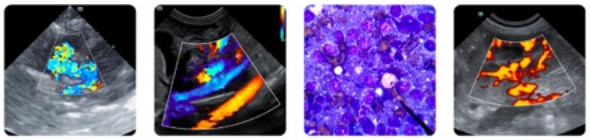


PATIENT

Rowina Sprigg

SPECIES

Canine

BREED

Pomeranian

SEX

Spayed female

AGE

7 years

WEIGHT

5.2 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Amanda Hockenbrock

HOSPITAL NAME

Lewisburg VH

REFERRING VET

Dr. Huepenbecker

INVOICE

74562

DATE

4/16/26

PRESENTING CLINICAL SIGNS

History: Patient presented for 3 week history of lethargy, decreased appetite and vomiting. Patient has lost 1 pound of body weight. Patient has also been straining to pass bowel movements with hard stool.
Abnormal PE/Chem/CBC/UA Results: Blood work shows mild non-regenerative anemia and inflammatory leukogram with band neutrophilia and monocytosis. Radiographs show a stomach which appears to be full of ingesta - client claims patient did eat a small amount of food a few hours prior to radiographs.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended, and the wall appears thin and smooth. The urine is anechoic. The bladder neck and proximal urethra appear normal. No uroliths are identified, and there is no ultrasonographic evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size, measuring 2.97×1.91 cm in the sagittal plane, with a cortical thickness of 0.30 cm. The cortex is isoechoic relative to the liver parenchyma. The corticomedullary ratio and definition are preserved. Very small mineral foci consistent with early nephrolith formation are noted. No pyelectasia or hydronephrosis is observed.

The right kidney is normal in shape and size, measuring 3.01×1.90 cm in the sagittal plane, with a cortical thickness of 0.28 cm. The cortex is isoechoic relative to the liver parenchyma. The corticomedullary ratio and definition are preserved. No pyelectasia, nephroliths, or hydronephrosis are observed.

Adrenal Glands

Not visualized.

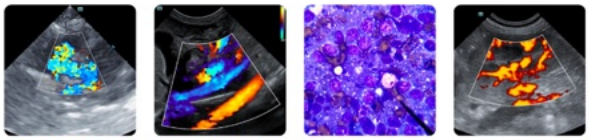
Spleen

Partially visualized. Splenic thickness is 0.62 cm. The parenchyma demonstrates normal echogenicity and a fine homogeneous echotexture. The dorsal extremity is not visualized.

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 with a small amount of biliary sludge. No evident dilation of the cystic duct or common bile duct is observed.



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Gastrointestinal

The stomach contains ingesta, with a mural thickness of 2.65 mm and preserved wall layering. The pylorus measures 4.67 mm. Duodenum: 3.08 mm. Jejunum: 2.68 mm, with preserved wall layering (individual layer measurements not obtained). Ileum: not confidently measured; wall layering appears preserved. The ileocecal junction was not visualized. No ultrasonographic evidence of foreign material, obstructive pattern, or focal mass is identified. Colon: 0.82 mm, containing formed feces in the descending segment.

Pancreas

Suboptimal visualization of the pancreatic area.

Free Abdomen

No sonographic evidence of abdominal effusion, peritonitis, or lymphadenomegaly is identified in the videos provided. The iliac trifurcation is normal.

PRIMARY FINDINGS

- Stomach containing ingesta without clear evidence of delayed emptying.
- Mild duodenal prominence (3.08 mm; within upper limits of normal for a small dog).

SECONDARY FINDINGS

- Very small left renal mineral foci (early nephrolithiasis).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is no ultrasonographic evidence of a discrete gastrointestinal mass or complete obstruction. However, the stomach contains ingesta despite a reported history of limited intake prior to imaging, which may raise concern for delayed gastric emptying, although this cannot be definitively confirmed on a single examination.

The pyloric and proximal duodenal regions are within upper limits of normal, and no focal lesion is identified. Mild duodenal prominence is noted but is nonspecific.

Given history and suboptimal visualization of several gastrointestinal structures, an early or partial obstructive processes and infiltrative disease cannot be reliably excluded, including:

- Pyloric outflow dysfunction.
- Early infiltrative disease.

Recommendations

- Consider:
    - Abdominal radiographs (serial) or a contrast study.
    - Repeat abdominal ultrasound performed under fasting conditions, ideally using a high-frequency linear transducer to allow detailed assessment of gastrointestinal wall

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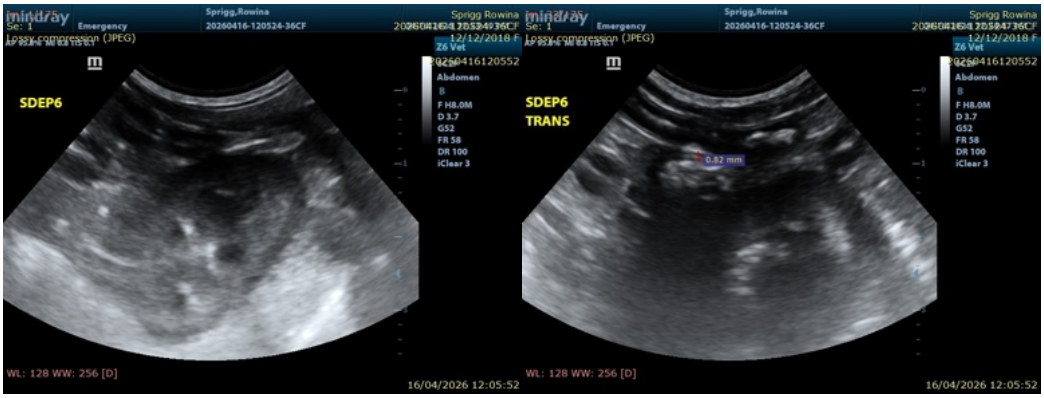
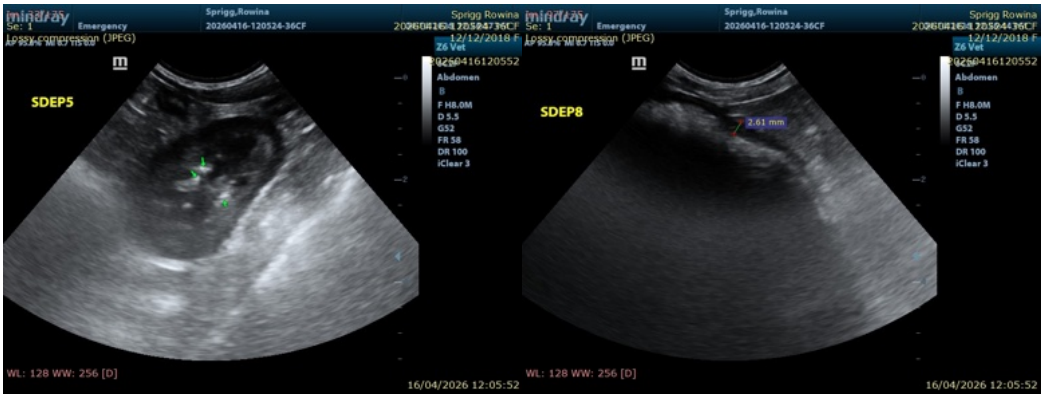
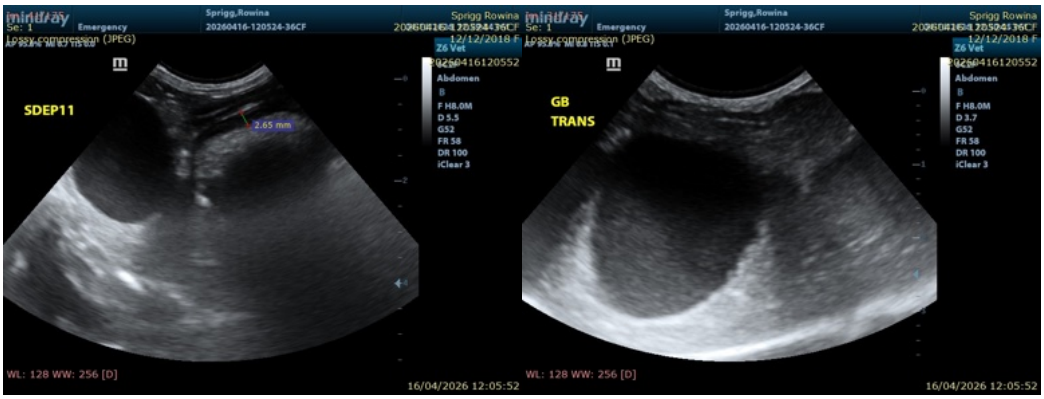
layering and improved detection of subtle abnormalities, including early mural changes, mild luminal narrowing, or focal areas of altered distensibility that may not be apparent on the current study.

- Endoscopic evaluation of the pylorus and proximal duodenum.

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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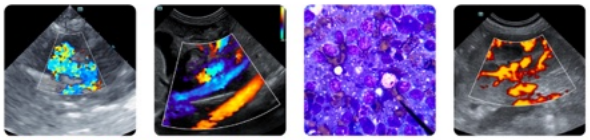

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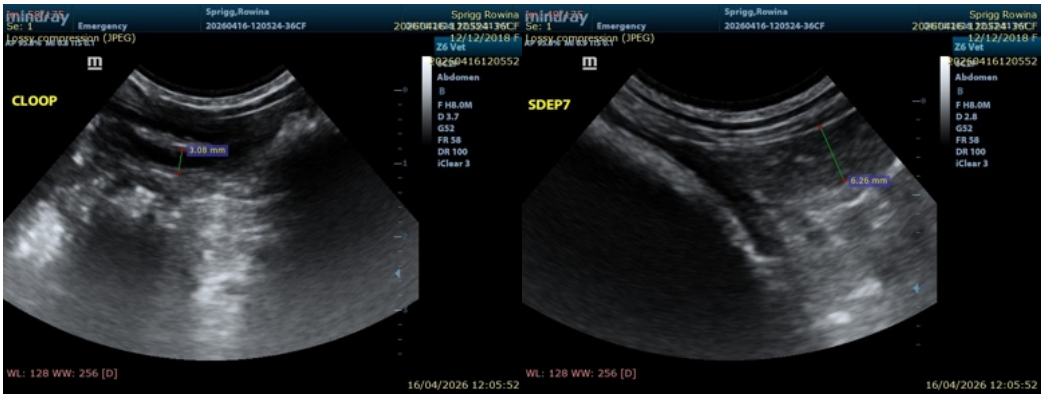

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

info@SonoPath.com