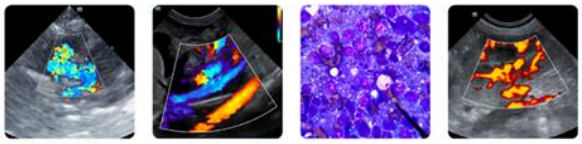

PATIENT

Teddy Beltran

SPECIES

Canine

BREED

Siberian Husky

SEX

MN

AGE

7

WEIGHT

97

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Ashley Gambon

HOSPITAL NAME

Lanier Animal Hospital

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PRESENTING CLINICAL SIGNS

Teddy presented for evaluation of vomiting and lethargy that began two nights ago (May 20, 2026). The signs started after he experienced a seizure, during which he fell off a couch. The post-ictal period was abnormal; he stood in one spot for approximately 2.5 hours while drooling profusely and was avoidant of interaction. For the past two days, he has been vomiting everything he consumes and has had no appetite, refusing even treats. The vomiting has occurred multiple times, including on the car ride to the clinic. He has been lethargic, dragging his feet, and has been urinating and defecating in his kennel while lying down. The owner notes he has been unusually docile. He has a known diagnosis of idiopathic epilepsy and experiences cluster seizures once or twice a month, with the last episode occurring three weeks prior to this one. The owner is concerned about a possible gastric dilatation-volvulus as the patient drank a large amount of water just before the seizure and subsequent fall. No diarrhea, coughing, or sneezing has been observed.

Current Medications/ supplements: Zonisamide (four tablets BID), Keppra 750 mg extended release (one tablet BID), and Phenobarbital 97.2 mg (one tablet BID).

Abnormal PE/Chem/CBC/UA Results: CBC: monocytosis 3.68; otherwise nsf Chemistry: BUN 43 (suspect secondary to dehydration from vomiting), hyperphosphatemia 8.5 (suspect pre-renal), mild hyperproteinemia 8.3, mild hyperglobulinemia 5.1, mixed hepatopathy (ALT 316, ALP over 2000, GGT 12) TBIL 2.9, hypercholesterolemia 426, elevated lipase 5513, hypochloremia 107 (suspect secondary to vomiting) TT4 low at 0.8 (suspect euthyroid sick syndrome)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2 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.

The area of the residual prostate appeared normal and free of pathology

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 7.3 cm in length. The right kidney measured 7.6 cm in length.

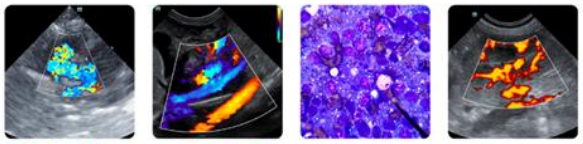
The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The left and right adrenal glands were not definitively visualized.

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



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thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

Liver/Gallbladder

The liver presented mildly enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented mildly thickened wall, most notable in the pylorus with gastric mural hypoechogenicity and lumen gas. The pylorus wall measured 0.66 cm in width.

The small intestine presented thickened overtly intact duodenum wall with upper to mid duodenal ileus and gas distension. The duodenum wall measured up to 0.75 cm wall width. The visualized jejunum exhibited normal intact wall layering maintained wall layer ratio and empty lumen to the level of the colon.

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

Pancreas

Diffuse enlargement of the pancreas with ill-defined, hypoechoic to heterogeneous parenchyma and asymmetrical contour was present. The surrounding omental fat around the enlarged to hypoechoic pancreas was echogenic indicative of reactive change, adhesions, focal peritonitis, or saponification. Mild localized free fluid was present around the abnormal pancreas.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

Peripancreatic to regional cranial abdomen hyperechoic omentum.

ULTRASONOGRAPHIC FINDINGS

Primary

- Enlarged hypoechoic pancreas with peripancreatic to cranial abdomen peritonitis -significant active pancreatitis, potential for pancreatic neoplasia
- Thickened stomach /duodenum with gastroduodenal hypomotility and gas distension
- Hepatopathy
- Sonographically normal gallbladder

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No definitive evidence of mechanical upper gastrointestinal obstruction or foreign material although the sonographic visualization of the gastroduodenal interior was somewhat limited by gas. Aggressive therapy for significant active potentially necrotizing pancreatitis and peritonitis with gastrointestinal support and close clinical monitoring is recommended. Recheck sonogram would be ideal in 48 - 72 hours, sooner if progressive clinical signs or evidence of upper gastrointestinal ileus. A pancreatic FNA

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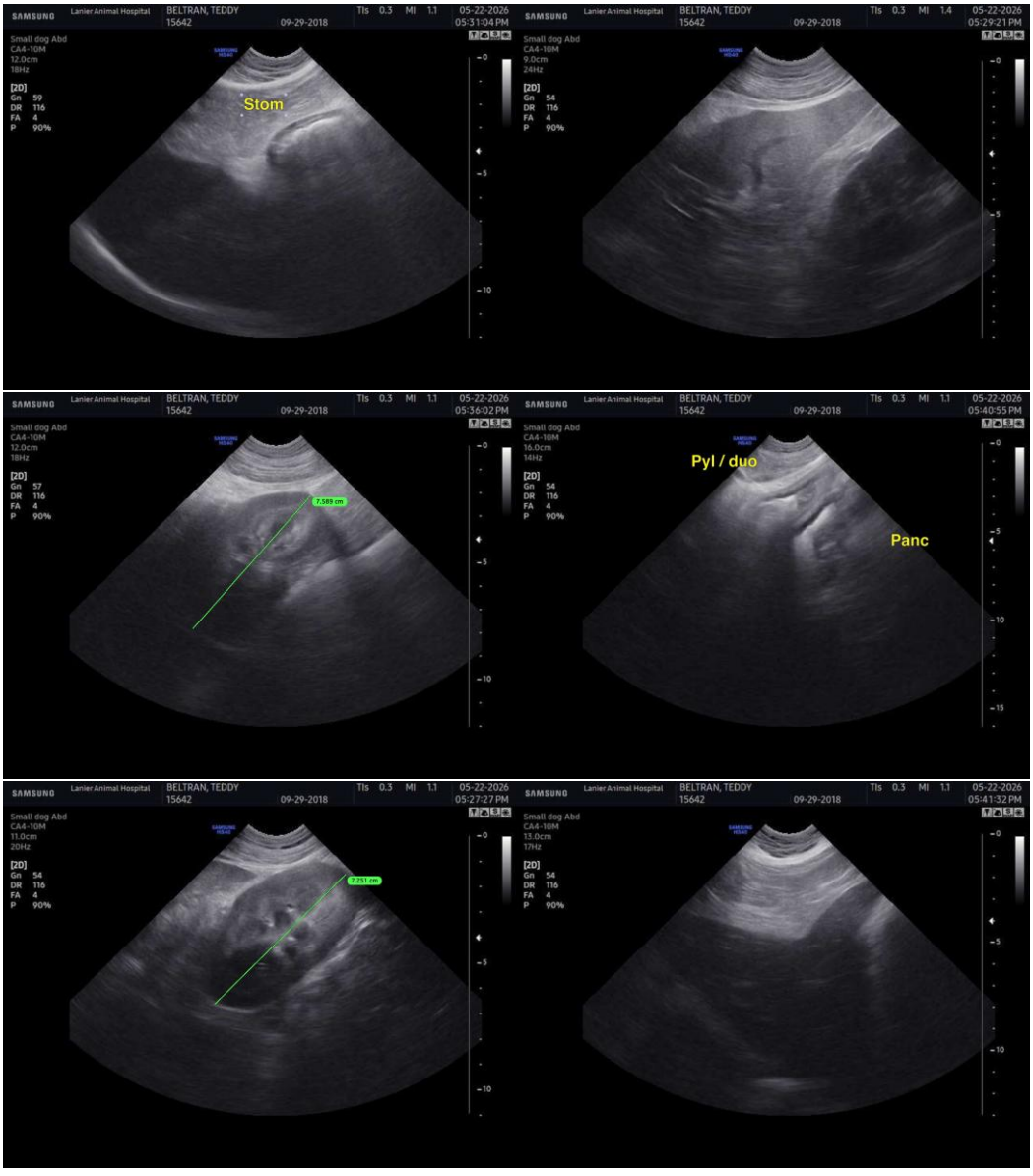
cytology could be considered for further assessment.



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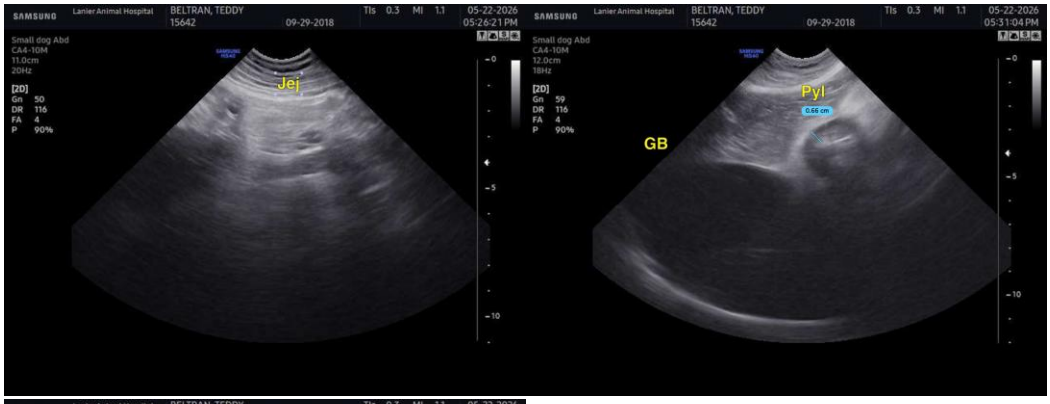

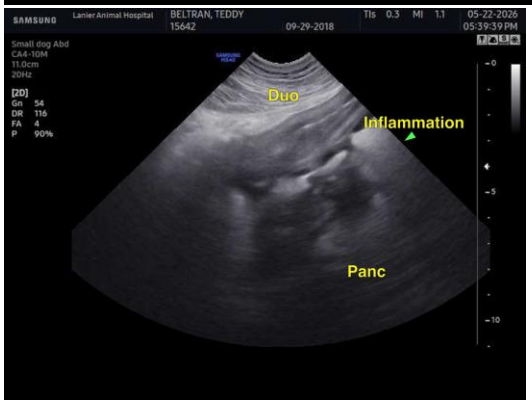

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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