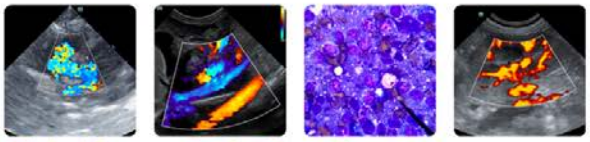


PATIENT

Darby Rivera

SPECIES

Canine

BREED

Italian Greyhond

SEX

Neutered Male

AGE

6 Years

WEIGHT

36 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Nikki Kollman, RVT

HOSPITAL NAME

Airpark Animal Hospital

REFERRING VET

Laura Owens, DVM

INVOICE

74100

DATE

3/31/26

PRESENTING CLINICAL SIGNS

Possible ingestion of grass containing fertilizer yesterday, called Pet Poison control and they were not concerned with systemic toxicity, reported possible mild GI signs. Vomited and had soft stool multiple times overnight. Suspected pancreatitis based on bloodwork. Had severe pancreatitis in 2023 and required hospitalization at a 24 hour facility. History of severe pleural effusion in 9/2025, CT revealed left cranial lung lobe torsion, had lung lobectomy and recovered well. Has had recurrent pleural effusion twice since the surgery, once in 10/25 and once in 12/25, both times >1 liter of modified transudate were removed. Culture of pleural fluid was negative. Cytology did not reveal any neoplastic changes. Had a repeat CT in 10/25 that did not see any cause for the recurrent pleural effusion.

Abnormal PE/Chem/CBC/UA Results: 5-7% dehydrated on PE HR 160 Mild to moderate left sided pleural effusion on rads. Scant peritoneal effusion seen on FAST scan and some sort of mass effect in cranial abdomen. CBC unremarkable other than bands suspected ALKP 264 Bili 1.7 Amylase 1779 Lipase 5682 Catalyst Pancreatic Lipase 1112

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 visualized areas of prostate and surrounding tissue appear normal. Unfortunately, the prostate is not fully visualized likely due to its intrapelvic location. Correlate with rectal exam findings.

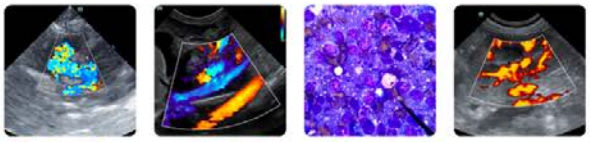
The left kidney has a normal shape and size (5.86 cm) with a hyperechoic foci in the cortex in the region of the caudal pole measuring 0.57 cm, most consistent with focal mineralization. Continued monitoring is warranted. Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (5.4 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 region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.

The right adrenal gland is normal in size measuring 0.50 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.



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Spleen

The spleen is subjectively normal in size (1.53 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 large in size with smooth peripheral margins. The parenchyma is hyperechoic and homogenous in 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 minimal luminal contents. Some areas of the gastric wall appear somewhat thickened, measuring up to 0.71 cm with slightly reduced detail of wall layering. No masses or focal lesions were observed.

Most of 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 0.49 cm. Jejunum wall measures 0.33 cm. Visualized peristalsis appears appropriate. The duodenum appears corrugated and somewhat thickened, most consistent with duodenitis. Some sections of small intestine appear thickened with surrounding reactive mesentery possibly consistent with focal enteritis, measuring up to 0.44 cm.

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 pancreas is large and hypoechoic (left limb > right limb). There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation and free fluid. Consistent with severe to severe pancreatitis.

Free Abdomen

There isa small amount of free abdominal fluid visualized. this is primarily visualized around the abnormal pancreas. A small amount is visualized in the cranial abdomen adjacent to the diaphragm. There is no significant lymphadenopathy. The omentum is severely reactive around the pancreas and in the cranial abdomen.

Other

Pleural effusion is visualized cranial to the diaphragm.

ULTRASONOGRAPHIC FINDINGS

- Large, hypoechoic pancreas surrounded by highly reactive mesentery and free fluid (left > right) – Findings are most consistent with severe pancreatitis.

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- Large, hyperechoic liver – The diffuse hepatic changes are non-specific and can be seen with vacuolar hepatopathy, reactive change, nodular hyperplasia or, less likely, inflammatory/immune-mediated disease, infiltrative neoplasia, or other hepatopathy.
- Thickened gastric wall – The stomach wall thickening could be consistent with inflammation, edema, infiltrative neoplasia, imaging artifact due to rugal folds, other.
- Thickened, corrugated duodenum with some sections of small intestine appearing somewhat thickened with reactive mesentery surrounding – Findings are most consistent with duodenitis/enteritis. A primary gastrointestinal lesion cannot be ruled out.
- Pleural and abdominal effusion.

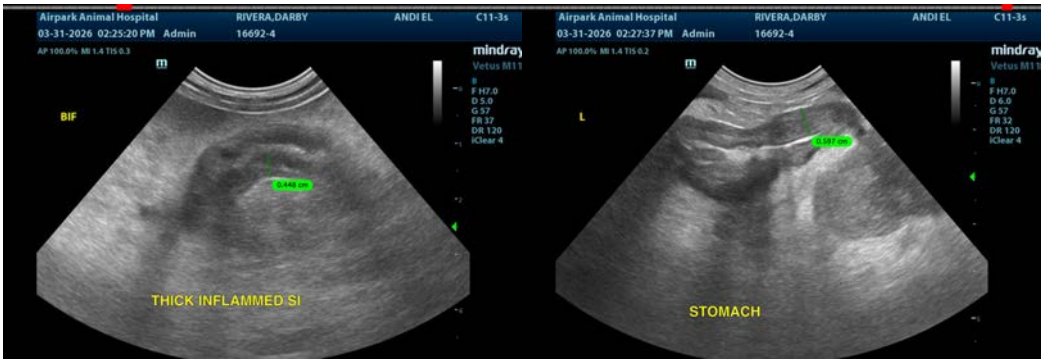
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The left lobe of the pancreas appears hypoechoic, large, and lobulated, with a large amount of reactive surrounding mesentery and free fluid. The body of the pancreas and the right limb are also prominent, but the left limb is most severe. Findings are most consistent with severe pancreatitis. An underlying neoplastic process seems less likely.

The stomach, duodenum, and some areas of small intestine appear thickened and slightly irregular, most likely consistent with concurrent gastroenteritis. Recommend aggressive therapy for pancreatitis and continued monitoring, looking for resolution of the concurrent enteritis and monitoring for the possible development of a pancreatic abscess or similar.

If symptoms are persistent despite aggressive therapy, you could consider a fine needle aspirate of the pancreas in the case of a possible neoplastic infiltrate (seems less likely). The effusion would be suspected secondary to vasculitis. Fluid analysis and cytology could be considered.

No evidence of a biliary obstruction is present at this time, but continued monitoring of the elevated bilirubin is recommended (could be hemolysis? Iatrogenic?).



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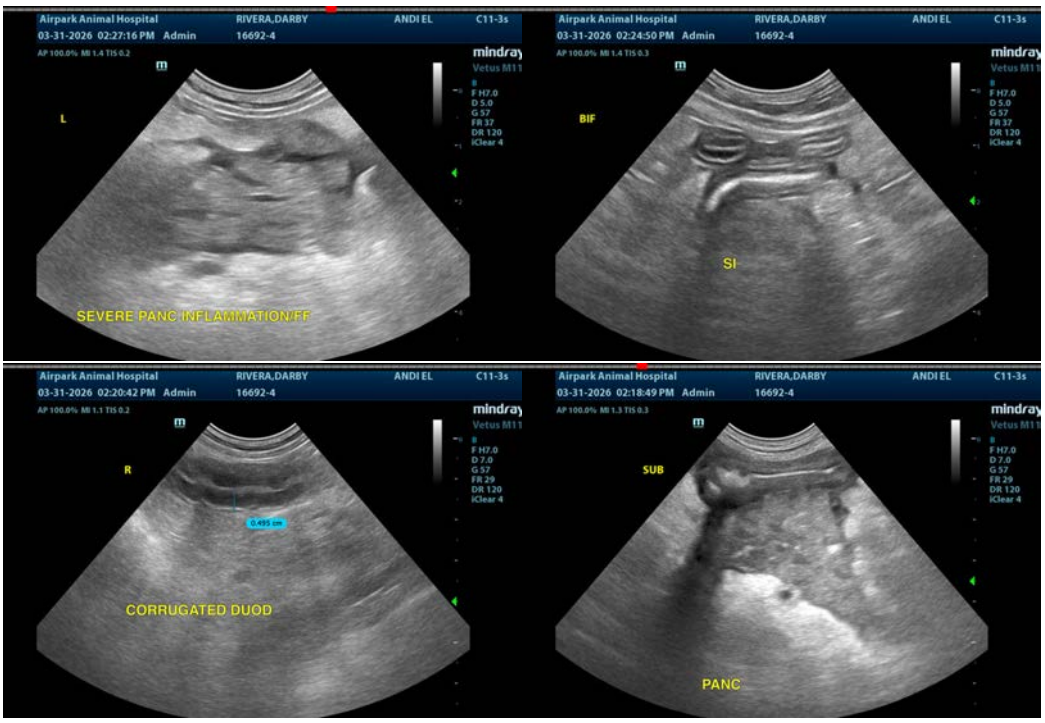

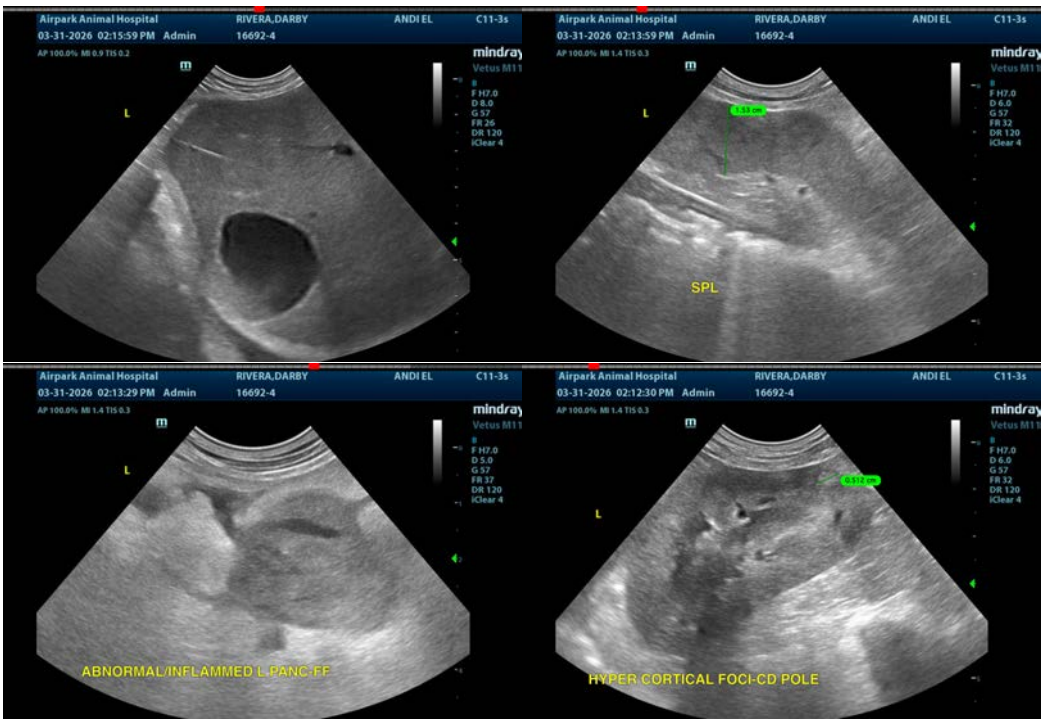

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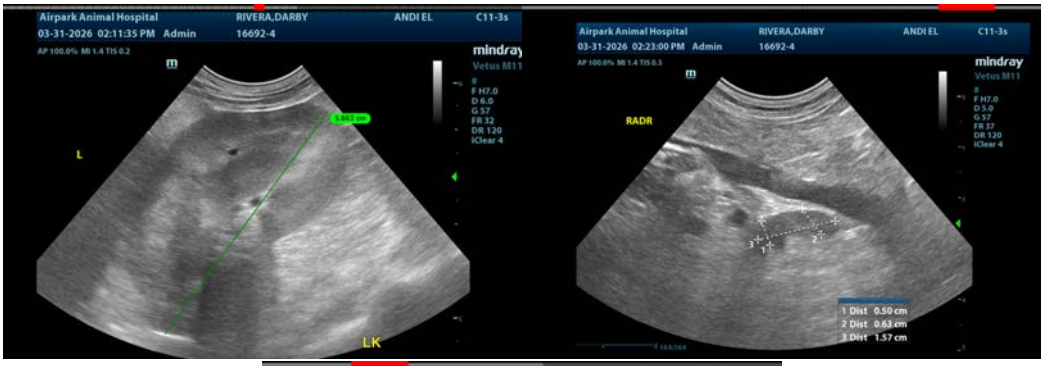

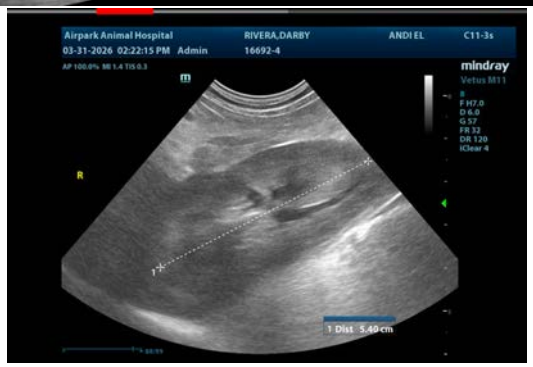

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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