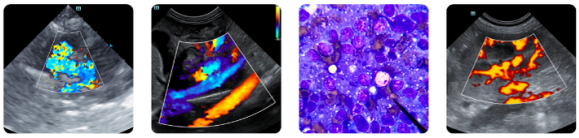


SonoPath www.carolinavetmobile.com
info@carolinavetmobile.com 800.808.5948

PATIENT

Pikachu Powers

SPECIES

Canine

BREED

Akita x

SEX

Neutered Male

AGE

2 Years

WEIGHT

31.6 kg

INTERPRETED BY

Tam Mengine, DVM, DABVP (canine/feline practice)

IMAGING PERFORMED BY

Kathleen Byrnes

HOSPITAL NAME

Animal Emergency Clinic of the High Country

REFERRING VET

Dr. Phipps

INVOICE

72791

DATE

2/8/26

PRESENTING CLINICAL SIGNS

P presented for vomiting blood with large blood clots, black diarrhea, lethargy, Switched food this week, ate chicken bones last month (no issues following that)

Rad report- The stomach contains gas and some homogenous soft tissue opacity material. non specific, could be ingesta but gastric foreign body cannot be ruled out, no obstruction identified

rdvm concern for gastric ulceration, neoplasia, ITP, other

Abnormal PE/Chem/CBC/UA Results: Yesterday Afternoon 4dx neg x 4 EPOC Lactate 4.56 (0.6-3), Glu 127 (63-124) CBC HCT 53.7, PLT 41, confirmed with smear- no clumps, macroplatelets seen Chem TP 4.3, AL 2, Glob 2.3, ALT 129 Last night PCV 48, TP 5 Today Will text you the results

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine, and no luminal sediment is present. The ureteral papillae, trigone and pelvic urethra (visible to 4.0 cm) are of normal appearance, and the ureters are not visible (normal). No masses, calculi or mucosal irregularities are noted.

The prostate is of appropriate size for patient age and neutering status, with a homogenous parenchyma and smooth capsule. The prostatic urethra is non-dilated with normal margins.

The kidneys are of normal size and shape and exhibit appropriate corticomedullary differentiation with a normal 1:3 cortex to medulla ratio. There is no evidence of nephrolithiasis, mineralization, pyelectasia, cystic change or hydronephrosis. The proximal ureter is not visible (normal). Left measures 6.6 cm. Right measures 6.3 cm.

Adrenal Glands

The adrenal glands are both identified in their normal locations. They are normal in size and shape with appropriate parenchymal echogenicity and normal phrenic vasculature. Left measures 5.5 mm at the cranial pole and 4.8 mm at the caudal pole. Right measures 5.7 mm at the cranial pole and 5.5 mm at the caudal pole.

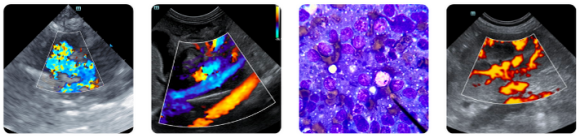
Spleen

The spleen is of appropriate size and has a normal, homogenous parenchyma with a smooth, continuous capsular surface. The splenic vasculature is normal with no evidence of congestion or thrombosis, and blood flow through the splenic hilus appears normal.

Liver

The liver is of appropriate size and shape, with sharp borders and a mildly coarse parenchymal echotexture that is hypoechoic to the spleen. The portal and hepatic vasculature are of normal size and appearance with no evidence of congestion or thrombosis.

The gallbladder is moderately distended with anechoic contents and a small amount of freely-moveable echogenic sludge. The wall was thin and continuous with no focal lesions. The cystic and common bile ducts are normal / not visible.



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Gastrointestinal

The stomach is mildly distended with gas and fluid. There is segmental thickening of the gastric wall with disrupted layering in the region of the fundus, measuring up to 1.2 cm in thickness. There is also mucosal disruption with small gas bubbles seen within the gastric tissue, consistent with ulceration. The rest of the stomach exhibits normal wall layering with normal deviations due to rugal folds. The pylorus is normal in appearance.

The visualized portions of the duodenum, jejunum, and ileum are of normal thickness with intact wall layering that exhibits the appropriate 1:3 muscularis to mucosa ratio. Intestinal motility appears normal.

The visible portions of the colon are of normal thickness (1.7 mm) with intact wall layering. The ileocecal junction is not seen.

Pancreas

The areas of the limbs and body of the pancreas are isoechoic to the surrounding mesenteric fat, with normal capsular appearance. There is no evidence of peripancreatic inflammation. The pancreatic duct appears normal.

Free Abdomen

There is no free fluid noted within the abdomen. There is hyperechoic, inflamed omental fat noted in the region of the stomach. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

PRIMARY FINDINGS

- Focally thickened gastric fundus, with mucosal disruption, supporting the presence of gastric ulcerations
- Perigastric steatitis
- Small amount of mineralized material in the gastric lumen - this may be incidental vs a cause of ulceration. Given that this was not seen radiographically, I suspect this material is incidental

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The sonographic findings are most typical of severe gastritis, with gastric neoplasia deemed unlikely but not completely excluded. Given the progressive decrease in hematocrit, endoscopy is recommended to further assess the severity of disease, and obtain biopsies for definitive diagnosis. If the patient is not responding to medical management, surgical resection of abnormal tissue may be necessary. The low platelet count may be secondary to breed-associated benign macrothrombocytopenia, and it appears the blood smear would support this.

Medial management for gastritis would include:

- Empiric treatment with antiemetics, such as maropitant and ondansetron, and antacid therapy, such as omeprazole and famotidine, and gastroprotectants such as sucralfate.
- Dietary therapy with either a highly digestible, low fat diet, or a hydrolyzed or novel protein diet is recommended. Feeding frequent small meals is preferred if feasible.
- Fecal parasite testing and empiric fenbendazole treatment

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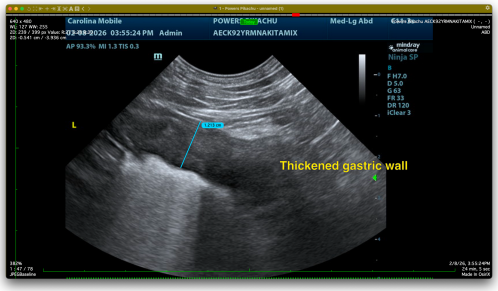
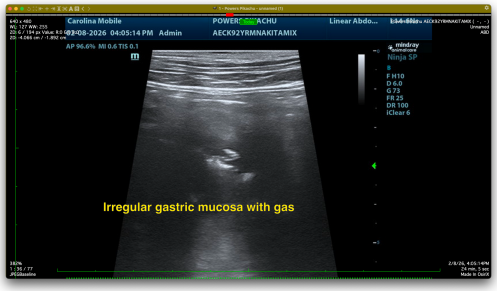
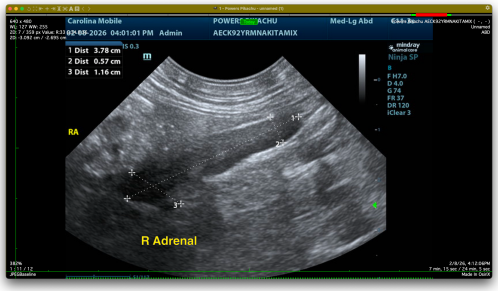
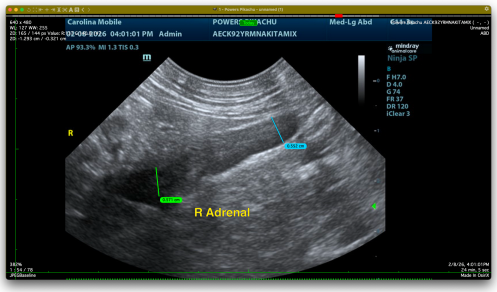
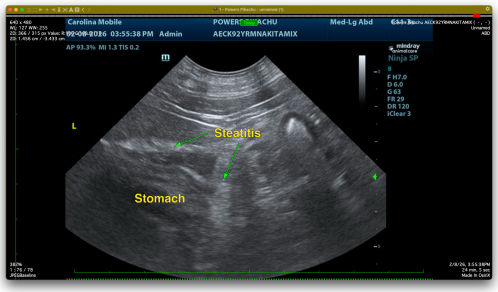
- A resting cortisol level to rule out atypical hypoadrenocorticism would be recommended, as this has been associated with gastric ulceration.
- Empiric treatment for helicobacter gastritis could be considered. Repeat ultrasound at the end of therapy can assess response, along with monitoring for resolution of clinical signs. Treatment protocol is as follows, for a duration of 28 days:
  - ➢ Azithromycin 5mg/kg PO once daily for 5 days, then every other day thereafter
  - ➢ Metronidazole 10mg/kg PO BID
  - ➢ Amoxicillin 20mg/kg PO BID
  - ➢ Omeprazole 0.7 - 1 mg/kg q24h











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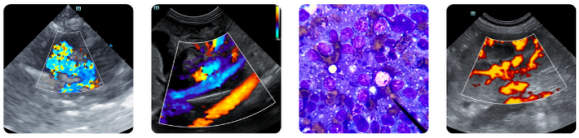

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Educational Teleconsultation Services™

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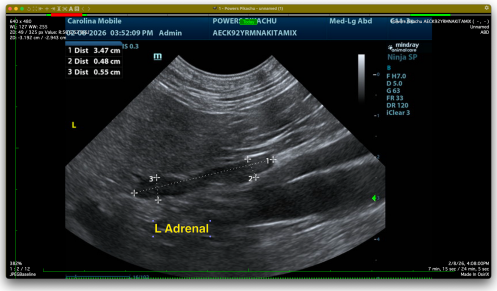

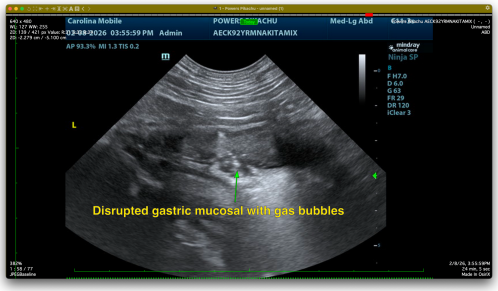

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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