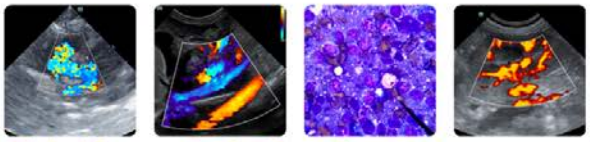


PATIENT

Cash Torres

SPECIES

Canine

BREED

French Bulldog

SEX

Male

AGE

3 Years 7 Months

WEIGHT

21.7 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Jessica Boudreaux-Milligan, DVM

HOSPITAL NAME

Dockside Veterinary Imaging

REFERRING VET

Melissa Floyd, DVM

INVOICE

72327

DATE

1/21/26

PRESENTING CLINICAL SIGNS

Cash was most recently seen for lethargy and vomiting. The owner reports that for the past 2 weeks, he has been vomiting a large amount of white foam in the mornings. After he vomits, his appetite is normal. He has been eating his regular meals plus an extra meal and a high-calorie supplement. The owner has been administering Pepcid 10mg in the morning, but it has not provided relief. The patient has also been experiencing increased water consumption. He is currently being treated for a flare-up of a previous back issue and was started on prednisone (currently on 2.5mg qAM and given prior to scan), gabapentin 100mg q12hrs, and diazepam approximately 2 weeks ago. An MRI was performed for this issue over the summer. The owner notes that while on these medications, he seems lethargic and sometimes disoriented when outside, which is abnormal behavior for him. He is still ambulatory but appears hunched and painful in his hindquarters. His appetite is good, and he is able to posture to urinate and defecate, though defecation takes longer than usual. Neurologist recommended abdominal U/S after reviewing abdominal rads.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The prostate is large and mildly mottled, measuring 1.51 cm in height in the sagittal view. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (5.47 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 pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (5.73 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 pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

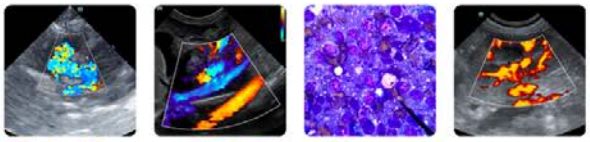
Adrenal Glands

The left adrenal gland is normal in size measuring 0.38 cm at the cranial pole and 0.39 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 0.56 cm at the cranial pole and 0.37 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 (1.34 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.



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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 gas (likely secondary to panting?) and mild fluid. 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. Gas artifact interferes with full evaluation of the stomach. The pylorus is visualized measuring 0.58 cm with mild fluid distention.

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. Duodenum wall measures 0.52 cm. Jejunum wall measures 0.39 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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 left limb of the pancreas is prominent and mildly mottled compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

Other

Both testicles were visualized and appear within normal limits.

ULTRASONOGRAPHIC FINDINGS

- Pancreatic changes consistent with mild pancreatic remodeling +/- mild chronic pancreatitis.
- Subjectively prominent/mildly thickened small intestine – The mild small intestinal wall changes may be a normal variant in this patient or could be consistent with an inflammatory process (e.g., inflammatory bowel disease).
- Large, mottled prostate – Findings are most consistent with benign prostatic hypertrophy +/- prostatitis. Correlate with a urinalysis +/- culture.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

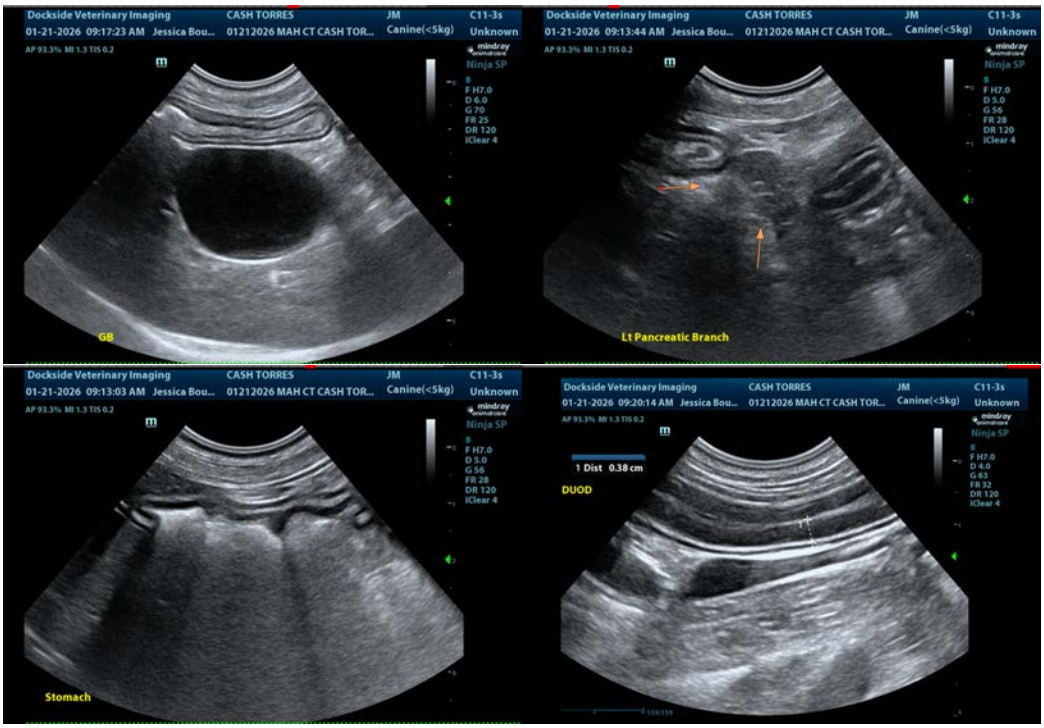
No focal lesions are visualized associated with the GI tract to explain the vomiting reported. Consider the possibility that this could be regurgitation, etc. Also consider the possibility of bilious vomiting syndrome.

Unfortunately, you can still have significant GI symptoms despite a relatively normal ultrasound sonographically. Consider the following:

- Recommend a hydrolyzed protein prescription diet.
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend a baseline cortisol to screen for Addison's.
- If not already done, recommend parasite screening and empirical deworming.

If symptoms are persistent, you could consider upper GI endoscopy to further evaluate and obtain biopsies of the proximal GI tract. At the same time, you could consider an upper airway exam. Patients with significant upper airway disease can have increased incidents of regurgitation and vomiting-like symptoms. Sometimes airway surgery can be of benefit.

The pancreatic changes are mild. Correlate with a quantitative PLI level. If this is significantly elevated, consider treatment for chronic pancreatitis.



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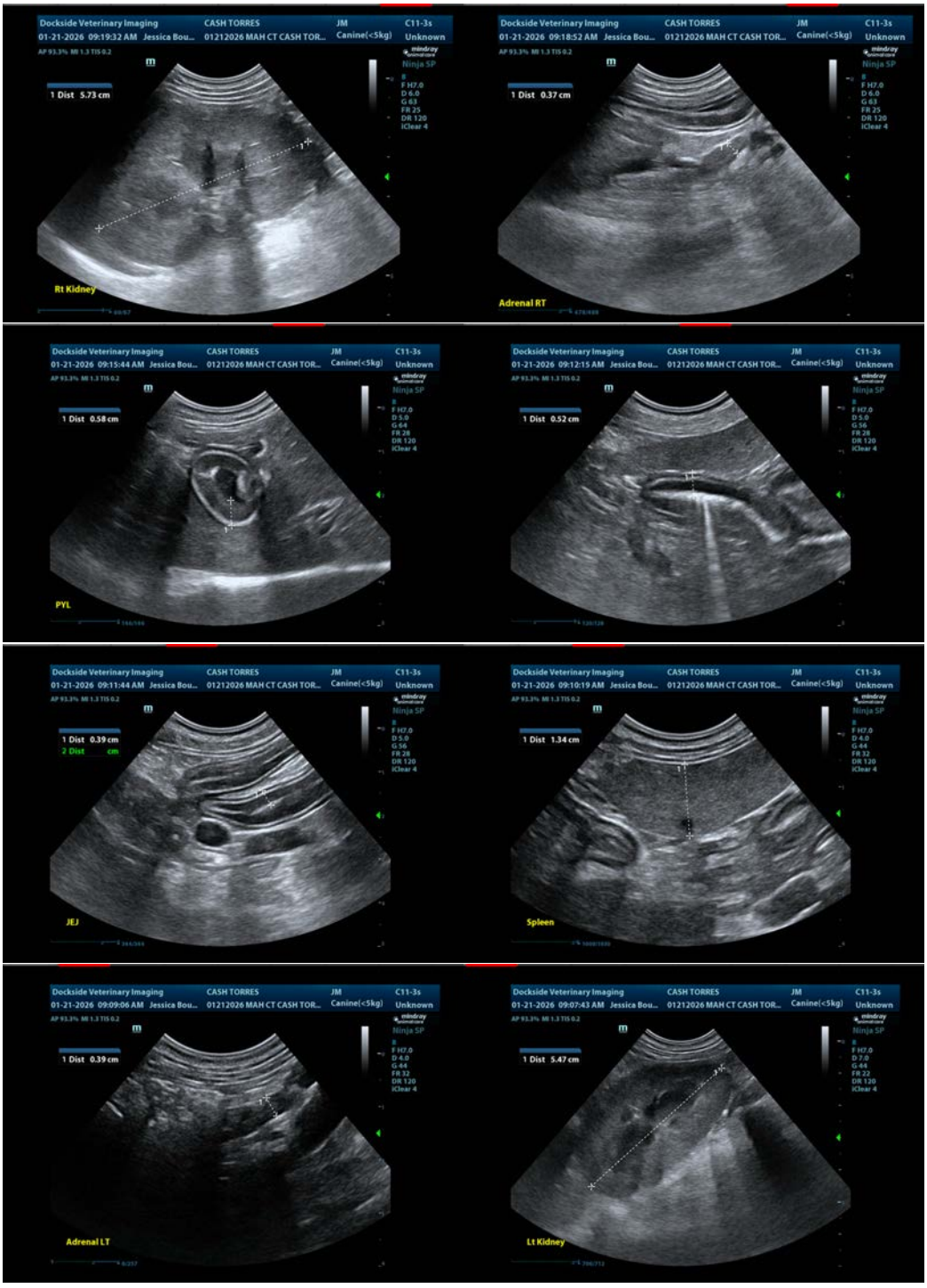

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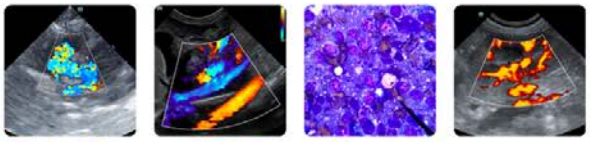

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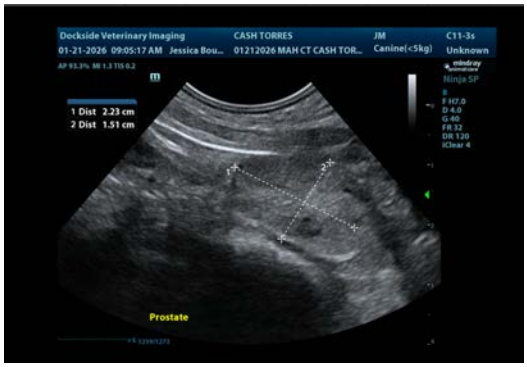

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)

info@sonopath.com