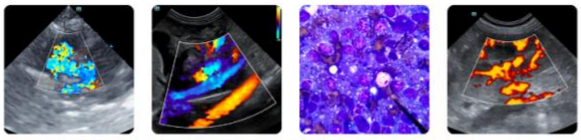


DATE

12/5/25

PATIENT

Chimera Poe

SPECIES

Canine

BREED

Great Dane

SEX

Spayed Female

AGE

9/21/20

WEIGHT

76 kg

INTERPRETED BY

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

HOSPITAL NAME

Mason Dixon AEH

REFERRING VET

Dr. McCafferty

INVOICE

12/5/25

PRESENTING CLINICAL SIGNS

Patient History: Vomiting and not eating started around Nov 30th. She doesn't want to walk. She seems painful. Very lethargic. She was hospitalized on Dec 3rd early am 4 am. she was treated with Metoclopramide, Ondansetron, Maropitant, Dopamine. Her WBC were low 3.6 and the chemistry unremarkable. Thyroid low. Treated with thyroid meds and sent home.

Current Medications: Maropitant 160 mg PO q 24 h, Levothyroxine 0.5 mg 1 and ½ tab by mouth every 12 hours (started 12/4/25 am).
Labwork Results: Labwork not submitted. Low WBC. Abnormal radiographs.
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Declined.
Stat Report: STAT requested.
Imaging Performed by: Rachel Brilhart, RDMS.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with a large amount of suspended echogenic debris present. The bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2.0 cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or calculi.

The left kidney has a normal shape and size (8.35 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of 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 (9.79 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The region of left adrenal (cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.94 cm at the cranial pole and 1.0 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 (1.75 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 primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach is moderately dilated with a moderate amount of fluid and some shadowing ingesta. It measures at a normal thickness of <0.36 cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layering is adequate and there is no impression of reduced peristaltic activity. Some focal hard shadowing ingesta is visualized; one shadowing area measures at 4.85 cm.

Some of the areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal to moderate 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. The jejunum measured as normal (0.32 cm). Visualized peristalsis appears appropriate. There is a general enteritis/ileus type pattern with some fluid distention and subjective reduced motility. A partial obstruction cannot be ruled out.

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 region of the pancreas is normal and isoechoic to surrounding 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.

ULTRASONOGRAPHIC FINDINGS

- Large amount of suspended echogenic debris in the urinary bladder- recommend urinalysis and culture.
- Fluid distended stomach with some hard shadowing material- correlate with the feeding history. Findings could be consistent with atypical ingesta, ingested foreign material, etc. A definitive obstruction is not visualized and seems unlikely but cannot be ruled out.
- Diffuse fluid distention and reduced motility of the small intestine- findings are most consistent with enteritis and ileus. A partially obstructive process cannot be ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

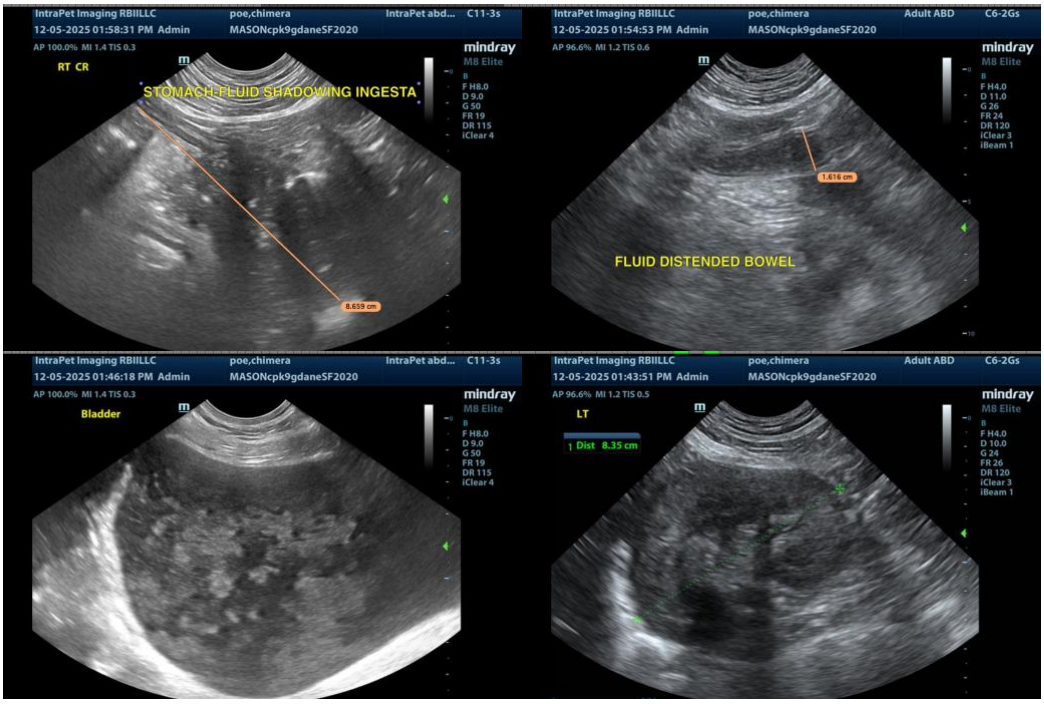
No large mass lesions or definitive obstructions are visualized on today's exam. The stomach has moderate

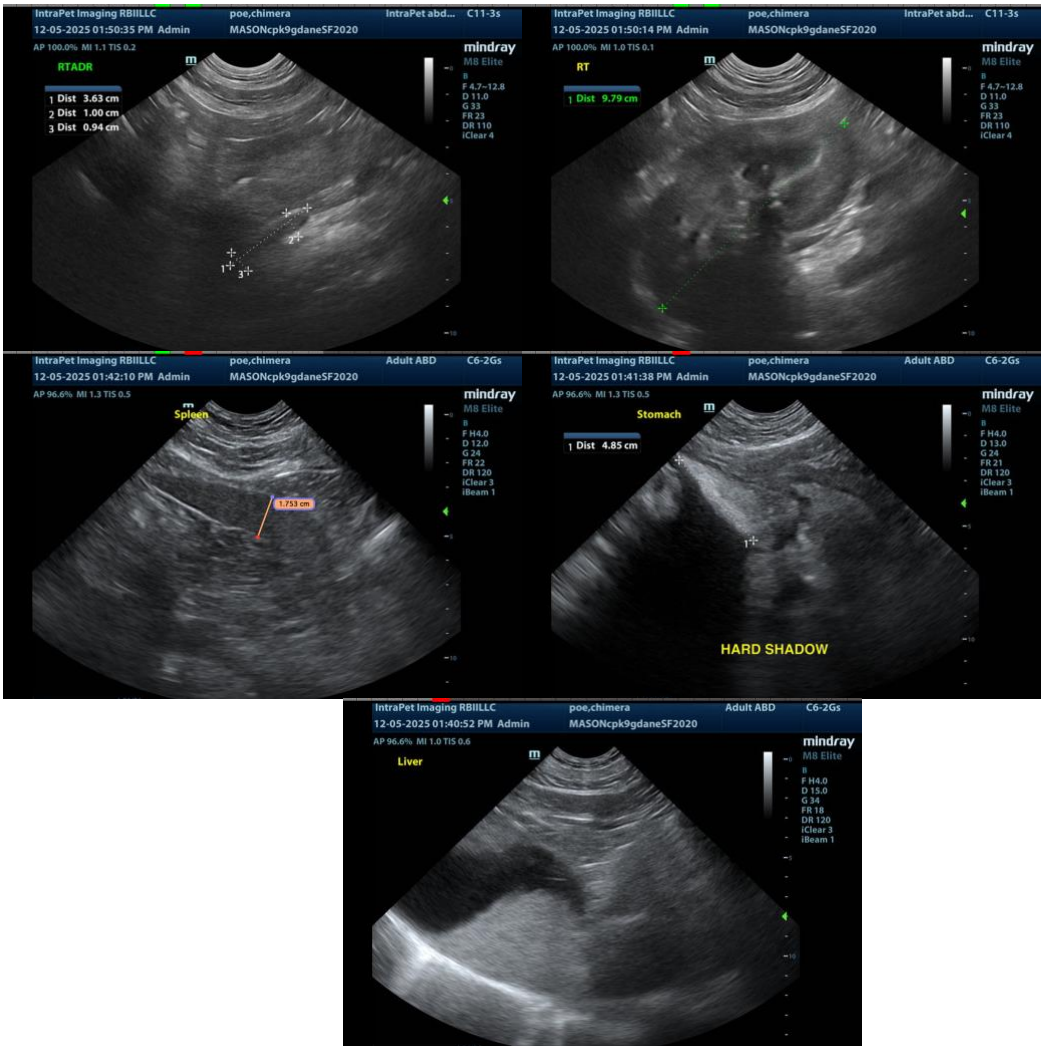
fluid distention with some hard shadowing material. Correlate this with radiographs and the recent ingestion of food products, medications, etc. This could represent atypical ingesta, ingested foreign material, etc. A definitive obstruction is not visualized, but with the size of this patient, this cannot be definitively ruled out.

Recommend empirical treatment for gastroenteritis. If there is significant concern for gastric foreign material, you could consider an upper GI endoscopy to further evaluate. If a megaesophagus is strongly suspected, you could consider screening for myasthenia gravis with an acetylcholine receptor antibody test, as this could explain some of the mobility issues described. Additionally, recommend a baseline cortisol to screen for Addison's disease.

Recommend 3 view thoracic radiographs, looking for possible aspiration pneumonia. If symptoms are persistent despite treatment, follow up imaging could be considered to determine if a more definitive obstruction is present.

Patient size and conformation (deep chested giant breed) limits image quality and visualization in many areas. Recommend sedation for future imaging.





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)

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