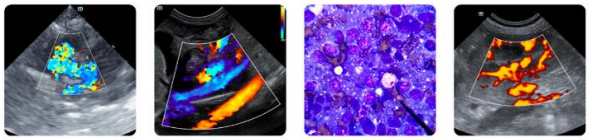


PATIENT

Bam Bam Ridgely

SPECIES

Canine

BREED

Shih Tzu

SEX

Male

AGE

11M

WEIGHT

5.7lbs

INTERPRETED BY

R. McKenzie Daniel, DVM, DABVP (Canine and Feline)

IMAGING PERFORMED BY

Nikki Kollman RVT

HOSPITAL NAME

Airpark Animal Hospital

REFERRING VET

Dr. Grace Kennedy

INVOICE

74055

DATE

3-5-26

PRESENTING CLINICAL SIGNS

- Acute over last 12-24 hours of profuse vomiting, refusing food and severe nausea with hypersalivation. Weight loss present last few months, but more so recently. Switched back to Royal Canin Shih tzu formula over the last month or so. Nothing the owners know he got into, no trash missing, no toxins or new things in the house that he got into, but always a possibility according to owner.

Abnormal PE/Chem/CBC/UA Results: Profuse hypersalivation and quiet but responsive mental status on presentation. Severe cachexia with severe matting in places. Tense generally on abdominal palpation. CBC: PCV 40% WBC 12.5 K/uL Platelets 267 K/uL Chemistry: Glucose 131 mg/dL Creatinine 0.8 mg/dL BUN 31 mg/dL (7-27) Phosphorus 2.4 mg/dL (2.5-6.8) Na:K ratio 40 Albumin 3.2 g/dL ALT 873 U/L (10-125) ALP 76 U/L (23-212) GGT 13 U/L (0-11) Amylase >2,500 U/L Lipase 2,589 U/L (200-1800) cPL 673 U/L (0-200)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Nondistended with urine and subnormal in size with indistinct visualization. No definitive evidence of urinary bladder mineral or calculi. The ureteral papillae were normal. The ureters were not visible, which is normal. No evidence of inflammatory or neoplastic changes were noted.

The prostate gland was not definitively visualized.

No evidence of pathology in the area of the aortic trifurcation.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 3.1 cm in length. The right kidney measured 3.1 cm in length.

Adrenal Glands

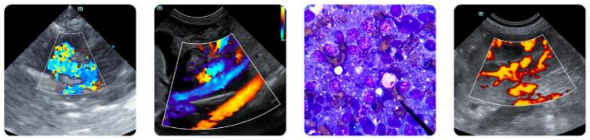
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.33 cm width at the caudal pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.39 cm width at the caudal pole.

Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver/ Gallbladder

The liver was subjectively normal in size, structure, and contour. Mildly congested hepatic vasculature with overall normal hepatic vascular volume was present. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture.



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The gallbladder was non-distended in size with thin walls and minor nonorganized gravity dependent gallbladder debris. The common bile ducts were not visualized.

Gastrointestinal

The stomach presented moderately to significantly distended with variably echogenic to hyperechoic focal progressively shadowing ingesta and retained fluid. An example of progressively shadowing ingesta in the area of the pylorus measured approximately 1.2 cm diameter without overt evidence of mechanical pyloric outflow obstruction or obstructive pyloric mural pathology.

The small intestine presented intact wall layering with normal wall layer ratio. The lumen of the small intestine was primarily empty with mild upper to mid duodenal ileus.

Normal visible colon wall layers were present with formed feces in lumen.

Pancreas

The parenchyma of the left limb, body and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease was evident.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Moderate to significant distended stomach with retained mildly hyperechoic to progressively shadowing ingesta and nonshadowing fluid.
- Primarily empty small intestine with mild upper to mid duodenal ileus.
- Sonographically normal pancreas.
- Normal volume to mild congested liver – consistent with benign hepatopathy.
- Minor nonorganized gallbladder debris.

Secondary Findings

- Normal bilateral kidneys/adrenal glands.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The gastric ingesta is nonspecific with considerations including variably dense retained gastric ingesta and metabolic gastric ileus with potential for partial fluid absorbing gastric foreign material i.e. stuffing, fabric, or similar. A definitive area of mechanical pyloric or upper intestinal outflow obstruction was not overtly visualized. However, given the degree of gastric distension in conjunction with reported anorexia and weight loss, exploratory laparotomy with gross inspection of the gastrointestinal tract and with gastrointestinal biopsies considered essential despite exploratory findings is warranted.

Three-view chest radiographs suggested prior to potential surgical considerations given evidence of mild hepatic congestion and if patient is non sedated.

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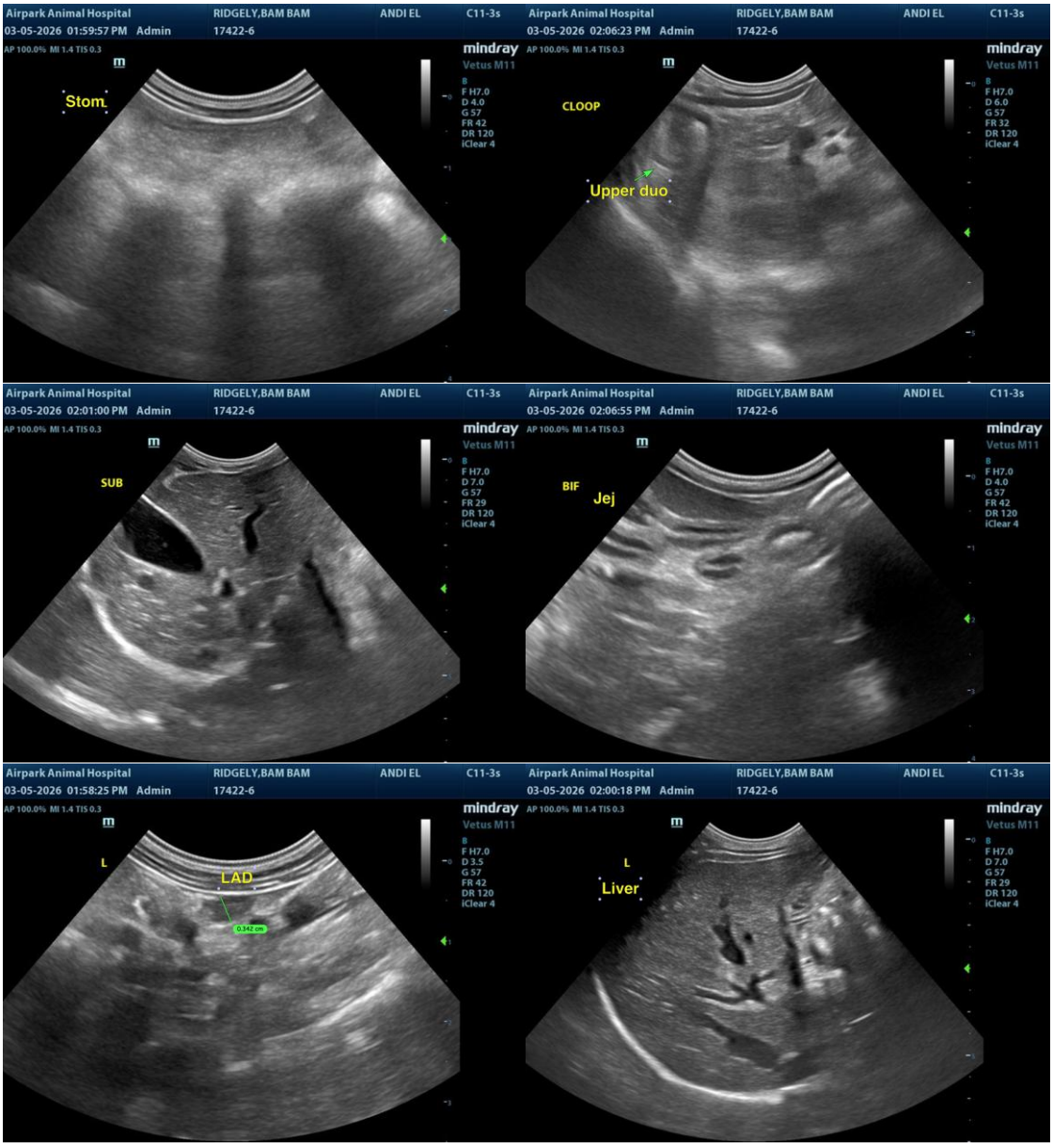
If normal clotting status, hepatic biopsies at the time of surgery are suggested.

No sonographic evidence of significant or active pancreatitis as a primary clinical player although mild pancreatitis may present sonographically normal.

A more conservative approach would be hospitalization with gastrointestinal support including IV fluids to promote gastrointestinal motility, documented 12-hour fast, sonographic monitoring of the gastrointestinal tract, and consideration for GI panel to include PLI/TLI/Cobalamin/Folate given weight loss.



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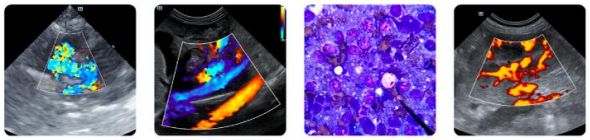

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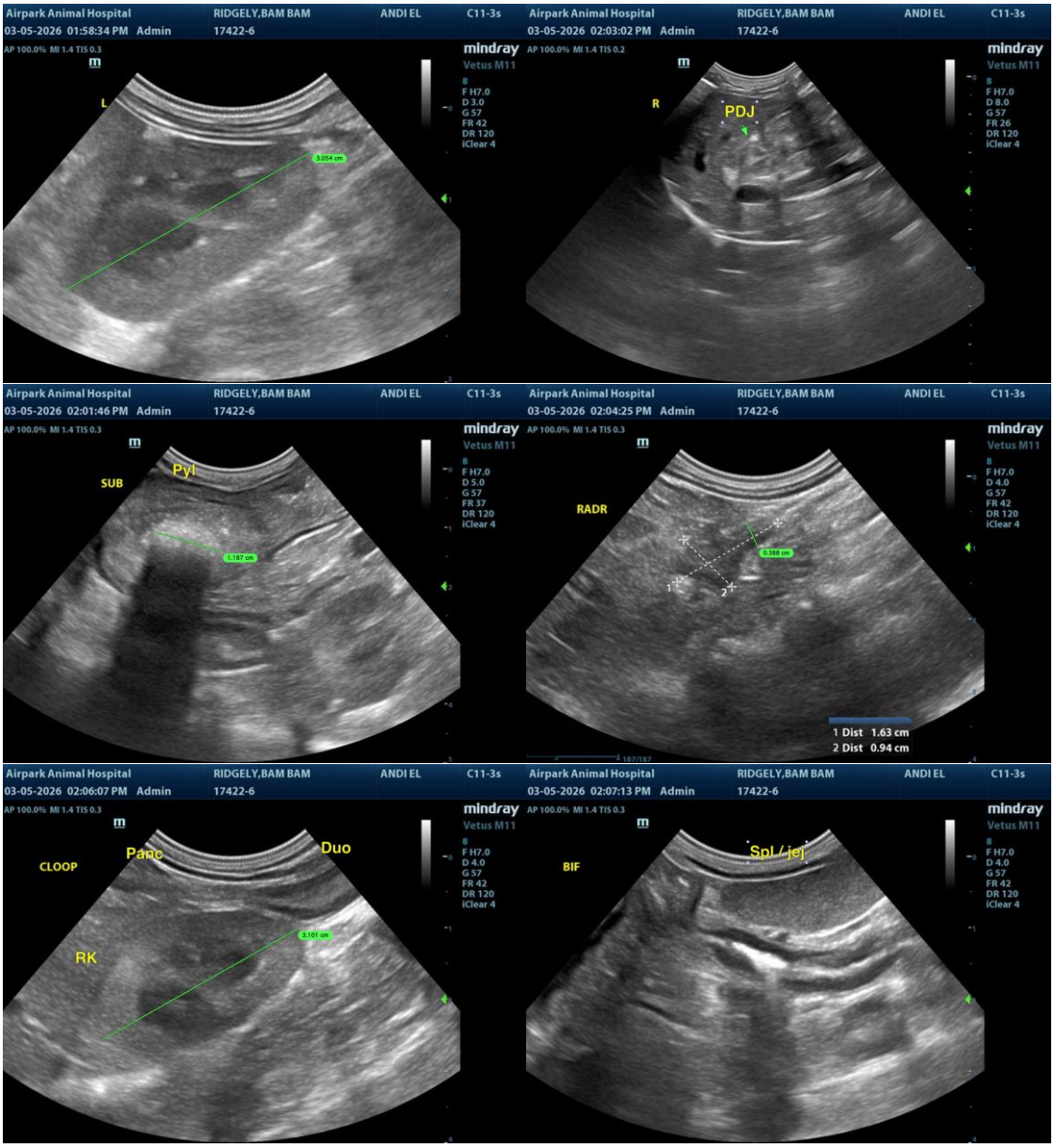

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine/Feline Practice)
info@sonopath.com