



## PATIENT

Bob Holmes

## SPECIES

Canine

## BREED

Shih Tzu

## SEX

Neutered male

## AGE

3 years

## WEIGHT

11.1 kg

## INTERPRETED BY

Alicia Angosto  
Guerrero, DMV,  
PgDip, MSc.

## IMAGING PERFORMED BY

Michelle DeMelo

## HOSPITAL NAME

Woodstock VH

## REFERRING VET

Dr. Norris

## INVOICE

73868

## DATE

3/26/26

## PRESENTING CLINICAL SIGNS

- Newly adopted dog to O (Dec 2025), with chronically softer stools with some improvement with probiotic use. Largely unknown previous history. Jan 2026 - Suspected acute abdominal pain, treated with Gabapentin. No diagnostics performed at that time. March 19th - acute episode of suspected gastric reflux (gulping, hard swallowing), with mild hyporexia. Chest xrays performed- no obvious sign of megaesophagus Treated with gastroprotectants/anti-emetics. March 24 - acute vomiting (several episodes, bile) and watery diarrhea, more anorexic and low energy. Mild abdominal discomfort but all vitals WNL (no pyrexia).. No known dietary indiscretion/foreign body ingestion. Has responded well to tylosin, anti-emetic & gastrointestinal food, but had one episode of vomiting (March 26 AM) despite Cerenia injection. Appetite & energy has improved and no further diarrhea. Patient was not fasted due to more urgent U/S booked same day d/t concerns with vomiting on anti-emetic. Ddx dietary intolerance vs food allergy vs IBD vs foreign body ingestion/obstruction vs other.
- cPL normal at 32 [N 0-200]. Bloodwork overall unremarkable other than very mild ALT at 169 [N 10-125] and mild hypochloridemia at 107 [N 109-122]. Fecal negative incl Giardia.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder is moderately distended, with a thin and smooth wall. The urine is anechoic. The bladder neck and proximal urethra have a normal appearance. No calculi or evidence of inflammatory or neoplastic changes are identified.

The left kidney is normal in shape and size: 4.95×2.67 cm, with a cortical thickness of 0.39 cm in the sagittal plane. The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is normal and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths, or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

The right kidney is normal in shape and size: 4.73×2.59 cm, with a cortical thickness of 0.40 cm in the sagittal plane. The cortex is isoechoic compared to the liver parenchyma. The corticomedullary ratio is normal and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephroliths, or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

### Adrenal Glands

Dorsoventral diameters measured in the sagittal plane: the left adrenal gland is partially visualized and measures 0.39 cm. The right adrenal gland measures 0.48 cm at both the cranial and caudal poles.

### Spleen

Splenic thickness is 2.24-2.36 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular. Splenic vasculature appears normal.



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## Liver

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

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

## Gastrointestinal

The stomach contains ingesta, with a mural thickness of 2.26 mm and preserved wall layering. The pylorus measures 4.07 mm and is filled with ingesta.

The duodenum measures 3.19 mm and is distended with ingesta. The jejunum measures 2.29–2.42 mm, with preserved wall layering (mucosa: 1.50 mm; submucosa: 0.50 mm; muscularis propria: 0.23 mm). Ileum: 1.38 mm. No signs of inflammation, ileus, or foreign material are identified.

The colon (transverse) measures 1.11 mm, with preserved wall layering and mildly heterogeneous, soft fecal content without significant distal acoustic shadowing. The descending colon measures 0.79 mm, with formed feces.

## Pancreas

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

## Free Abdomen

No sonographic evidence of abdominal effusion, peritonitis, or lymphadenomegaly is identified. The iliac trifurcation appears normal.

## PRIMARY FINDINGS

- Gastrointestinal tract distended with ingesta (non-fasted study).

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is no ultrasonographic evidence of mechanical obstruction, foreign material, or segmental ileus. Intestinal wall thickness and layering are within normal limits, and no focal or mucosal abnormalities are identified.

In the context of the clinical history and response to treatment, the findings are most consistent with a functional or inflammatory gastrointestinal disorder (chronic enteropathy/dysbiosis spectrum) rather than obstructive disease.



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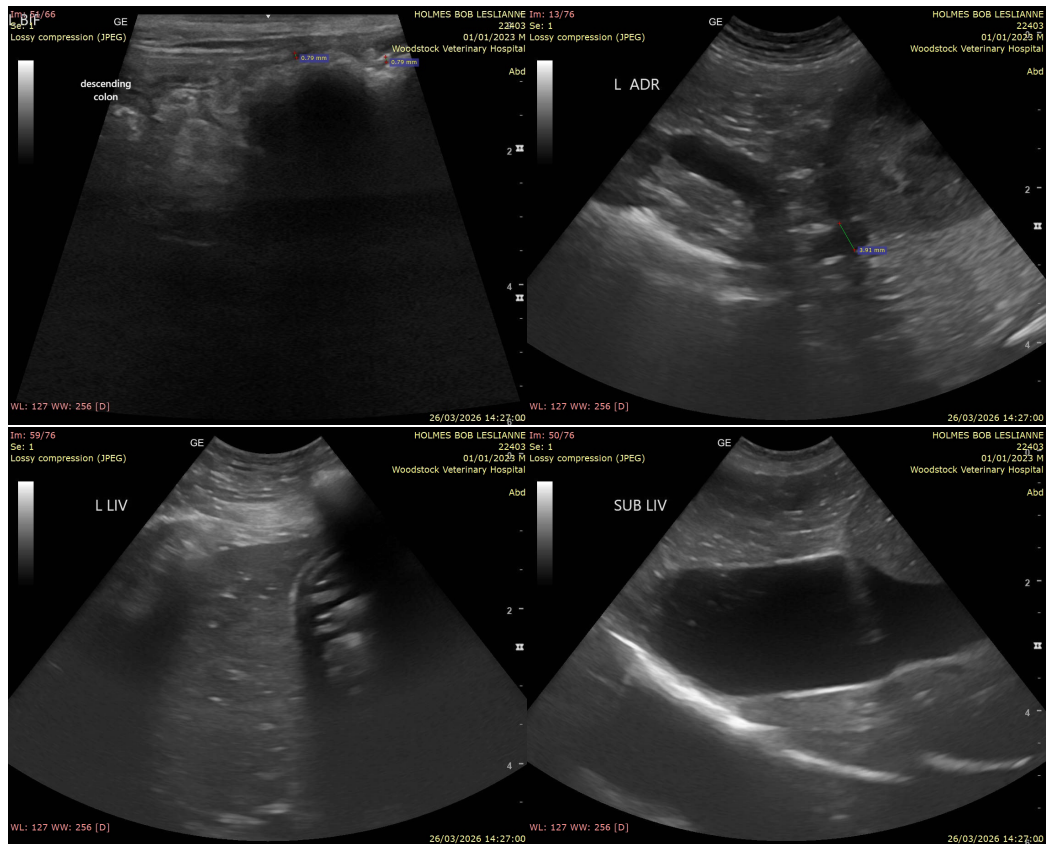
3/26/26

This is a non-fasted abdominal ultrasound, with the stomach and proximal small intestine containing ingesta. This limits assessment of gastric emptying and may give the appearance of mild intestinal distension.

**Recommendations**

- Continue current medical and dietary management, given the positive clinical response. A stepwise approach (dietary trial ± microbiome modulation) is appropriate.
- Consider gastrointestinal panel (including cobalamin/folate) and additional diagnostics if clinical signs persist or recur.
- If concern for gastric emptying or obstruction persists, a fasted repeat ultrasound or alternative imaging may be considered for improved assessment.

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





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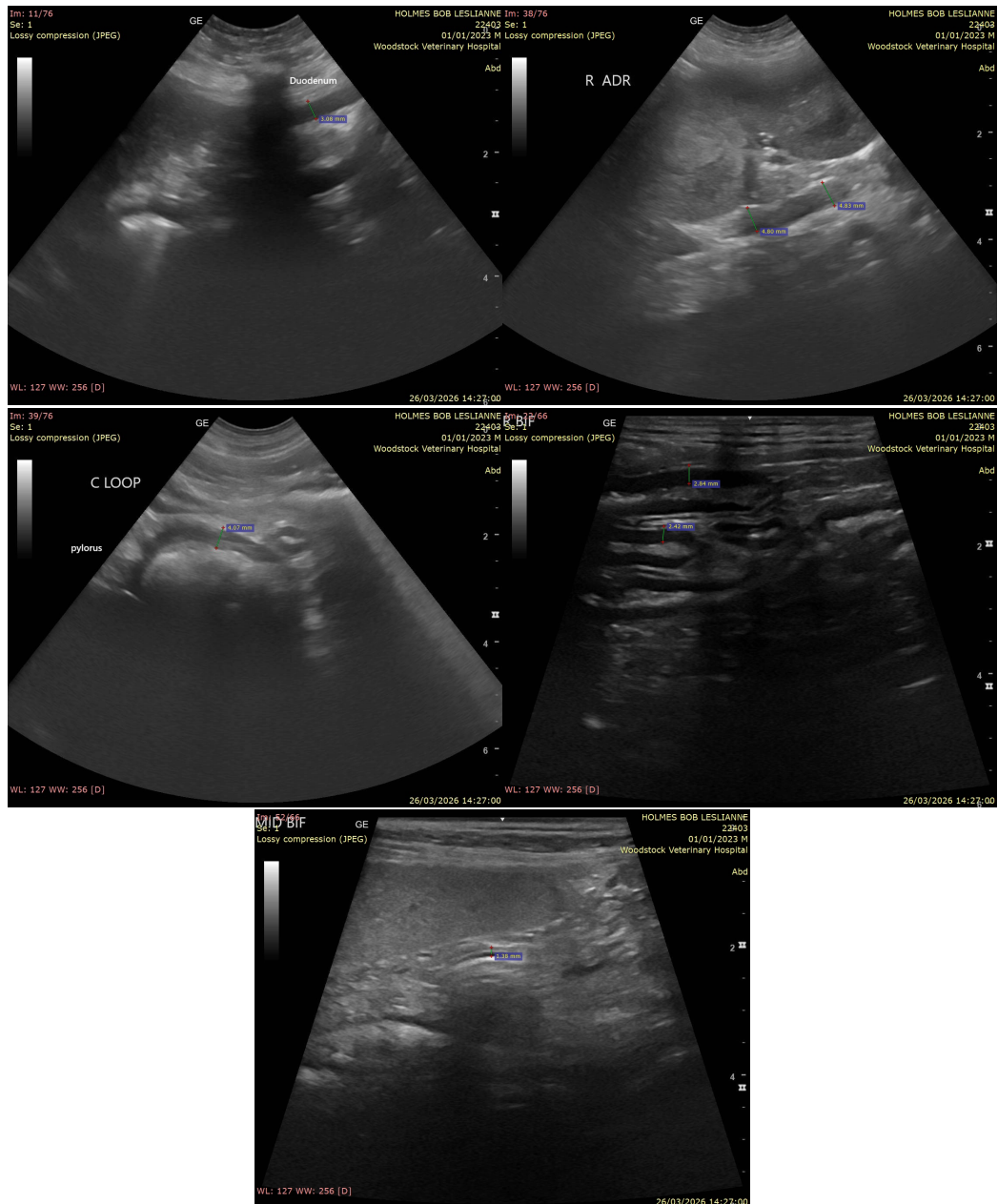
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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