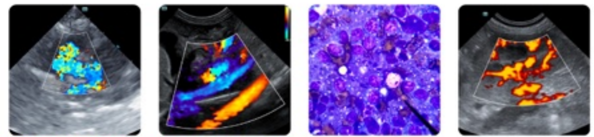


PATIENT

Shaylee Campbell

SPECIES

Canine

BREED

Nova Scotia Duck Trolling Retriever

SEX

Spayed female

AGE

8 years

WEIGHT

10.2 kg

INTERPRETED BY

Remo Lobetti, BVSc, MMedVet (Med), PhD, Dipl. ECVIM

IMAGING PERFORMED BY

Danielle RVT

HOSPITAL NAME

Orchard VC

REFERRING VET

Dr. Antonopoulos

INVOICE

70915

DATE

1/26/26

PRESENTING CLINICAL SIGNS

- Anorexia and vomiting
- Presents for health exam for really not feeling well in last 24 hours.
- Hasn't been well for a couple weeks, but really bad in the last day. She is
- vomiting large amounts, not wanting to eat at all. Low appetite for a couple days, now refusing everything. Eating RAW diet, but have tried many things to entice. Trying to feed small
- amounts. There seems to be mucous in the vomit. In the morning she will have ropey drool. She is eating snow. There's yellow bile, but the last 2 large vomits in the last 4-5 days

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is small with a normal thickness and smooth appearance of the wall. Normal anechoic urine with no sediment or uroliths evident.

Normal appearance of the trigone area, proximal urethra, and iliac blood vessels.

Normal appearance and size of the iliac lymph nodes. Ureters not visualized, which can be considered a normal finding.

Normal renal size (left measured 5.3 cm, right measured 4.8 cm), architecture, echogenic appearance, cortico-medullary differentiation, which maintains a 1:3 cortex to medulla ratio, pelvis, and capsule. No infarcts, mineralization or renoliths evident. Normal color flow pattern is evident in both kidneys.

Adrenal Glands

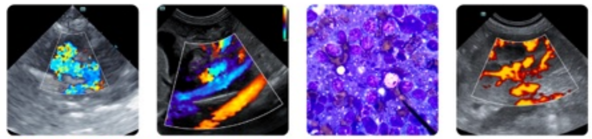
The adrenal glands are small in size, but maintained normal shape, echogenic appearance, position, and appearance of the visible peri-adrenal vasculature. Left adrenal gland measured 1.4 cm in length x 0.34 cm and 0.32 cm in width. The right adrenal gland measured 0.35 cm and 0.4 cm in width.

Spleen

Normal size and echogenic appearance. Smooth homogenous parenchyma and regular curvilinear capsule. Normal volume of the splenic vasculature without any overt congestion or thrombosis evident. No inflammatory, neoplastic, infarction, or infiltrative changes evident. The spleen measured 1.1 cm in width.

Liver

Normal size, echogenic appearance, portal markings, and regular curvilinear capsule. No nodules or masses evident. Normal appearance of the hepatic and portal vasculature.



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Gallbladder

The gallbladder is full containing a moderate amount of non-adhered, hyperechogenic sediment. Normal thickness and echogenic appearance of the wall. Normal size and appearance of the cystic and common bile duct.

Gastrointestinal

Thickening of the gastric wall (up to 0.9 cm) with some loss of layering and a hypoechogenic appearance of the mucosal layer. A small amount of ingesta and gas is present in the stomach. Normal appearance of the duodenum, small intestine, ileo-cecal junction, and colon with no loss of layering, 1:3 muscularis to mucosa ratio, normal wall thickness and peristaltic activity, and no distension of the lumen.

Pancreas

The left pancreas measured 1.3 cm in width with a mottled, echogenic appearance and an irregular capsule. Hyperechogenic appearance of the mesentery and fat surrounding the pancreas.

Free Abdomen

Normal mesenteric lymph nodes.

No ascites evident.

ULTRASONOGRAPHIC FINDINGS

- Pancreatitis.
- Gastric thickening.
- Gallbladder sediment.
- Small adrenal glands?

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

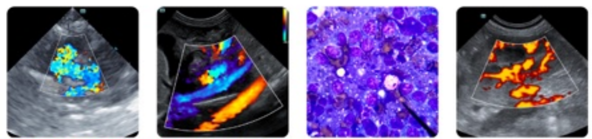
Although the appearance of the pancreas would be consistent with pancreatitis, neoplasia would be a differential diagnosis.

Etiologies for the gastric thickening would be gastritis secondary to pancreatitis, ulcerative disease, Helicobacter gastritis, parasitic gastroenteritis, inflammatory bowel disease and emerging neoplasia.

Although the small adrenal glands may merely be a reflection of the patient's size, underlying atypical Addison's disease should still be considered.

Further assessment would be fecal analysis, basal cortisol, CPL/PSL assay and FNA cytology of the gastric wall and pancreas.

Endoscopy of the upper gastrointestinal tract with biopsies could also be considered.



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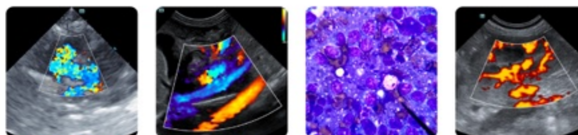
Specific therapy would be dependent on an etiological diagnosis.

Symptomatic management would be fluid therapy if needed, correction of any electrolyte anomalies, antiemetics, analgesics, gastric protectants (Sucralfate, Omeprazole) and feeding small frequent meals of a low fat intestinal type diet.



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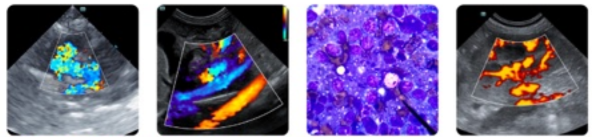

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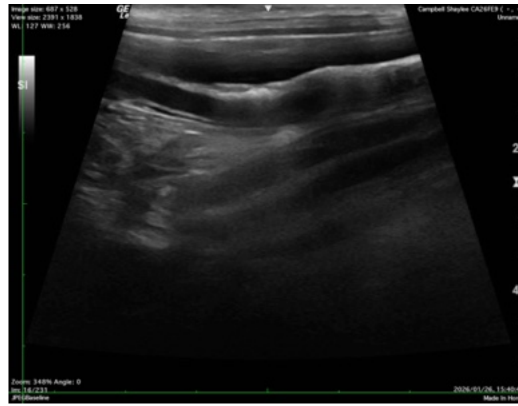

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Remo Lobetti, BVSc, MMedVet (Med), PhD, Dipl. ECVIM (Internal Medicine)

info@sonopath.com