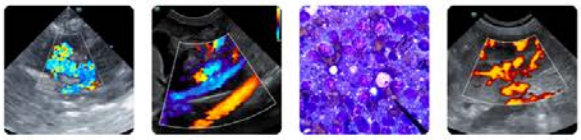


DATE

3/27/26

PATIENT

Charlie Jenkins

SPECIES

Canine

BREED

Mini Doodle x

SEX

Spayed Female

AGE

3/26/18

WEIGHT

6 kg

INTERPRETED BY

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

HOSPITAL NAME

Mason Dixon Animal Emergency Hospital

REFERRING VET

Dr. McCarty

INVOICE

74054

PRESENTING CLINICAL SIGNS

Patient History: Charlie presented for evaluation of ongoing vomiting and diarrhea for the last 2 weeks. She was treated 3/24/26 symptomatically with intravenous fluids and antiemetics. Radiographs at the time did not show a clear foreign body obstruction. Blood work at the time was largely unremarkable. She was eating well at
discharge and initially was doing well at home, but has since regressed and is not not eating, and has had continued vomiting, diarrhea, and inappetence. On presentation, Charlie was bright and alert with normal vital signs. She was mildly painful on palpation of her abdomen. She was admitted to the hospital for continued care and to pursue a full abdominal ultrasound.

Current Medications: None listed.
Labwork Results: Labwork not attached, reported as: Diagnostics 3/36/26: Chem 6/lytes: K 3.7 (L). PCV/TS: 52%/6.6g/dL. Resting cortisol: 4.86 ug/dL - not consistent with Addison's disease. cPL: 51.8 ng/mL - normal
Date of Previous IntraPet Ultrasound: No previous.
Sedation: DEX CRI, Propofol.
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 (4.25 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 (3.99 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 0.46 cm at the cranial pole and 0.55 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 0.32 cm at the cranial pole and 0.45 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 (1.37 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. 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/moderate fluid and gas. The gastric wall appears prominent with intact wall layering, measuring up to 0.71 cm. The pylorus appears slightly prominent, measuring at 0.55 cm with intact wall layering.

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. Duodenum wall measures 0.44 cm. Jejunum wall measures 0.29 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. Sections of colon are visualized with non-formed fecal material and gas shadowing distally. The descending colon wall appears slightly prominent with intact wall layering, measuring up to 0.35 cm.

Pancreas
The pancreas is prominent and mottled, particularly in the right limb. 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. There is no significant lymphadenopathy. An occasional prominent mesenteric lymph node is visualized, an example measures 0.40 cm x 0.34 cm. The omentum is slightly hyperechoic in the cranial abdomen.

PRIMARY FINDINGS

- Pancreatic changes most consistent with chronic pancreatic remodeling +/- chronic pancreatitis.
- Mild fluid and gas visualized within the stomach and mild gastric wall thickening with intact wall layering – Findings are most suggestive of gastritis. Early neoplastic disease seems less likely. A small unseen focal lesion cannot be ruled out.
- 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).
- Prominent/mildly thickened distal colon – The findings are most consistent with colitis. Early neoplastic change is less likely.

SECONDARY FINDINGS

- 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 appears slightly prominent with some intraluminal fluid and gas. There is prominent rugal folding, and the stomach wall is subjectively thickened in some regions with intact wall layering. These changes could be consistent with gastritis. No significant intraluminal foreign material is visualized, but a small foreign object or mucosal lesion cannot be definitively ruled out. The pylorus is slightly prominent but does not appear overtly thickened and wall layering is intact.

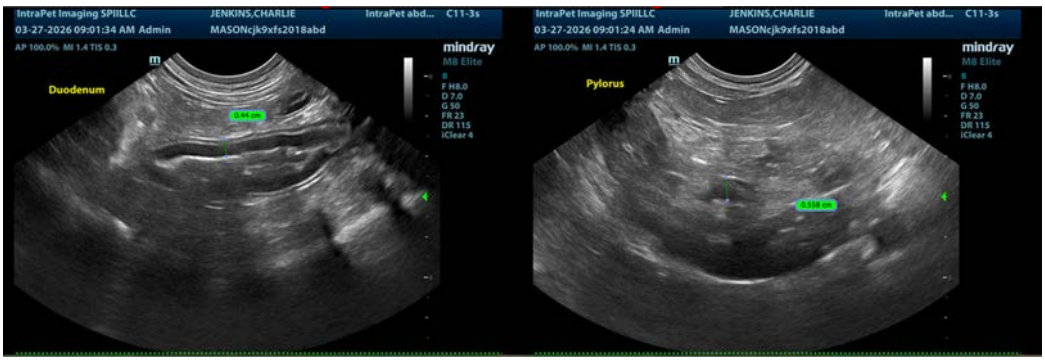
The right limb of the pancreas is hypoechoic and prominent. Findings are most consistent with chronic pancreatic remodeling, but mild inflammation is possible. Correlate with PLI level.

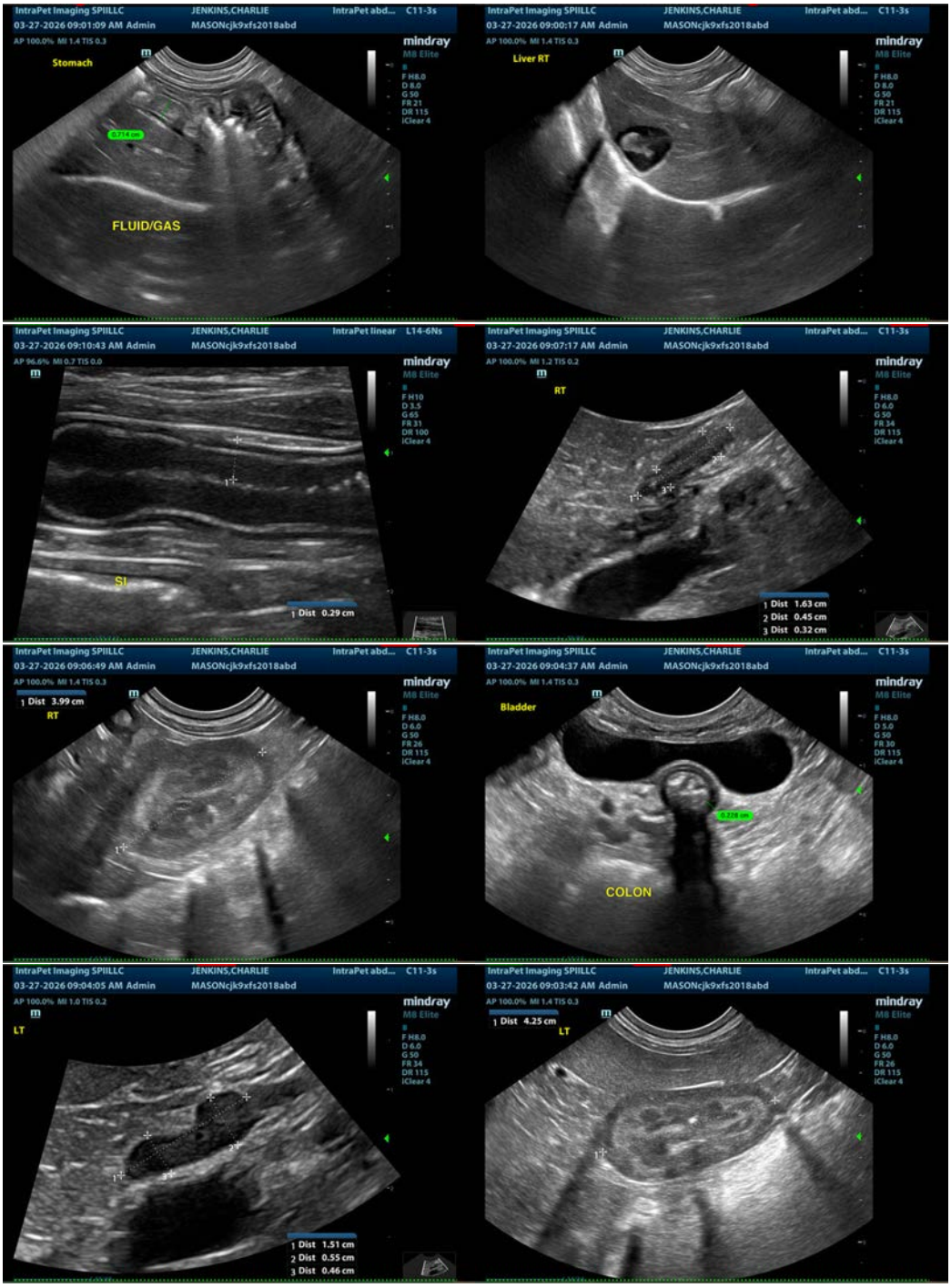
Some areas of small intestine appear mildly thickened with some mild fluid distention, possibly consistent with a mild enteritis type pattern. Additionally, the colon is mildly thickened in some regions, possibly consistent with colitis.

Consider the following:

- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- If not already done, recommend empirical deworming and parasite screening as well as screening for infectious causes of diarrhea (bacterial, viral, etc.).
- 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 probiotic therapy.

If symptoms are persistent despite additional aggressive supportive care and further evaluation, then ultimately biopsies of the GI tract may be warranted. Additionally, you could consider repeat imaging in the future, as a small unseen focal lesion cannot be ruled out.

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Stomach
FLUID/GAS
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2 Dist 0.45 cm
3 Dist 0.32 cm
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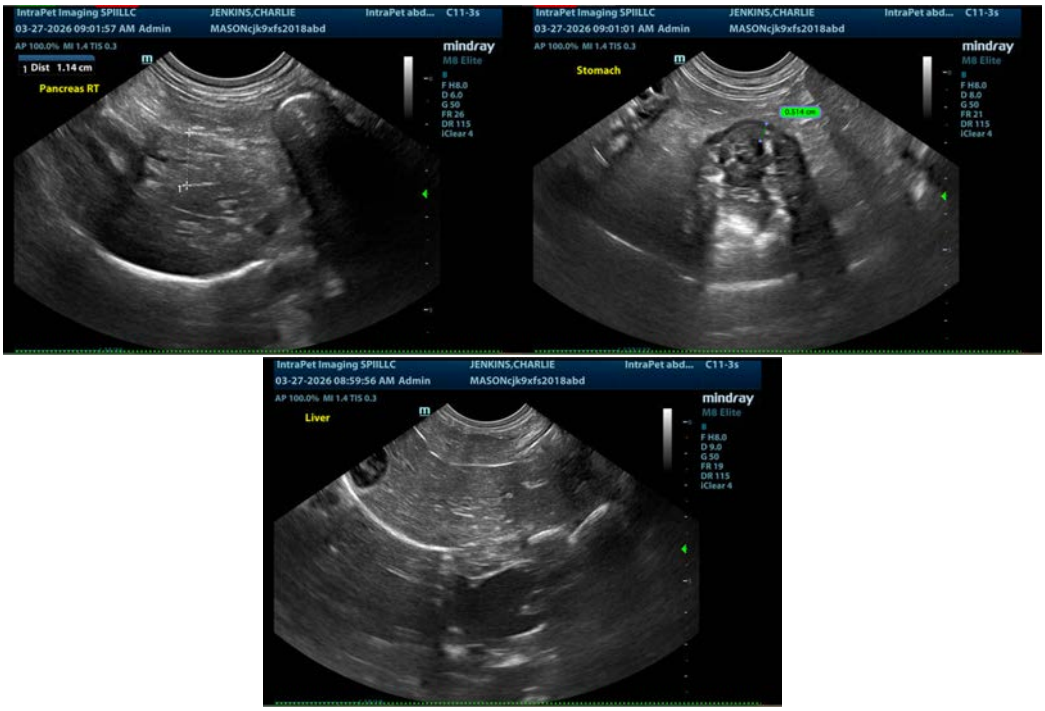

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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