



PATIENT

Missy Griffin

SPECIES

Canine

BREED

Poodle

SEX

Spayed female

AGE

7 years

WEIGHT

6.54 lbs

INTERPRETED BY

Dr. Alicia Angosto
Guerrero

IMAGING PERFORMED BY

Dr. Celia Galanti

HOSPITAL NAME

Craig Road AH

REFERRING VET

Dr. Celia Galanti

INVOICE

69285

DATE

12/3/25

PRESENTING CLINICAL SIGNS

History: Patient is a 7yr 1mo FS poodle presented this past Saturday for vomiting and continued weight loss. O first began noticing P losing weight in early Summer. O tried changing Ps food to Solid Gold Gut Health 3 weeks ago but P still not gaining weight. O feeding 1/2 can per day (418kcal/can). Two days prior P snuck another dog's food and shortly after began vomiting. That night P vomited 9 + times. The next night P vomited two more times. Ps energy and appetite remain unchanged. P hasn't been drinking much water. P was also having soft stools the last few days. Only recently P has seemed to have a sensitive stomach. Vomiting and soft stools resolved with supportive care. ALT rising from blood panel one month prior, new anemia and albumin at low end of normal. P was fasted over 18 hours prior to ultrasound.

Abnormal PE/Chem/CBC/UA Results: CBC, Chem: Ca 8.1 (Corrected Calcium 8.6), globulin 1.5, ALT 212, lymphocytes 0.43, Hct 36.2, RBC 5.64 ..CPLi was normal

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is normally distended, and the wall of the urinary bladder appears thin and smooth. The urine is anechoic. Normal appearance of the proximal urethra and vesicoureteral junction. There are no calculi and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size: 3.80x2.02 cm, and the cortical thickness is 0.30 cm in the sagittal plane. The right kidney is normal in shape and size: 3.83x1.84 cm, and the cortical thickness is 0.27 cm in the sagittal plane. Both kidneys have cortices that are isoechoic compared to the liver parenchyma. The corticomedullary ratio is normal, and the corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths, or hydronephrosis.

Adrenal Glands

Both adrenal glands show normal shape and echogenicity. The left adrenal gland measures 0.43 cm at the cranial pole and 0.38 cm at the caudal pole. The right adrenal gland measures 0.40 cm at the cranial pole and 0.44 cm at the caudal pole.

Spleen

Splenic thickness is 1.16 cm. The parenchyma demonstrates normal echogenicity and a fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver

The liver is subjectively normal in size, with sharp edges and a regular contour. The liver parenchyma appears uniform and isoechoic compared to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.



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The gallbladder lumen is normally distended. The wall is thin, and the contents are primarily anechoic. No evident dilation of the cystic duct or common bile duct is observed.

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Gastrointestinal

The stomach is distended, particularly at the fundus, where the wall is thinned due to gastric distension, and there is abundant digested content or food slurry. No discrete food fragments are visible, but the stomach contains a significant amount of material.

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Mural thickness:

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- Fundus: 1.97 mm.
- Body: 2.88 mm.
- Pylorus: 4.29 mm (muscularis 2.27 mm).

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Duodenum: 2.73 mm. Jejunum: 2.78 mm (Mucosa: 1.82 mm, Submucosa: 0.61 mm, Muscularis propria: 0.25 mm). Ileum: 1.35 mm. Wall layering is preserved. All intestinal segments are markedly dilated, containing digested food slurry mixed with fluid. Peristalsis is markedly increased, and the combination of dilation and hypermotility makes accurate mural measurement challenging.

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Colon wall thickness: 0.82 mm, with formed feces in the descending segment.

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Pancreas

The pancreas could not be adequately evaluated due to significant acoustic artifact caused by the markedly distended gastrointestinal tract filled with ingesta.

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Peritoneal Cavity

No abdominal effusion or peritonitis is observed. Cranial mesenteric lymph nodes measure 5–5.5 mm in thickness with normal shape and echogenicity. The iliac trifurcation is normal.

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ULTRASONOGRAPHIC FINDINGS

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- Generalized dilation of all intestinal segments (small intestine and stomach) containing large amounts of digested food slurry and fluid.
- Markedly increased intestinal peristalsis.
- Mild pyloric muscularis thickening.
Cranial mesenteric lymph nodes mildly thickened (5–5.5 mm), though shape and echogenicity remain normal.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The pylorus shows mild muscular thickening, which may reflect chronic functional outflow resistance or pylorospasm, particularly given the hypermotility and gastric distension. However, there is no mass or structural cause of obstruction.

The diffuse gastric and intestinal content retention despite an 18-hour fast is clinically significant. Normal cats and dogs typically clear gastric contents within 6–8 hours; thus, the persistence of large-volume contents suggests delayed gastric emptying or impaired small intestinal transit.

Possible causes include:

- Functional motility disorder (most likely) due to recent vomiting episodes, gastric irritation, dietary change, stress or sympathetic activation.
- Chronic enteropathy/malabsorption (supported by weight loss, low-normal albumin, low globulin).
- Early protein-losing enteropathy – not confirmed but compatible with clinical trends.
- Partial/functional gastric outflow dysfunction (pylorospasm, motility disorder).

The cranial mesenteric lymph nodes are mildly thickened (5–5.5 mm), although their oval shape, smooth margins, and normal echogenicity favor reactive lymphadenopathy rather than neoplastic infiltration.

The liver and gallbladder appear normal and do not currently support a primary hepatobiliary or systemic cause for the chronic weight loss, though the elevated ALT may reflect secondary hepatocellular leakage from recent vomiting, malnutrition, or enteropathy.

Recommendations

Although ultrasonography does not demonstrate overt mucosal abnormalities, lymphangiectasia, intestinal wall thickening, or free abdominal effusion, the combination of chronic weight loss, low-normal albumin, decreased globulins, rising ALT, generalized intestinal dilation with markedly increased motility, and prolonged gastric content retention despite extended fasting raises strong concern for a significant underlying chronic enteropathy. While small-cell lymphoma and infiltrative disease appear less likely based on preserved wall layering, a moderate-to-severe inflammatory enteropathy or early protein-losing enteropathy is highly suspected. Obtaining intestinal biopsies (endoscopic or surgical) is recommended to definitively characterize the underlying pathology and guide long-term therapy.

Additional less invasive recommendations:

- Complete GI panel (TLI, folate, and cobalamin) to assess malabsorption, dysbiosis, and exocrine pancreatic function.
- Fecal PCR or fecal panel (Giardia, Tritrichomonas if diarrhea persists).
- Supportive care and strict diet.



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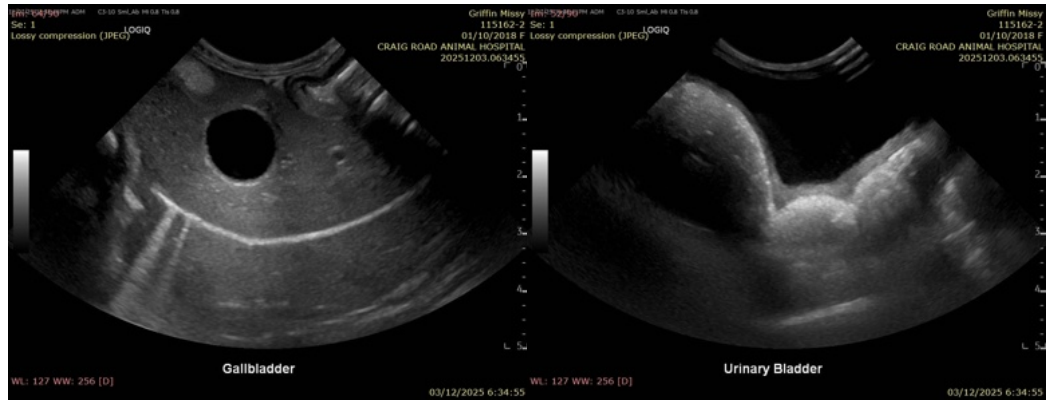
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

MV Esp Ultrasound in Domestic and Wild Animals

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