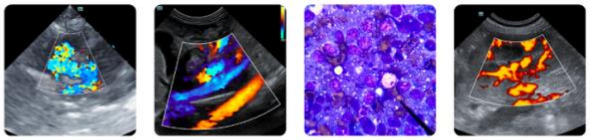


PATIENT

Trigger Hart

SPECIES

Canine

BREED

Golden Retriever

SEX

Neutered Male

AGE

3 Years

WEIGHT

45 Pounds

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Dr. Christina Wagner

HOSPITAL NAME

Angeles Clinic of Animals

REFERRING VET

Dr. Christina Wagner

INVOICE

36620

DATE

4/14/26

PRESENTING CLINICAL SIGNS

History: Intermittent diarrhea starting in Feb of this year, appetite loss, episodes of vomiting for now. Hx HBC with decreased CP on pelvic limbs with ataxia and muscle atrophy.

Abnormal PE/Chem/CBC/UA Results: ACTH stim normal CBC -HCT 34.4% --retic 180 --WBC 3266 with 7600 immature neutrophils, 25980 neutrophils chem NSF GI panel pending.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is incompletely distended, with a smooth wall measuring 3.88mm. The urine is anechoic. The bladder neck and proximal urethra appear normal. No uroliths or ultrasonographic evidence of inflammatory or neoplastic changes are identified.

In both kidneys, the cortex is isoechoic relative to the liver parenchyma. The corticomedullary ratio is within normal limits and corticomedullary definition is preserved. No pyelectasia, nephrolithiasis, or hydronephrosis is identified. The left kidney is normal in shape and size, measuring 6.16×3.29cm, with a cortical thickness of 0.44cm. The right kidney measures 5.91×3.45cm.

Prostate

The prostate is small, homogeneous, and hypoechoic, consistent with post-castration atrophy.

Adrenal Glands

The left adrenal gland measures 0.57–0.58cm in dorsoventral diameter, within normal limits. The right adrenal gland is not confidently visualized.

Spleen

The spleen measures 2.66–3.0cm in thickness, with tapered margins. The parenchyma is homogeneous with normal echogenicity. No focal lesions are identified.

Liver

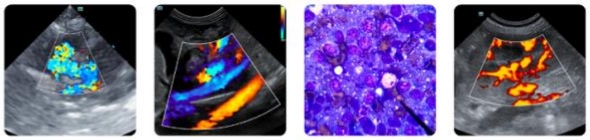
The liver is subjectively normal in size, with sharp edges and a regular contour. The liver parenchyma looks uniform and isoechoic compared to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder lumen is 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.

Gastrointestinal

The stomach contains a small amount of heterogeneous, non-characterizable material, without a typical food pattern. The gastric wall appears within normal limits; however, complete evaluation is limited. No perigastric fat reaction, pneumoperitoneum, or evidence of perforation is identified. The pylorus is not clearly visualized.

The duodenum measures 2.80mm.
The jejunum measures 2.63–3.34mm, with preserved wall layering.
No small intestinal dilation or obstructive pattern is identified. The ileocecal junction is not visualized.



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The colon measures 1.59mm and contains formed fecal material with marked acoustic shadowing, significantly limiting evaluation. The presence of inspissated feces versus intraluminal material (including a possible foreign body mixed with feces) cannot be definitively determined.

Pancreas

Not confidently visualized.

Free Abdomen

Mild anechoic abdominal effusion is present. Cranial mesenteric lymph nodes measure approximately 1.35cm in thickness, are rounded, and hypoechoic. The iliac trifurcation region is normal.

PRIMARY FINDINGS

- Mild abdominal effusion
- Enlarged cranial mesenteric lymph nodes (1.35cm), rounded and hypoechoic
- Abnormal gastric content with incomplete evaluation of pyloric region
- Colon with marked acoustic shadowing.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The most important findings are the presence of mild abdominal effusion and enlarged, rounded, hypoechoic mesenteric lymph nodes. In the context of a degenerative left shift (leukopenia with increased immature neutrophils), this strongly raises concern for a severe inflammatory or potentially septic intra-abdominal process.

The gastrointestinal tract, particularly the small intestine, appears structurally preserved, with normal wall thickness and layering, making a diffuse primary enteropathy less likely to explain the current severity of the clinical picture.

The stomach is suboptimally evaluated. The luminal contents are heterogeneous and not clearly characterizable, and the pyloric region is not confidently visualized. While no overt obstructive pattern is identified, gastric outflow obstruction, intraluminal foreign material, or focal gastric pathology cannot be excluded. The absence of perigastric fat reaction or pneumoperitoneum is reassuring against perforation at this time.

The colon contains markedly shadowing intraluminal material, most consistent with severe fecal impaction, although the presence of mixed material, including possible foreign material, is also possible.

The pancreas is not visualized; therefore, pancreatitis remains a relevant differential, particularly given the clinical signs and inflammatory leukogram.

Recommendations:

- Abdominocentesis and fluid analysis:
  - Cytology ± lactate/glucose comparison, essential to differentiate septic vs non-septic effusion.
- Spec cPL to assess for pancreatitis given limited pancreatic evaluation.
- Repeat targeted abdominal ultrasound. Focused assessment of:

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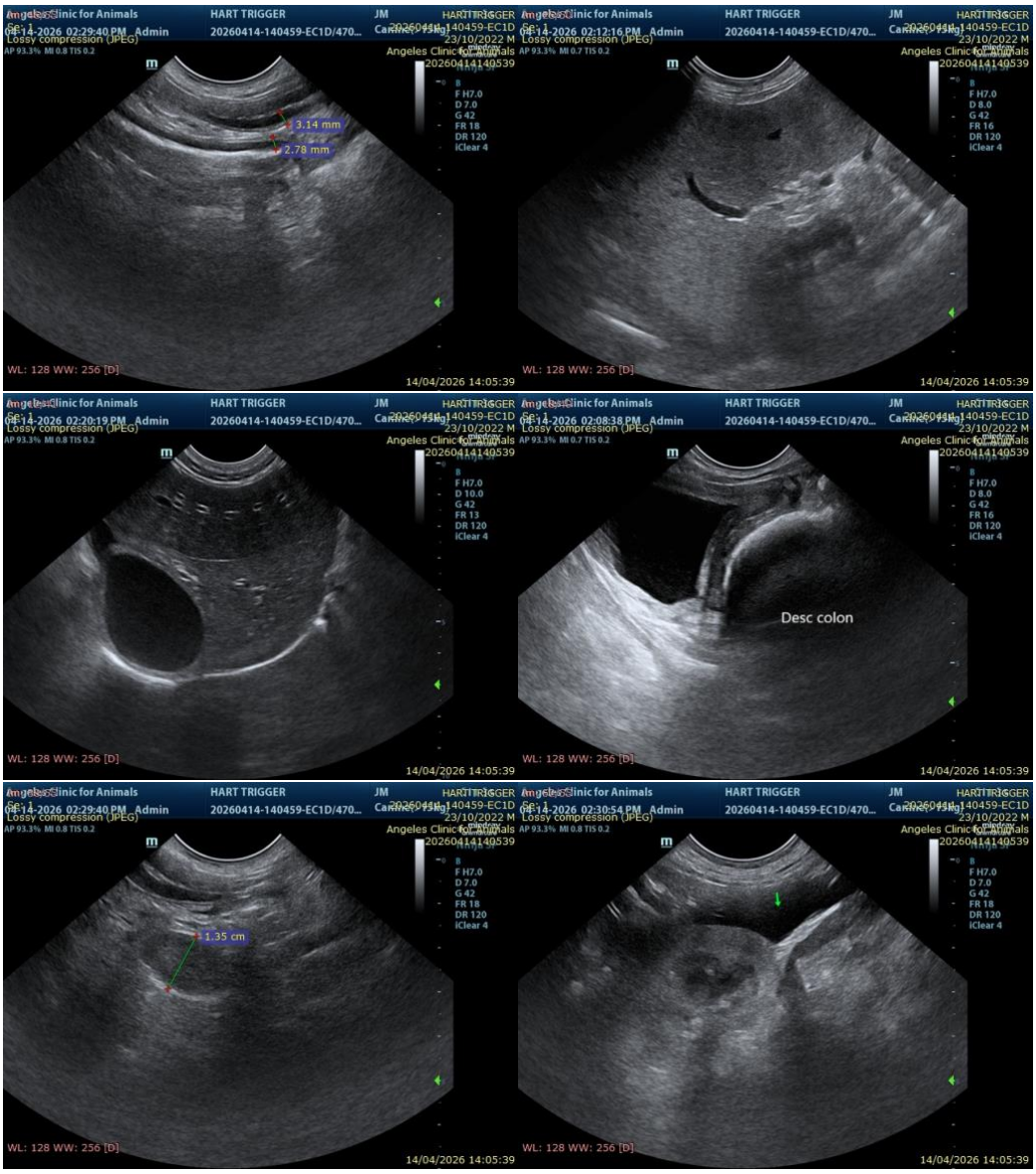
  - Stomach (fundus, body, pylorus)
  - Pancreas
- Or consider abdominal radiographs (± contrast study).

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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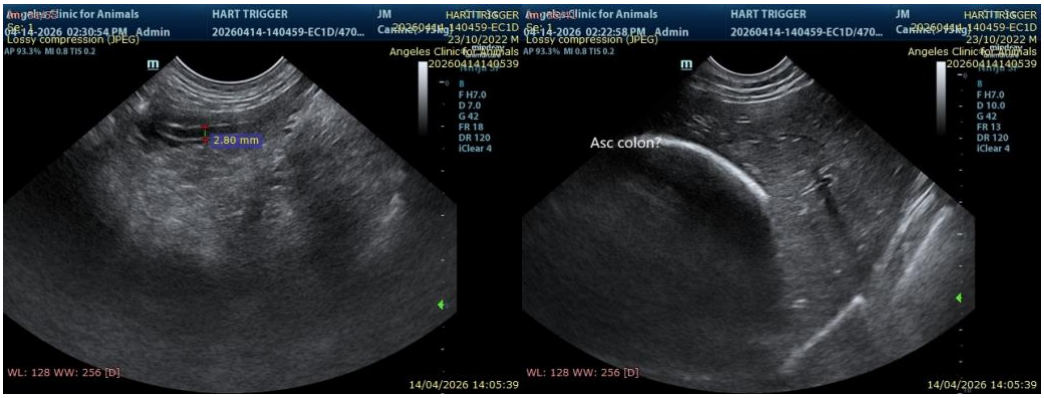

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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