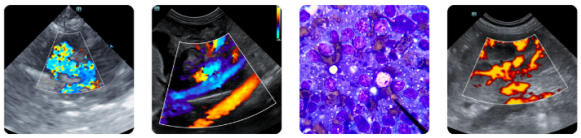


DATE

1/30/2026

PATIENT

Miss Daisy Browning

SPECIES

Canine

BREED

Westie

SEX

Spayed Female

AGE

6 years

WEIGHT

12.5 kg

INTERPRETED BY

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

HOSPITAL NAME

Mason Dixon Animal Emergency Hospital

REFERRING VET

Dr. Parr

INVOICE

11202

PRESENTING CLINICAL SIGNS

Patient History: Diminished appetite with vomiting food and bile for the last 2 mornings. Acute vomiting and regurgitation. History of picky appetite. Had blood work done 1/29/26 with rapid decrease in blood proteins and recent albumin 1.5. Cortisol was normal, CBC unremarkable, Cpl was in the gray zone.

Current Medications: Apoquel and cytopoint long term for allergies.

Labwork Results: labwork not attached.

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Requested.

Imaging Performed by: Stephanie Warga RDCS, RVT.

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 left kidney has a normal shape and size (4.45 cm). Overall echogenicity is slightly hyperechoic with poor 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 (4.33 cm). Overall echogenicity is slightly hyperechoic with poor 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 0.6 cm at the cranial pole and 0.56 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 0.58 cm at the cranial pole and 0.52 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 (1.35 cm) and the echotexture is homogenous. The splenic capsule is smooth with no visible irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver

The liver is large in size, and normal in echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. 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. There is a moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains mild fluid/gas. There's a focal hyperechoic shadowing structure visualized within the stomach measuring 0.14 cm in diameter, which does not appear obstructive at this time. In some areas the gastric wall appears normal measuring at 0.42 cm. Other areas are somewhat thickened with mildly reduced detailed wall layering and surrounding inflammation. I this area it can measures up to 1.18 cm in thickness.

The visualized areas of duodenum (0.36 cm), jejunum (0.35 cm) and ileum have a uniform diameter with minimal fluid distension. Wall thickness is increased (enter measurement if given). Bowel loops follow a typical curvilinear path. Visualized peristalsis appears appropriate. There's diffuse thickening and mucosal fogging of the small intestine with generalized mesenteric inflammation.

The descending colon wall appears mildly thickened at 0.32 cm with intact wall layering. Sections of colon are visualized with formed fecal material and gas shadowing distally.

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 moderate pancreatitis particularly in the cranial aspect of the right limb.

Free Abdomen

Evaluation of the peritoneal cavity revealed a small amount of free abdominal fluid. There is no significant lymphadenopathy. 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.

PRIMARY FINDINGS

- Pancreatic changes most consistent with moderate pancreatitis particularly in the right limb.
- Small to moderate fluid and gas distension of the stomach with a focal shadowing structure and segmental wall thickening with mildly reduced wall layering. Findings are most consistent with severe gastritis. An early neoplastic process cannot be ruled out.
- Diffusely thickened small intestine with mucosal fogging and surrounding inflammation. Findings are suggestive of a primary enteropathy.

- Scant free abdominal fluid and generalized mesenteric inflammation.

SECONDARY FINDINGS

- Mild age-related changes visualized associated with both kidneys.
- Large heterogenous liver. The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, infiltrative neoplasia (less likely) or other hepatopathy.
- Moderate gallbladder debris. The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting but seems unlikely to be causing a current issue. Recommend continued monitoring.

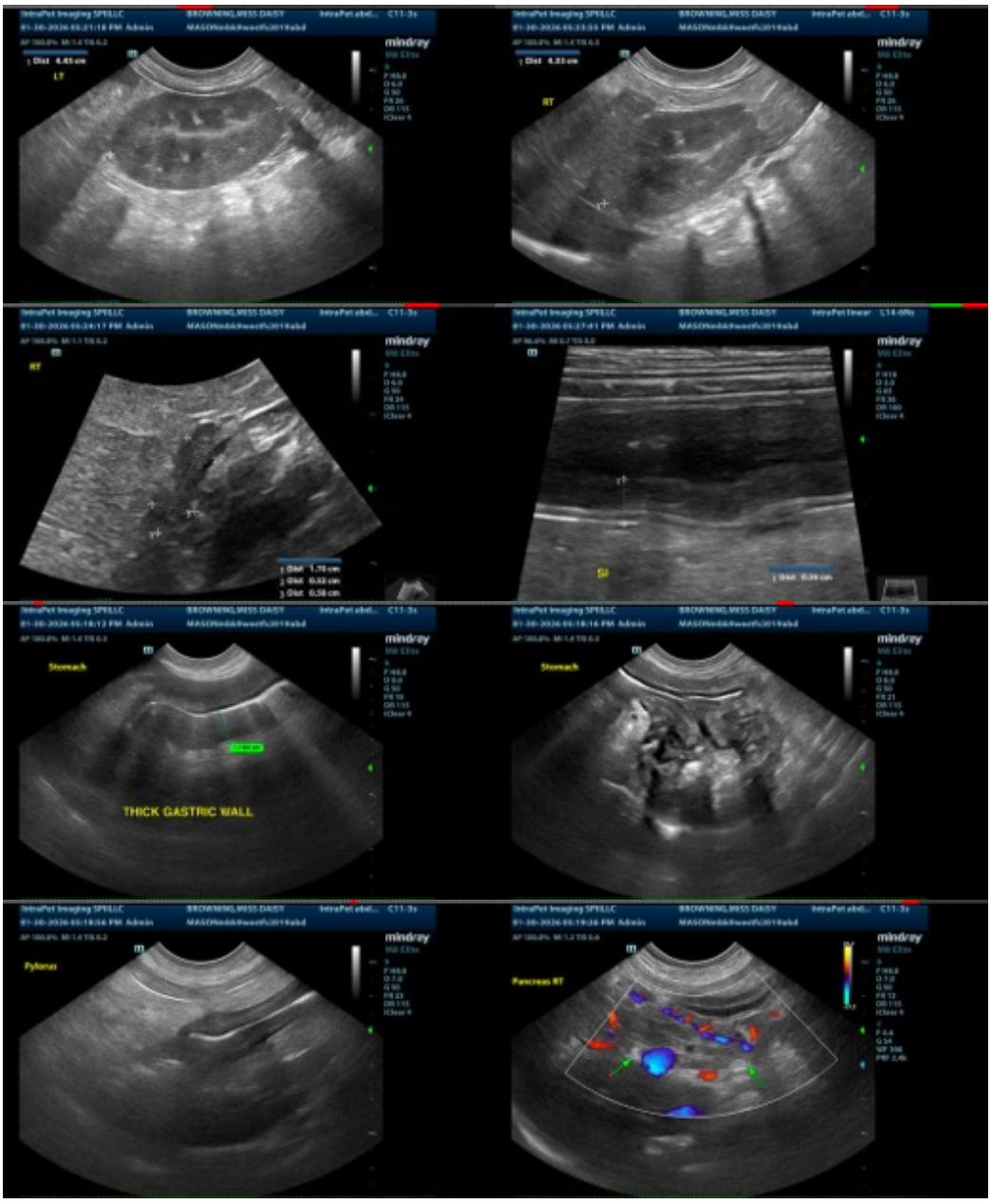
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The stomach has a mild to moderate amount of fluid and gas with some focal shadowing material which does not appear obstructive at this time. Areas of the gastric appear thickened and prominent with somewhat reduced detailed wall layering in these areas and surrounding inflammation. Additionally, the pancreas in this area is large, mottled and hypoechoic with surrounding inflammation most consistent with pancreatitis. Findings are suggestive of significant gastroenteritis and pancreatitis with secondary ileus, but a neoplastic process cannot be definitively ruled out.

Additionally, the small intestine is diffusely thickened with changes consistent with edema and mucosal fogging. Findings are suggestive of a possible concurrent chronic enteropathy. Possibly exacerbated by pancreatitis? Low albumin levels increase concern for an underlying protein losing enteropathy. Primary differentials would include severe IBD, lymphangiectasia, or less likely underlying neoplasia. Biopsies of the GI tract would be necessary to differentiate.

Recommend aggressive medical therapy for pancreatitis/gastroenteritis with an ultra-low fat diet being fed (ideally a hydrolyzed ultra-low fat diet) and judicious use of fluids. A GI panel could be sent to Texas A&M for a qualitative fPLI/TLI, cobalamin, and folate as low B12 levels could be supportive of a chronic enteropathy as well as pancreatitis.

If the patient can be stabilized, biopsies of the GI tract may be considered in the future. If the patient is not responding to therapy, consider repeat imaging to reassess and look for the development of new lesions.


LT
RT
RT
SI
Stomach
THICK GASTRIC WALL
Stomach
Pylorus
Pancreas RT

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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