



## PATIENT

Dunkin Whiting

## SPECIES

Canine

## BREED

Beagle Mix

## SEX

Neutered male

## AGE

14 years

## WEIGHT

33.6

## INTERPRETED BY

Alicia Angosto  
Guerrero, DMV,  
PgDip, MSc.

## IMAGING PERFORMED BY

Grace Jayne CVT

## HOSPITAL NAME

Ark Animal Homecare

## REFERRING VET

Dr. DeBeckers

## INVOICE

74637

## DATE

4/20/26

## PRESENTING CLINICAL SIGNS

History: Worsening chronic vomiting. Some improvement on a bland diet.

Abnormal PE/Chem/CBC/UA Results: 4/6/26 Chems WNL 4/20 CBC: RBC 4.44 Hematocrit 25.7 Hemoglobin 9.0 MCV 57.9 MCH 20.3 Reticulocytes 179.4 Reticulocyte Hemoglobin 21.4 WBC 22.86 Neutrophils 18.47 Monocytes 1.18 Plateletcrit 0.48

## 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 have a normal appearance. No calculi or evidence of inflammatory or neoplastic changes are identified.

The left kidney is normal in shape and size, measuring 6.17×3.49 cm, with a cortical thickness of 0.76 cm in the sagittal plane. The cortex is isoechoic compared to the hepatic parenchyma. A 4.5×6.5 mm cortical cyst is present. The corticomedullary ratio is normal, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

The right kidney is normal in shape and size, measuring 5.95×2.92 cm. Cortical thickness is not provided. The cortex is isoechoic compared to the hepatic parenchyma. The corticomedullary ratio is normal, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

### *Adrenal Glands*

The left adrenal gland measures 0.95 cm at the caudal pole, which is mildly enlarged (expected <0.7–0.75 cm in most dogs), although interpretation should consider patient size and body condition. The right adrenal gland is not confidently visualized.

### *Spleen*

Splenic thickness is 1.33 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture with several around 3.88×4.1 mm hypoechoic foci. The splenic capsule is smooth and regular. Splenic vasculature appears normal.

### *Liver*

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

The gallbladder is normally distended. The wall shows changes consistent with mucosal (mucinous gland) hyperplasia. A very small amount of biliary sludge is present. No dilation of the cystic duct or common bile duct is observed.



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## *Gastrointestinal*

The stomach is distended with ingesta and fluid, with a mural thickness of 1.70 mm and preserved wall layering. The pylorus measures 3.08 mm. The duodenum measures 4.12 mm, and the jejunum measures 2.43–2.85 mm, with mucosa 1.86 mm, submucosa 0.80 mm, and muscularis propria 0.27 mm; wall layering is preserved. No evidence of focal thickening, mass lesion, or mechanical obstruction is identified.

The colon measures 0.94–1.21 mm, with preserved wall layering and semiliquid fecal content 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 are not visualized, and the surrounding regions appear unremarkable. The right gastric lymph node measures 6.40×8.50 mm, with normal shape and mildly hypochoic echogenicity. The iliac trifurcation is normal.

## PRIMARY FINDINGS

- Mild left adrenal enlargement (0.95 cm)
- Small splenic hypochoic foci.
- Gallbladder mucosal hyperplasia with minimal sludge.

## SECONDARY FINDINGS

- Mild enlargement of the right gastric lymph node.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The stomach is distended with ingesta and fluid. In the absence of mural abnormalities or evidence of obstruction, this finding is nonspecific and may reflect recent feeding or mild functional hypomotility rather than true delayed gastric emptying. No focal gastrointestinal lesion, mass, or loss of wall layering is identified, and intestinal wall thicknesses are within expected limits for a dog of this size (generally <5 mm for small intestine), with preserved layering throughout. This makes a large, overtly infiltrative gastrointestinal neoplasm less likely based on imaging alone.

However, the presence of moderate regenerative anemia indicates ongoing blood loss or destruction. In the context of chronic vomiting, gastrointestinal bleeding remains a primary concern, even in the absence of ultrasonographic abnormalities. It is important to recognize that mucosal disease (ulceration, erosive gastritis, early neoplasia) may not be detectable on ultrasound, particularly when confined to superficial layers.

A regional lymph node, most consistent with the right gastric lymph node based on location, measures



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6-8 mm in thickness, which is mildly increased relative to expected values (<5-6 mm). However, morphology is preserved, supporting a reactive rather than infiltrative process.

The presence of semiliquid fecal material within the descending colon is considered a nonspecific finding and may reflect altered gastrointestinal motility rather than primary colonic disease, particularly given the preserved wall layering.

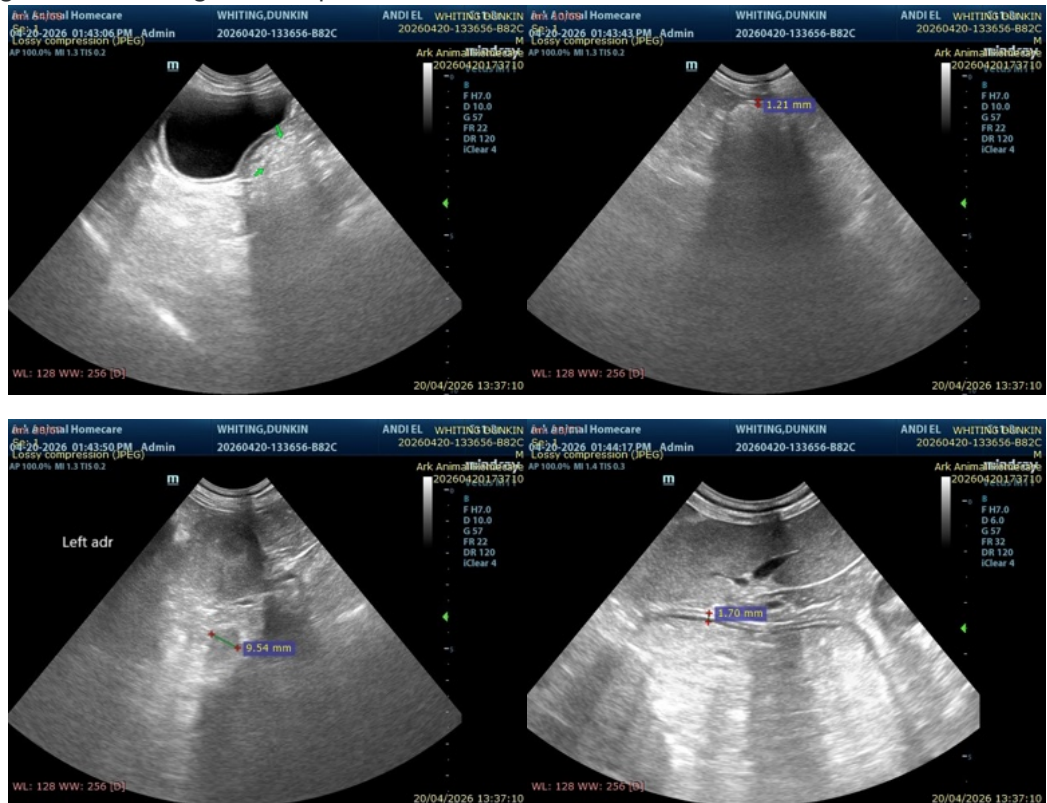
The splenic hypoechoic foci are small and nonspecific; in an older dog, these most commonly represent benign changes such as nodular hyperplasia. Extramedullary hematopoiesis is also a reasonable consideration given the presence of regenerative anemia.

The left adrenal gland is mildly enlarged, which may be incidental or age-related; correlation with endocrine testing (if clinically indicated) would be required for further assessment.

### Recommendations

- Upper gastrointestinal endoscopy (gastroscopy ± duodenoscopy) is strongly recommended, as it allows direct evaluation of the mucosa and identification of ulceration, erosive disease, or infiltrative processes not visible on ultrasound.
- Endoscopic biopsies are essential for definitive diagnosis.
- Consider fecal occult blood testing or monitoring for melena to support GI bleeding.

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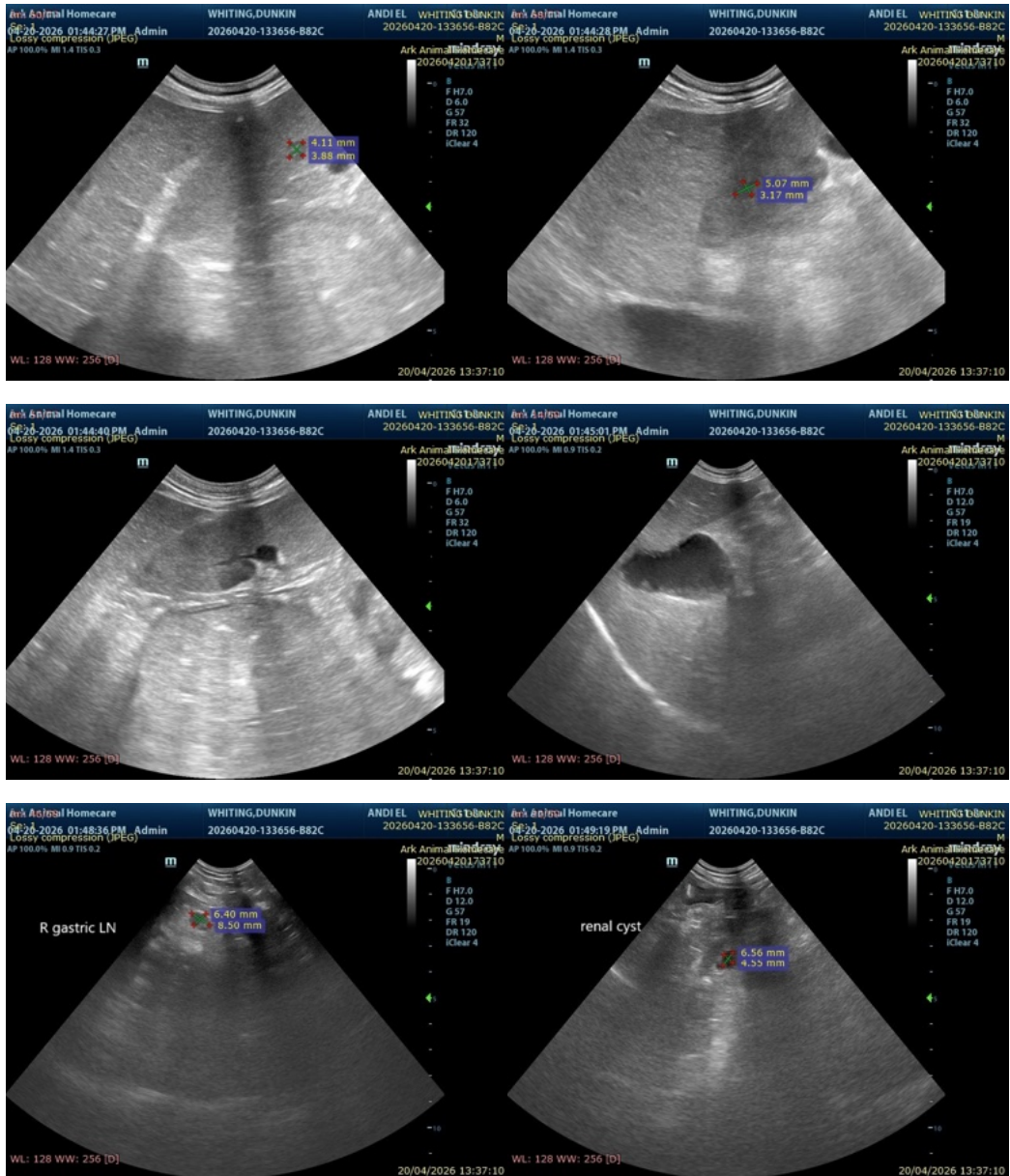
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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