



PATIENT

Latte Moss

SPECIES

Canine

BREED

Doberman

SEX

FS

AGE

1

WEIGHT

26.1kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Sarah Barthelemy

HOSPITAL NAME

Petzoic Vet

REFERRING VET

Dr Almeida

INVOICE

24578

DATE

04/22/2026

PRESENTING CLINICAL SIGNS

Patient was spayed with gastropexy 1 week ago at rDVM. Post-op vomiting occurred which resolved with outpatient treatment. Patient then developed rhinitis and was mildly febrile which has significantly improved with antimicrobials and IVF in hospital. Clinically at this time appears much improved, but AUS to investigate spec cPL elevation

Abnormal PE/Chem/CBC/UA Results: Mild ALT and ALP elevation Mild spec cPL elevation Severe C reactive protein elevation Mild monocytosis Non-regenerative anemia

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no evidence of urine/lumen sediment, mineral, or calculi. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

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 6.8 cm in length. The right kidney measured 7.5 cm in length.

Adrenal Glands

The bilateral adrenal glands were overtly normal in size, position and shape. The left adrenal gland measured 0.75 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 0.52 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 presented mildly enlarged in size. The hepatic parenchyma revealed diffuse reduced echogenicity compared to the spleen and renal cortical parenchyma with a mild coarse echotexture. Mild increased portal vein prominence was evident. The capsule of the liver was normal in margination. Distinct masses or nodules were not evident. Normal vascular volume. The hepatic and portal vasculature were normal in appearance. The gallbladder was non-distended in size with mild non-organized debris. The common bile duct was not visualized without overt evidence of dilation or post hepatic obstructive criteria.

Gastrointestinal



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The stomach presented overall intact wall. The stomach contained a mild to moderate amount of retained echogenic fluid and gas. The area of the pyloric outflow was indistinctly visualized owing to gastropexy and regional peripyloric omental artifacts.

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The small intestine presented overall intact wall layering with normal wall layer ratio and empty lumen. Mild segmental areas of cranial abdomen jejunal corrugation.

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

Pancreas

The pancreas exhibited subjective enlarged to swollen appearance exhibiting non-homogenous hypoechoic parenchyma, most notable in the area of the pancreas base and right pancreatic limb.

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Free Abdomen

Peripancreatic to generalized cranial to mid abdomen, non-homogenous hyperechoic omentum.

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Concurrent scant pockets of mid to cranial abdomen / peripancreatic effusion.

Definitive significant or swollen mesenteric lymphadenopathy was not obvious, yet indistinctly visualized owing to enlarged to swollen pancreas and omental artifact.

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Focally enlarged mid abdominal medial iliac lymph nodes were present. These lymph nodes were homogenous, mildly hypoechoic and smoothly margined. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic inflammation was present. An example of lymph node size was 2.8 cm x 0.89 cm.

ULTRASONOGRAPHIC FINDINGS

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R. McKenzie Daniel,
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(Canine and Feline)

Primary

- Mild to moderate hypomotile stomach
- Hypoechoic swollen pancreas
- Overall normal empty small intestine with mild segmental intestinal corrugation
- Peripancreatic to generalized mid abdomen/ cranial abdomen, non-homogenous hyperechoic omentum and minor effusion
- Non-congested hepatomegaly exhibiting mild hyperechoic parenchyma
- Mild non-organized gallbladder debris

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The appearance of the pancreas is consistent with active pancreatitis with evidence of peripancreatic to mid / cranial abdomen peritonitis. Ultrasound guided abdominocentesis into the area of effusion for analysis, cytospin cytology and C/S if evidence of inflammatory effusion component is recommended with potential consideration for FNA cytology into the area of hyperechoic omentum. There is concern for possible emerging omental adhesions in the area of the pyloric outflow /gastropexy with potential delayed pyloric outflow given retained pyloric fluid as well as adjacent to cranial abdomen intestinal segments in conjunction with hyperechoic peri intestinal omentum and mild segmental intestinal corrugation.

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Despite improved clinical presentation, continued empirical therapy for pancreatitis/ peritonitis with serial clinical and sonographic monitoring going forward is advised. If recurrent or progressive



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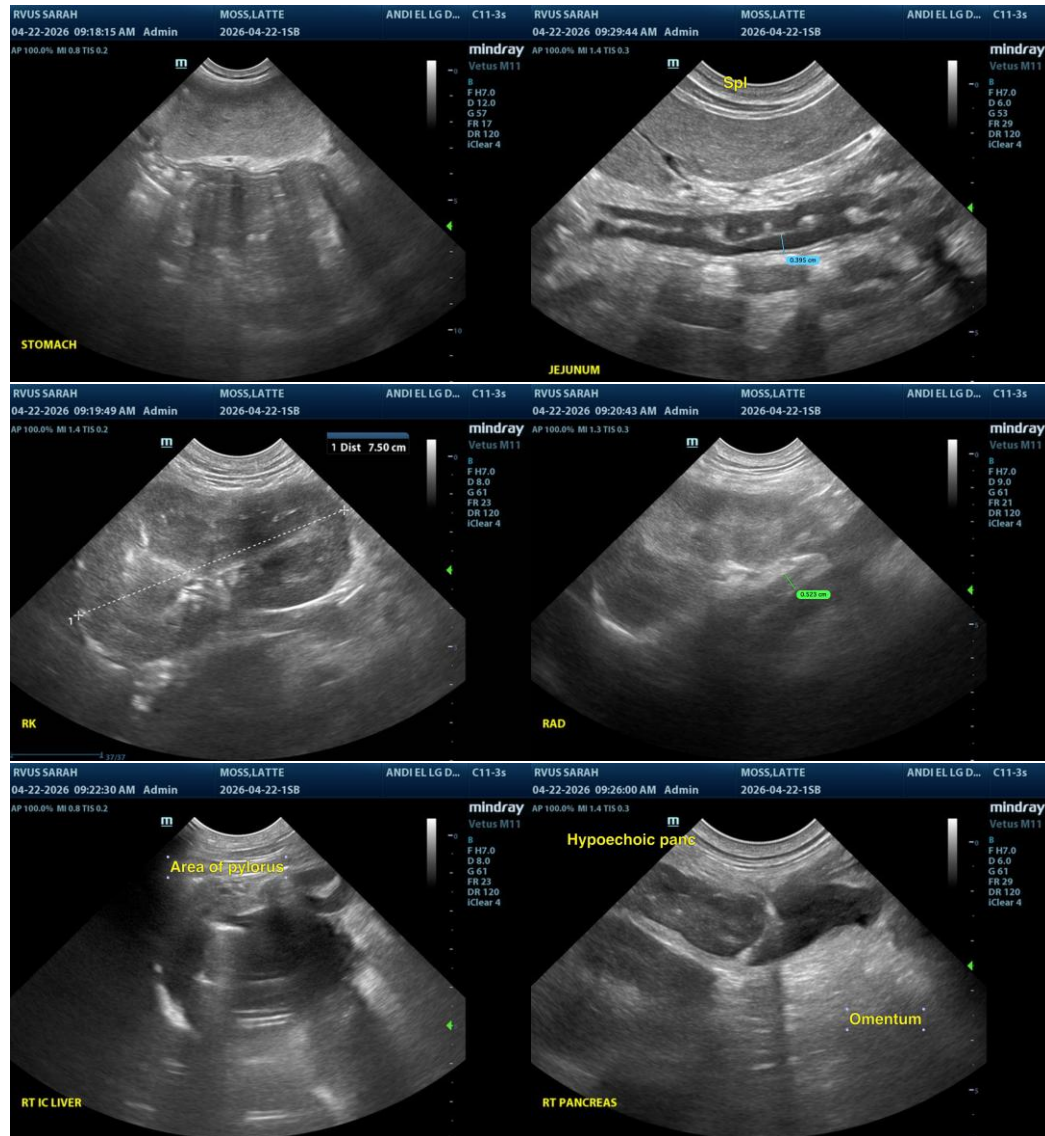
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gastrointestinal signs, abdominal pain or evidence of persistent inflammation, exploratory laparotomy with gross inspection of the cranial abdomen and gastrointestinal tract may be indicated.





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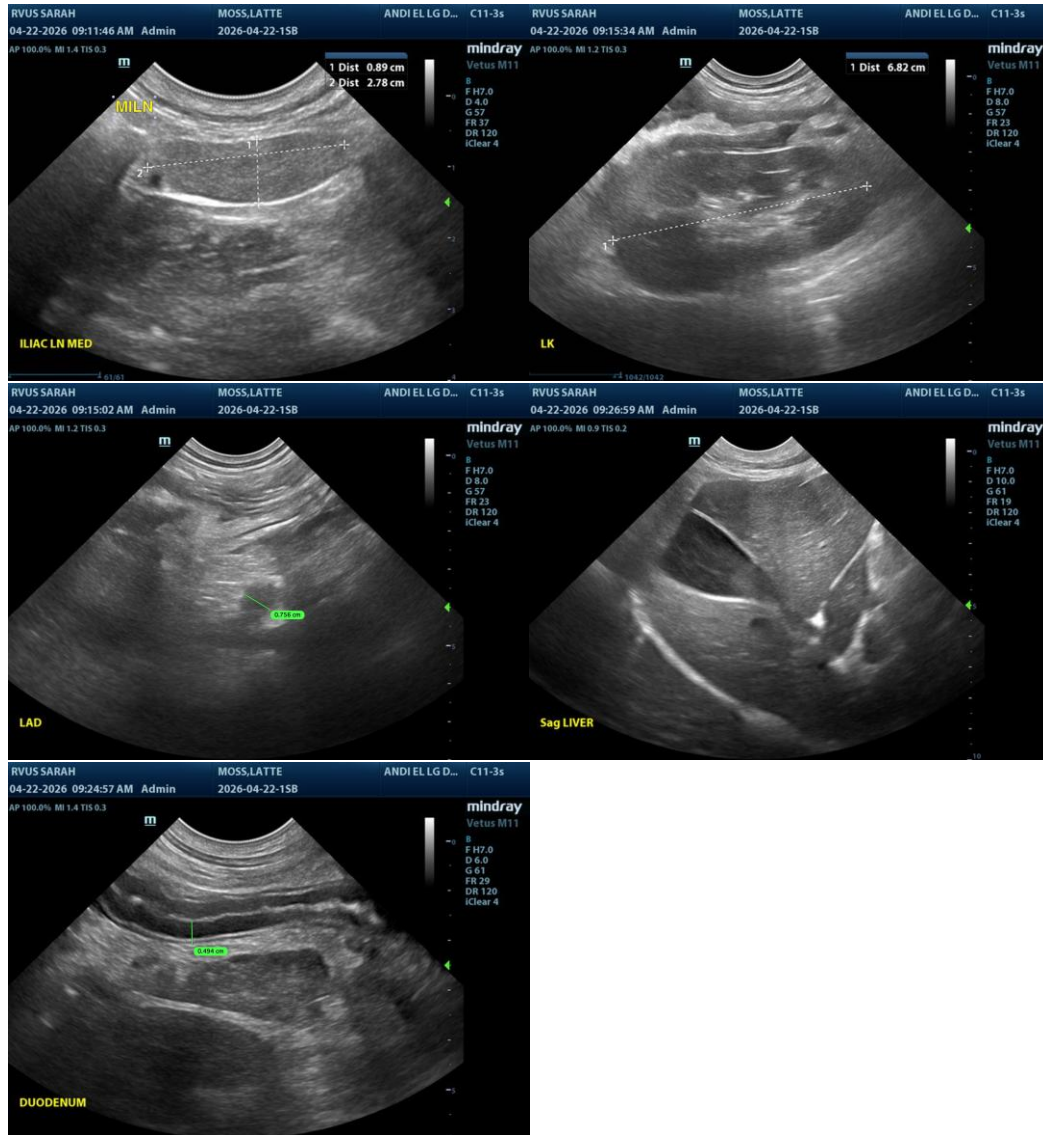
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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