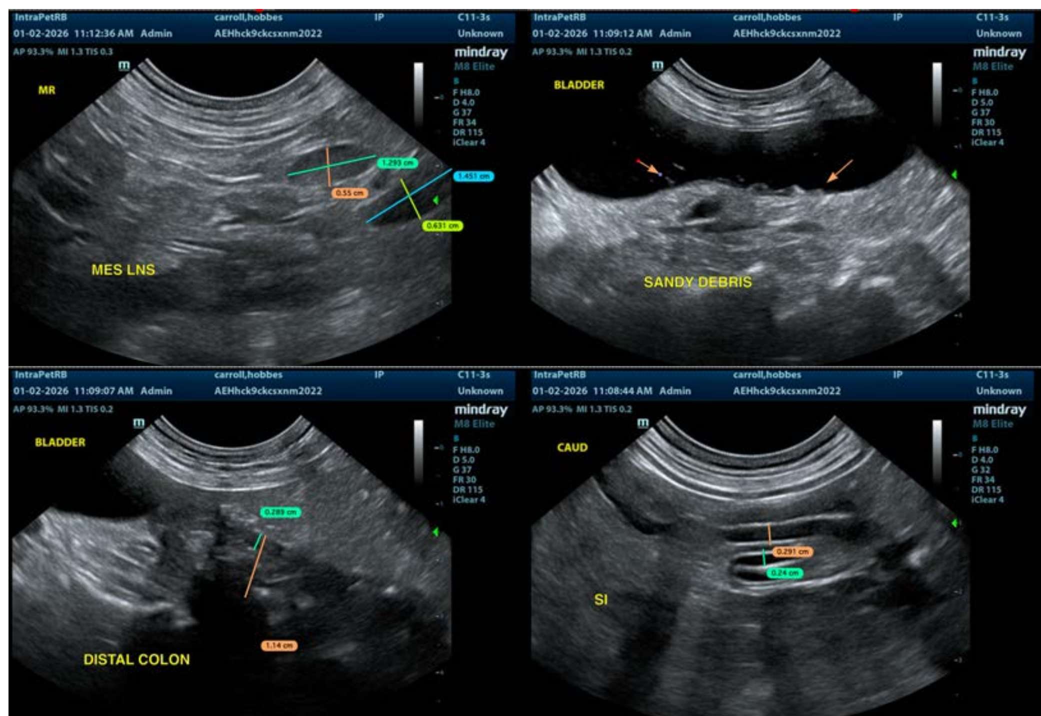
- Suspended and dependent echogenic/sandy debris visualized in the urinary bladder – The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus.

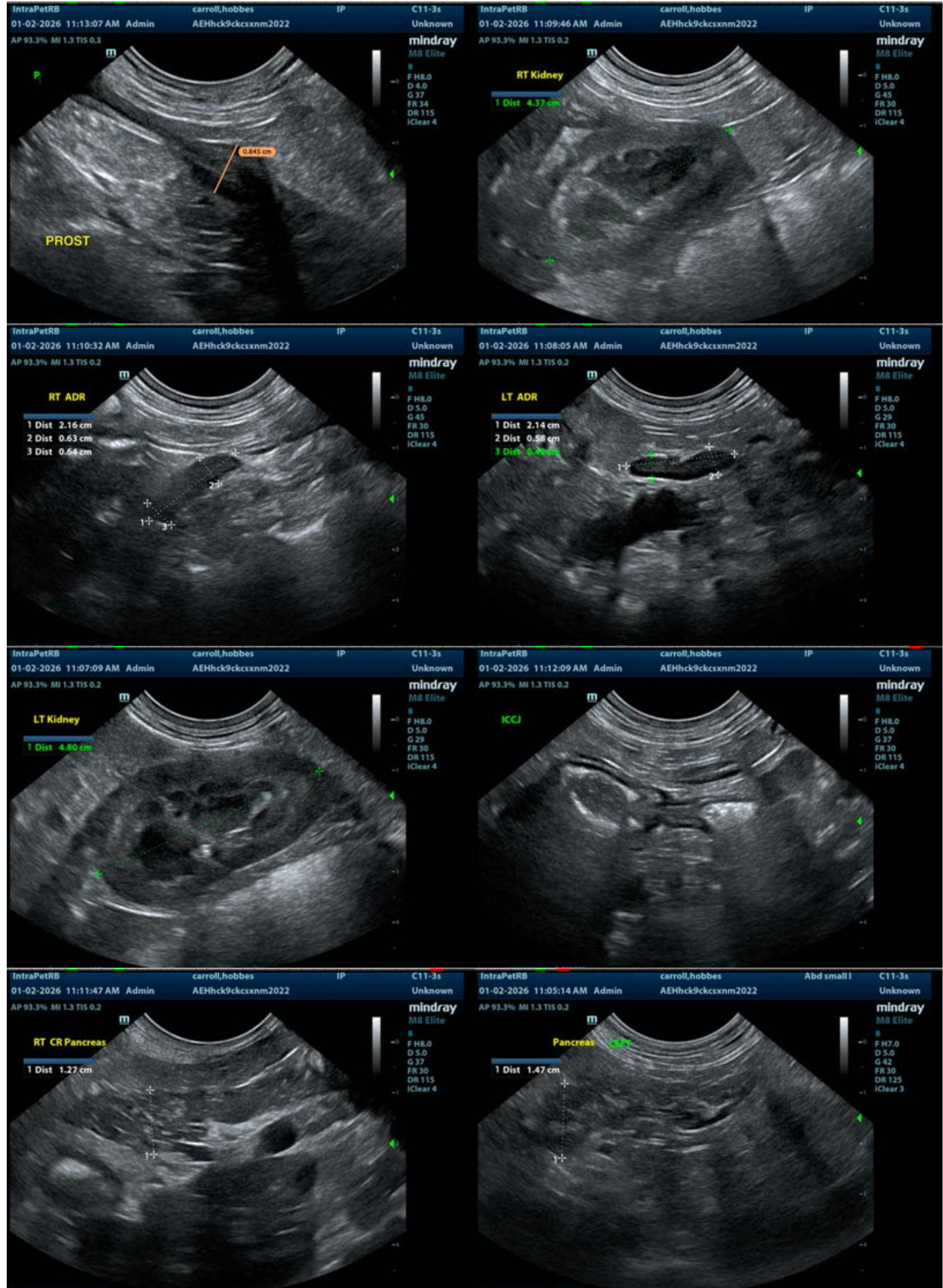
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Both limbs of the pancreas are prominent and hypoechoic with some surrounding reactive mesentery. The presentation and appearance of the pancreas is consistent with mild to moderate pancreatitis. The elevated PLI level further supports this. Consider hospitalization for treatment of pancreatitis.

Additionally, there is some shadowing ingesta visualized within the gastric lumen. This does not appear obstructive at this time but could represent a small amount of normal ingesta, medication, etc., or possibly ingested foreign material that is not readily passing. Recommend continued monitoring. If this material is persistent, upper GI endoscopy may be warranted to further evaluate.

The small intestine appears mildly thickened with some areas exhibiting mild fluid distention. I suspect this is consistent with enteritis. Recommend continued monitoring. If these symptoms are persistent, additional diagnostics may be warranted.

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3 Dist 0.64 cm
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2 Dist 0.58 cm
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DR 115
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RT CR Pancreas
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IntraPetRB
carroll,hobbes
Abd small I
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Pancreas
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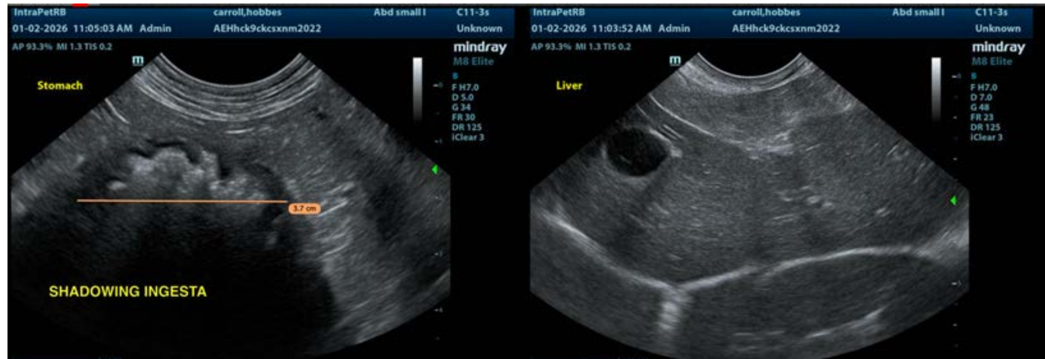

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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info@sonopath.com