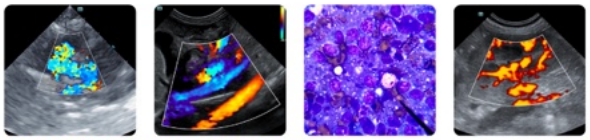


PATIENT

Sadie Stoop

SPECIES

Canine

BREED

Miniature Schnauzer

SEX

Spayed female

AGE

12 years

WEIGHT

6.62 lbs

INTERPRETED BY

Dr. Alicia Angosto Guerrero

IMAGING PERFORMED BY

Jessy Butcher

HOSPITAL NAME

Healing Paws

REFERRING VET

Dr. Klickman

INVOICE

70218

DATE

1/16/26

PRESENTING CLINICAL SIGNS

History: Several month history of intermittent vomiting (~q 1-2 weeks) and weight loss with normal appetite, no change in food amount or type. No diarrhea, no resp signs, normal energy/activity, no prior similar episodes, no PUPD.
Superchem- Alb 2.3 (2.7-4.4), rest WNL; CBC Plt 577 (170-400), rest WNL; T4 1.5; UA USG 1.032, protein neg, rest WNL; Keyscreen fecal neg; Accuplex neg Planning to do bile acid on day of US

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended. The urinary bladder wall appears thin, smooth, and regular. The bladder lumen contains anechoic urine. The bladder neck and proximal urethra are unremarkable. There is no sonographic evidence of urolithiasis or inflammatory or neoplastic changes.

The left kidney is normal in shape and size, measuring 3.50×1.55 cm, with a cortical thickness of 0.32 cm in the sagittal plane. The right kidney is normal in shape and size, measuring 3.99×1.94 cm, with a cortical thickness of 0.32 cm in the sagittal plane. In both kidneys, the renal cortex demonstrates normal echogenicity. Corticomedullary ratio and corticomedullary definition are preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

Adrenal Glands

The left adrenal gland demonstrates normal shape and echogenicity, measuring approximately 0.34 cm at the cranial pole and 0.38 cm at the caudal pole. The right adrenal gland is not visualized.

Spleen

The spleen measures approximately 0.67 cm in thickness. The splenic head is not visualized. The splenic parenchyma demonstrates normal echogenicity and a fine, homogeneous echotexture without focal lesions. The splenic capsule is smooth and regular.

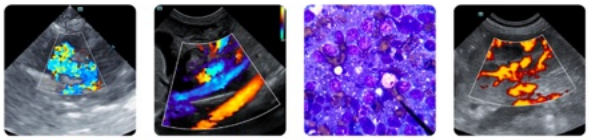
Liver

The liver is subjectively normal in size. The hepatic parenchyma is uniform and mildly hyperechoic relative to the falciform fat and renal cortex, with a normal echotexture. No hepatic lymphadenopathy is identified.

The gallbladder is normally distended. The gallbladder wall is thin, and the lumen contains predominantly anechoic bile with a small amount of biliary sludge. There is no sonographic evidence of dilation of the cystic duct or common bile duct.

Gastrointestinal

The stomach is mildly distended, containing a small amount of food and fluid. Gastric wall thickness measures approximately 2.42 mm, with preserved wall layering.



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An intestinal segment presumed to represent proximal small intestine (duodenum or proximal jejunum) demonstrates a focal, marked mural thickening measuring up to 5.67 mm, with poorly defined or lost wall layering. The exact segment cannot be definitively identified due to lack of clear continuity with the pylorus. Immediately cranial to this abnormal segment, there is accumulation of intraluminal material with marked distal acoustic shadowing, suggestive of dense ingesta or material causing luminal stasis, accompanied by fluid accumulation. Distal to the abnormal segment, the intestinal wall thickness and luminal diameter return to normal, and there is no evidence of distal obstruction. The adjacent peritoneum appears reactive, with increased echogenicity, though no free gas is identified and no overt free abdominal fluid is present in this region. An adjacent small intestinal loop demonstrates a corrugated appearance, which may reflect localized spasm or altered motility in the context of regional inflammation; no definitive adhesions can be confirmed sonographically.

More caudally, a presumed distal duodenal segment measures approximately 4.26 mm and appears within normal limits, with preserved wall layering.

Other intestinal measurements include:

Jejunum: approximately 2.99 mm, normal wall layering. Ileum: approximately 1.55 mm, normal wall layering

The ileocecal junction is not visualized. The colon measures approximately 0.75 mm, with formed fecal material present in the descending segment.

Pancreas

The pancreas is not clearly visualized. There is no sonographic evidence to suggest that pancreatitis is the primary process based on the surrounding tissues.

Peritoneal Cavity

A very small amount of free abdominal fluid is suspected within the rectovesical recess. Cranial mesenteric and ileocecal lymph nodes are not visualized; the surrounding regions appear unremarkable. The iliac trifurcation is normal.

ULTRASONOGRAPHIC FINDINGS

PRIMARY FINDINGS

- Focal, severe proximal small intestinal mural thickening (up to 5.67 mm) with loss of wall layering.
- Proximal luminal stasis with dense intraluminal material and marked acoustic shadowing
- Regional peritoneal reactivity.

SECONDARY FINDINGS

- Very small volume abdominal effusion.
- Mild diffuse hepatic hyperechogenicity.
- Mild biliary sludge.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The abdominal ultrasound identifies a focal, severe abnormality of the proximal small intestine, characterized by marked mural thickening with loss of normal wall layering, associated luminal narrowing, proximal luminal stasis, and regional peritoneal reactivity. Distal intestinal segments demonstrate normal mural thickness and preserved layering.

In a geriatric dog with chronic intermittent vomiting and progressive weight loss, this ultrasonographic pattern is most consistent with a focal intestinal neoplastic process causing partial obstruction. However, a chronic inflammatory lesion secondary to prolonged partial obstruction or long-standing intraluminal foreign material cannot be entirely excluded, as such processes, although uncommon, may closely mimic neoplasia both clinically and ultrasonographically.

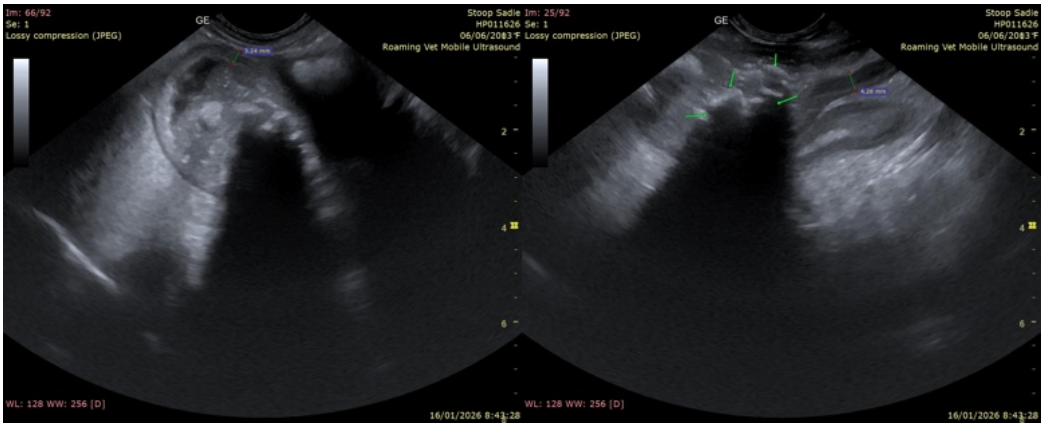
Marked acoustic shadowing is associated with dense intraluminal material immediately proximal to the affected intestinal segment. While this finding raises consideration for intraluminal foreign material, the prolonged clinical course, continued fecal passage, and presence of a severe focal mural lesion with loss of layering suggest that luminal accumulation is more likely secondary to a primary intestinal wall abnormality rather than a primary acute foreign body obstruction.

The absence of documented abdominal lymphadenopathy does not exclude neoplasia, particularly given that gastric and periportal lymph nodes were not identified on the provided imaging, and because focal intestinal tumors may occur without measurable nodal involvement.

In the absence of biochemical data, hepatic hyperechogenicity is a nonspecific finding and may reflect mild diffuse hepatopathy or vacuolar change.

Recommendations

Surgical exploration is recommended as the diagnostic and therapeutic modality of choice. Exploratory surgery would allow direct assessment of intestinal viability, removal of accumulated intraluminal material, and definitive treatment of a potential obstructive or infiltrative process, including enterotomy or enterectomy if indicated.



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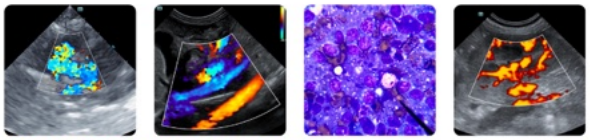

Clinical Sonography & Telecytology
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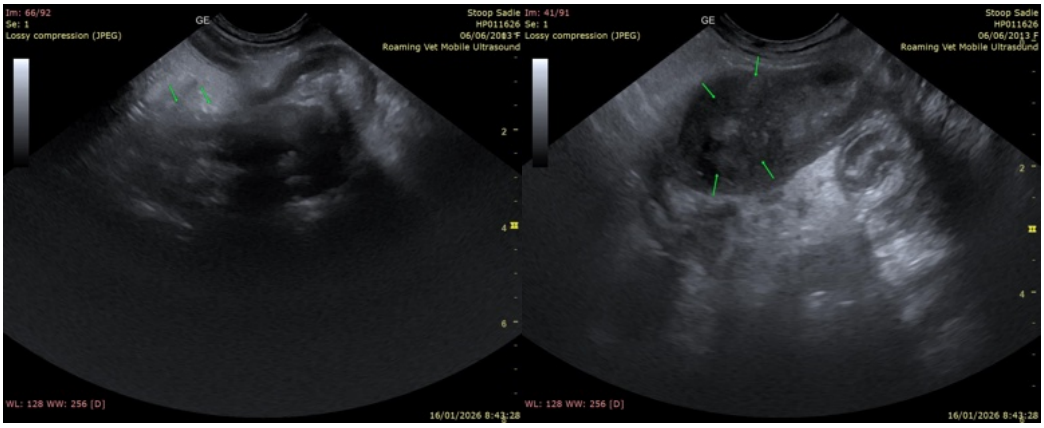

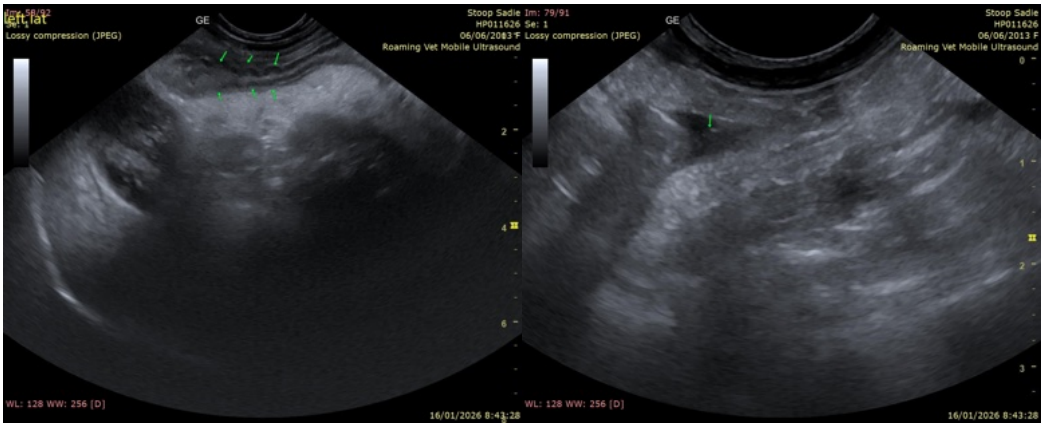

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

MV Esp Ultrasound in Domestic and Wild Animals

info@SonoPath.com