



PATIENT

Bonnie Maynard

SPECIES

Canine

BREED

Miniature Schnauzer

SEX

Spayed female

AGE

7 years

WEIGHT

9.3 lbs

INTERPRETED BY

Dr. Alicia Angosto
Guerrero

IMAGING PERFORMED BY

Christina Wagner

HOSPITAL NAME

Angeles Clinic for
Animals

REFERRING VET

Dr. Wagner

INVOICE

69944

DATE

1/7/26

PRESENTING CLINICAL SIGNS

History: Owner reports approx 1 month duration vomiting 1-3 times per day. Vomiting improved with maropitant. Weight loss.

BCS 3/9 CBC - monocytes 1170, otherwise NSF Chem --Phos 2.3 --Ca 7.8 --TP 4.4, albumin 1.8
Pancreatic lipase - normal at 100 UA w/UP:C, B12, folate, PLI pending

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is normally distended. The urinary bladder wall appears thin and smooth. The urine is predominantly anechoic with scant suspended echoes. The bladder neck and proximal urethra appear normal. No uroliths or sonographic evidence of inflammatory or neoplastic change is identified.

Both kidneys are normal in shape and size (left: 3.75×2.14 cm; right: 4.09×1.92 cm). Renal cortical thickness is within normal limits. The renal cortex is isoechoic relative to the liver parenchyma. Corticomedullary definition and corticomedullary ratio are preserved. No pyelectasia, nephroliths, or hydronephrosis are identified. Doppler evaluation demonstrates normal renal perfusion.

Adrenal Glands

Both adrenal glands are visualized and appear normal in shape and echogenicity.

- Left adrenal gland: 0.51 cm (cranial pole) × 0.43 cm (caudal pole).
- Right adrenal gland: 0.30 cm (cranial pole) × 0.31 cm (caudal pole).

Spleen

Splenic thickness measures 1.48 cm. 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 with sharp margins and a regular contour. Hepatic parenchyma is homogeneous and isoechoic relative to the falciform fat. No hepatic lymphadenopathy is identified.

The gallbladder is normally distended with a thin wall. A small amount of biliary sludge is present. No dilation of the cystic duct or common bile duct is observed.



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Gastrointestinal

The stomach is largely empty, containing gas and a small amount of residual ingesta. Gastric wall thickness measures approximately 3.05 mm with preserved wall layering. The pylorus is not clearly visualized.

The duodenum measures approximately 4.20 mm. The jejunum measures 2.33–2.79 mm with preserved wall layering. A focal intestinal segment raises concern for localized wall thickening with partial loss or distortion of wall layering. This finding is only visualized briefly in a limited number of cine loops and was difficult to consistently evaluate due to patient movement and apparent discomfort at the time of imaging. Mild proximal luminal gas distension with minimal digested ingesta is noted cranial to this segment.

The colon measures approximately 0.89 mm and contains formed feces in the descending segment.

Pancreas

The pancreas appears sonographically normal.

Peritoneal Cavity

No abdominal effusion or evidence of peritonitis is identified.

Cranial mesenteric lymph nodes are mildly enlarged, measuring approximately 2.26 × 0.96 cm and 1.95 × 0.83 cm. The lymph nodes appear mildly rounded and mildly hypoechoic. Surrounding mesenteric fat appears unremarkable. The iliac trifurcation appears normal.

ULTRASONOGRAPHIC FINDINGS

- Mild to moderate cranial mesenteric lymphadenopathy.
- Questionable focal small intestinal wall thickening with partial loss/distortion of layering (limited visualization). Mild proximal intestinal gas distension adjacent to the affected segment.
- Gastric wall thickness at the upper end of normal.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The majority of the gastrointestinal tract demonstrates normal ultrasonographic appearance, with intestinal wall thicknesses within accepted reference limits and preserved mural layering throughout the duodenum, jejunum, and colon. There is no sonographic evidence of diffuse enteropathy, including no mucosal striations, no hyperechoic mucosal speckling, no submucosal hyperechogenicity, and no generalized intestinal wall thickening. No free abdominal effusion is identified to suggest advanced protein-losing enteropathy.



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A focal segment of small intestine is intermittently visualized with mild wall thickening and partial loss or distortion of normal mural layering. This finding is not consistently reproducible across all cine loops, likely due to patient movement and discomfort at the time of examination, which limits complete characterization. Mild luminal gas distension with minimal digesta is noted immediately proximal to this segment, raising concern for localized functional or mechanical compromise at this level (transient ileus, inflammatory stenosis, or early infiltrative disease).

The cranial mesenteric lymph nodes are mildly to moderately enlarged, mildly rounded, and mildly hypoechoic. The surrounding mesenteric fat remains unremarkable. This lymph node pattern is most consistent with reactive or inflammatory change, although early infiltrative disease cannot be excluded based on ultrasonography alone.

In dogs, segmental inflammatory disease, focal intestinal lymphoma, or early infiltrative pathology may produce subtle or transient ultrasonographic changes, particularly in the early stages of disease. Correlation with the patient's clinical signs (including persistent vomiting, weight loss, and hypoalbuminemia) is essential, as these findings may not be fully explained by diffuse inflammatory bowel disease alone in the absence of widespread ultrasonographic abnormalities.

RECOMMENDATIONS

- Repeat targeted abdominal ultrasound focusing on the small intestine is recommended to further evaluate the suspected focal segment, ideally under improved patient comfort or mild sedation to allow thorough and reproducible assessment.
- Consider endoscopic or surgical intestinal biopsies if clinical signs persist, worsen, or fail to respond to appropriate medical management, particularly if concern remains for localized infiltrative or neoplastic disease.
- Serial monitoring of body weight, serum albumin, and total protein is advised.
- Additional gastrointestinal testing (cobalamin, folate) may provide supportive information regarding malabsorption or chronic intestinal disease but may not fully characterize focal pathology.





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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

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