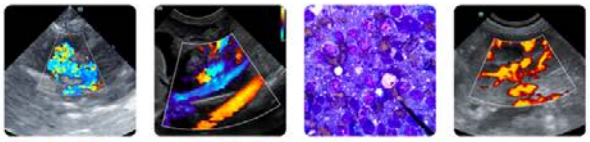


PATIENT

Slater Roman

SPECIES

Canine

BREED

Pit Bull x

SEX

Intact Male

AGE

6 Weeks

WEIGHT

3.7 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Brandi Kurzowski

HOSPITAL NAME

Corfu Veterinary Clinic

REFERRING VET

Dr. Brooke Beatty

INVOICE

73896

DATE

3/20/26

PRESENTING CLINICAL SIGNS

P is a bottle fed baby from a rescue that has been given to this current o for further care. P has had delayed vomiting sporadically since 2 weeks old- bringing up curdled formula. P is severely undersized compared to littermates (about 1/3 the size), poor muscle mass. Normal mentation, eats readily. P started having diarrhea on 3/3 and has a severely distended abdomen (improved moderately with fasting for u/s- p was given milk morning of u/s to prevent hypoglycemia)

Abnormal PE/Chem/CBC/UA Results: 3/19/26 CBC- RBC 3.88 M/uL, HCT 31.6%, HGB 9.1 g/dL, MCV 81 fL, MCHC 28.8 g/dL, Retic 252 k/uL, Retic/HGB 23.5 pg, WBC 26 k/uL, Neut 16.12 K/uL, Lymph 5.6 k/uL, Mono 3.8 k/uL, PLT 753 k/uL Chem- GLU 126 mg/dL, SDMA 15 ug/dL, BUN 68 mg/dL, Phos 11.2 mg/dL, Ca 12.4 mg/dL, Cl 106 mmol/L, TP 4.8g/dL, ALB 2.6 g/dL, Glob 2.2 g/dL, ALT 11 U/L, AST 15 U/L, ALP 170 U/L,

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is mildly underdistended, and the wall of the urinary bladder appears thin and smooth. The urine is predominantly anechoic with scant suspended echoes. Normal appearance of the bladder neck and proximal urethra. There are no calculi and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size: 3.67×2.45 cm, and the thickness of the cortex is 0.39 cm in the sagittal plane. The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is normal and the corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

The right kidney is normal in shape and size: 3.68×2.10 cm, and the thickness of the cortex is 0.30 cm in the sagittal plane. The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is normal and the corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

Adrenal Glands

Not visualized.

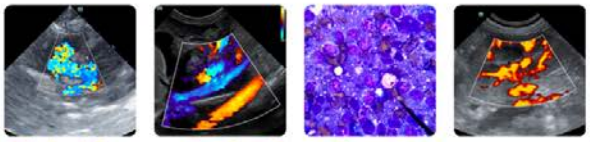
Spleen

Splenic thickness is 0.77 cm. The parenchyma demonstrates normal echogenicity and 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 is uniform and isoechoic compared to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.

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



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Gastrointestinal

The stomach is markedly distended with fluid and gas, with mural thickness (1.73 mm) and preserved wall layering. The pylorus measures 4.59–7.28 mm. The pyloric canal lumen, as appreciated on cine evaluation, measures approximately 2–2.6 mm, although pyloric spasm may accentuate this appearance.

Duodenum: 3.16 mm. Jejunum: 2.25 mm, with normal wall layering. No evidence of intestinal inflammation, ileus, or foreign material is identified. Colon: 0.95 cm, with a small amount of formed fecal material in the descending segment.

Pancreas

The evaluated pancreatic areas do not show evidence of overt inflammation or neoplastic disease.

Free Abdomen

No abdominal effusion or peritonitis is observed. Cranial mesenteric lymph nodes measure 4.09 mm in thickness, with normal shape and echogenicity. Ileocecal lymph nodes are not visualized, but the surrounding regions appear unremarkable. No sonographic evidence of abdominal effusion, peritonitis, or lymphadenomegaly is identified. The iliac trifurcation is normal.

PRIMARY FINDINGS

- Marked gastric distension.
- Subjective narrow pyloric canal (approximately 2–2.6 mm).
- Pyloric thickness up to 7.28 mm (possibly influenced by spasm).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Marked gastric distension with fluid and gas, in combination with a relatively narrow pyloric canal, is most consistent with delayed gastric emptying. In this young patient with chronic postprandial vomiting and poor growth, a congenital pyloric outflow disorder (including pyloric stenosis or functional outflow obstruction) is considered the primary differential. Pyloric spasm may contribute but is less likely to fully explain the chronicity and severity of clinical signs.

The remainder of the gastrointestinal tract is within normal limits, with wall thicknesses appropriate for age and preserved layering, making primary intestinal disease or distal obstruction unlikely.

No evidence of mechanical obstruction (foreign body) or significant inflammatory abdominal disease is identified.

Overall, findings support a primary gastric outflow disorder, most likely congenital in origin.

Recommendations

Further evaluation of gastric outflow is recommended:

- Contrast radiography to assess gastric emptying and confirm functional vs structural pyloric obstruction.
- Gastroscopy may be considered for direct evaluation of the pylorus and potential therapeutic intervention.

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In the interim, conservative management is appropriate:

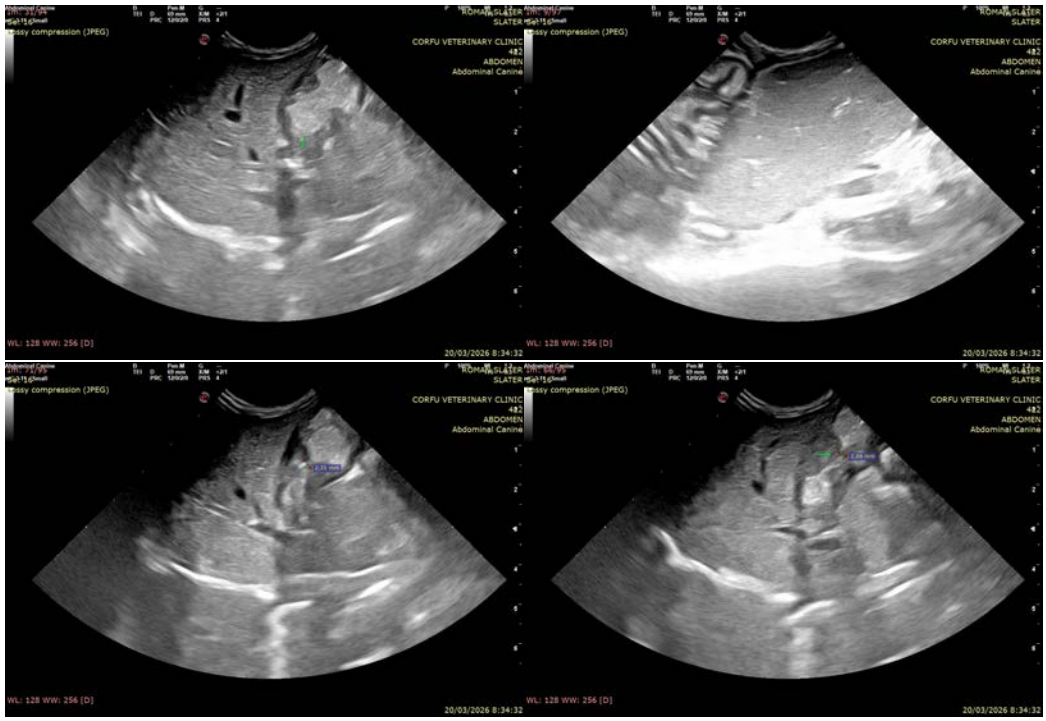
- Frequent, small-volume feedings .
- Liquid or highly diluted diet to facilitate gastric emptying.

Consider prokinetic therapy depending on clinical evolution.

Given the patient's age and origin, infectious disease screening (including parvovirus testing) is recommended, although the clinical presentation is not typical.

Close monitoring of growth, nutritional status, and hydration is strongly recommended.

Final diagnostic and therapeutic decisions should be made by the attending veterinarian, who can best integrate these findings with the patient's clinical status and ongoing response to treatment.



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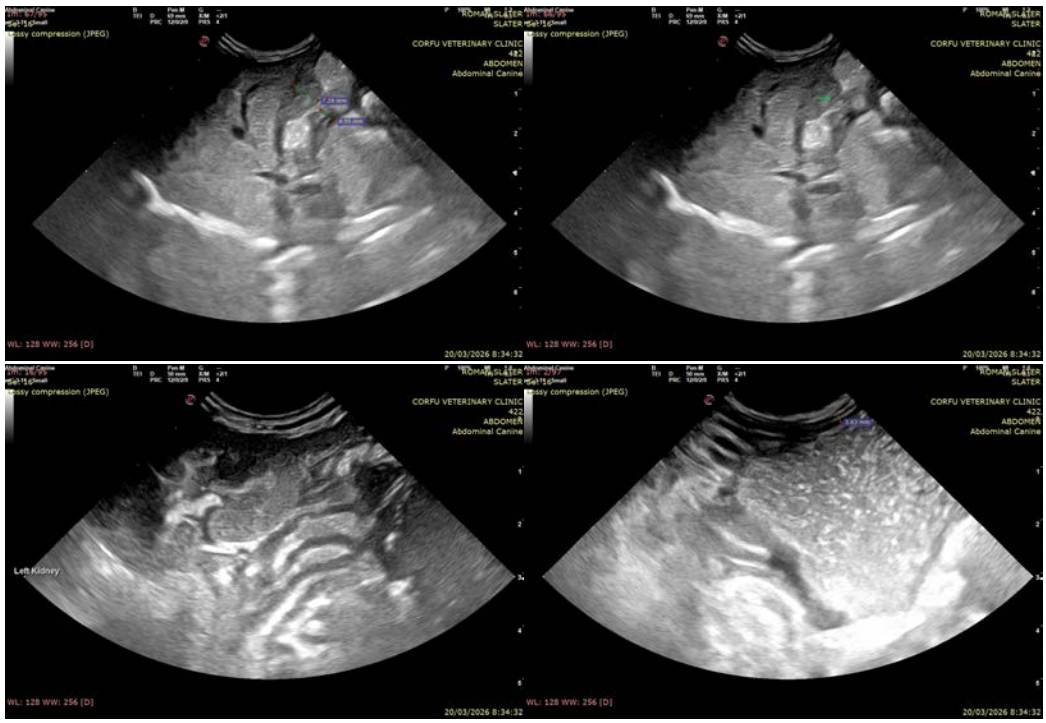

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

info@SonoPath.com