



## PATIENT

Kukui Schram

## SPECIES

Canine

## BREED

Mexican Street Dog

## SEX

Spayed female

## AGE

4 years

## WEIGHT

12.54 lbs

## PRESENTING CLINICAL SIGNS

- Patient presented (3/21/26) with acute illness (vomiting, inappetence and hematochezia) and marked dehydration, evidenced by hemoconcentration on CBC and increased osmolality. Hospitalized and treated with IV fluid therapy. Recheck (3/23/26) shows resolution of hemoconcentration with new hypoproteinemia and mild non-regenerative anemia.
- Symptoms improved with supportive care but has had two follow-up bouts of hematochezia, vomiting since. Improvement on GI biome, cerenia.
- Rechecking labs today (sending to lab), likely performing malabsorption panel. catalyst pancreatic lipase WNL, acth stim well within normal. fecal neg.
- CBC 3/21/26 (Presentation) RBC: 9.48 M/ $\mu$ L (RI 5.65–8.87)  $\uparrow$  Hematocrit: 63.1% (37.3–61.7)  $\uparrow$  Hemoglobin: 22.6 g/dL (13.1–20.5)  $\uparrow$  Neutrophils: 81.6%  $\uparrow$  Lymphocytes: 15.1%  $\downarrow$  3/23/26 (Post-IVF) Hematocrit: 36.9% (37.3–61.7)  $\downarrow$  Reticulocytes: 8.5 K/ $\mu$ L (10.0–110.0)  $\downarrow$  Platelets: 135 K/ $\mu$ L (148–484)  $\downarrow$  (mild thrombocytopenia) PDW: 8.3 fL (9.1–19.4)  $\downarrow$  Neutrophils: 68.4%  $\uparrow$  Lymphocytes: 22.0%  $\downarrow$  Monocytes: 7.5%  $\uparrow$  nRBCs: suspected (recommend smear confirmation) Chemistry 3/21/26 (Presentation) Osmolality: 303 mmol/kg  $\uparrow$  TP: 6.0 (normal) 3/23/26 (Post-IVF) Total Protein: 4.5 g/dL (5.2–8.2)  $\downarrow$  Albumin: 2.0 g/dL (2.3–4.0)  $\downarrow$  A:G Ratio: 0.8 (~1.1)  $\downarrow$  BUN: 12 mg/dL  $\downarrow$  Creatinine: 0.5 mg/dL  $\downarrow$  Osmolality: 297 mmol/kg (normalized) Sodium/Chloride: high-normal

## INTERPRETED BY

Alicia Angosto  
Guerrero, DMV,  
PgDip, MSc.

## IMAGING PERFORMED BY

Karen Hemmerich

## HOSPITAL NAME

Tigard AH

## REFERRING VET

Dr. Schram

## INVOICE

74191

## DATE

4/6/26

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder is mildly underdistended. The bladder wall appears thin, smooth, and regular. The luminal contents are anechoic. The bladder neck and proximal urethra have a normal appearance. No evidence of urolithiasis or inflammatory or proliferative changes is identified.

The left kidney is normal in shape and size, measuring 4.13x2.17 cm in the sagittal plane. Cortical thickness is 0.32 cm. The cortex is isoechoic compared to the hepatic parenchyma. The corticomedullary ratio is within normal limits, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

The right kidney is normal in shape and size, measuring 4.45x2.05 cm in the sagittal plane. Cortical thickness is 0.39 cm. The cortex is isoechoic compared to the hepatic parenchyma. The corticomedullary ratio is within normal limits, and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

### Adrenal Glands

Not confidently visualized.



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## *Spleen*

Splenic thickness is 1.96 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 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 very small amount of biliary sludge. No evident dilation of the cystic duct or common bile duct is observed.

## *Gastrointestinal*

The stomach is empty and folded, containing a small amount of fluid within the lumen. Wall thickness measures 2.36 mm, with preserved layering.

Duodenum measures 3.90 mm and demonstrates a corrugated appearance. Jejunum measures 3.86 mm, with mucosa 2.40 mm, submucosa 0.75 mm, and muscularis propria 0.71 mm. Ileum measures 2.54 mm, with mucosa 0.99 mm, submucosa 1.19 mm, and muscularis propria 0.62 mm. Wall layering is preserved. Additional small intestinal segments also demonstrate a corrugated appearance. No sonographic evidence of mucosal striations or intestinal lymphangiectasia is identified.

Colon: ascending colon measures 0.99 mm and contains fluid; additional segments measure approximately 0.67 mm with gas content.

## *Pancreas*

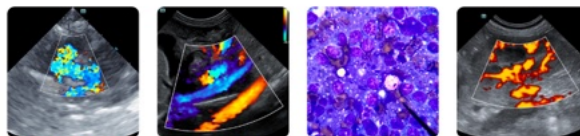
The evaluated pancreatic areas do not show evidence of overt inflammation or neoplastic disease.

## *Free Abdomen*

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

## PRIMARY FINDINGS

- Mild small intestinal wall thickening (duodenum and jejunum).
- Diffuse small intestinal corrugation.
- Mild amount of fluid content within gastric and intestinal lumen.



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## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Small intestinal wall thickness in the duodenum (3.90 mm) and jejunum (3.86 mm) is mildly increased relative to expected canine reference ranges (generally  $\leq 3.0$ – $3.5$  mm depending on size), supporting mural involvement. However, wall layering is preserved, and the muscularis-to-mucosa ratio remains within expected limits (jejunum  $\sim 0.30$ ), which does not support a prominent muscularis hypertrophy pattern typically described in chronic enteropathies, although this parameter is less specific in dogs than in cats.

No ultrasonographic evidence of intestinal lymphangiectasia is identified, despite the presence of hypoproteinemia. This suggests that protein loss may be secondary to acute mucosal damage; however, a protein-losing enteropathy cannot be completely excluded at this stage.

The corrugated appearance of the small intestine is a key feature and is most commonly associated with acute enteritis (inflammatory or infectious), intestinal spasm, early or transient inflammatory change.

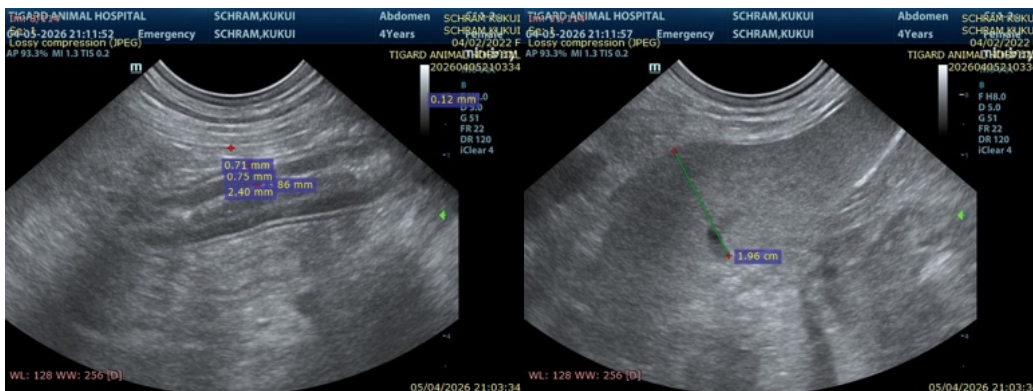
In this clinical context—acute onset vomiting, hematochezia, dehydration followed by hypoproteinemia—these findings are most consistent with acute to subacute inflammatory enteropathy, such as acute hemorrhagic diarrhea syndrome or severe enteritis with mucosal injury.

The absence of lymphadenomegaly, preserved layering, and lack of focal mass lesions make neoplastic disease less likely based on this study.

### Recommendations

- Continue supportive care and medical management for acute inflammatory enteropathy.
- Correlation with pending GI panel is recommended to further assess intestinal function and rule out concurrent malabsorption.
- Monitor serum protein and albumin levels to assess for ongoing or resolving protein loss. If hypoproteinemia persists or worsens, further evaluation for protein-losing enteropathy may be warranted.

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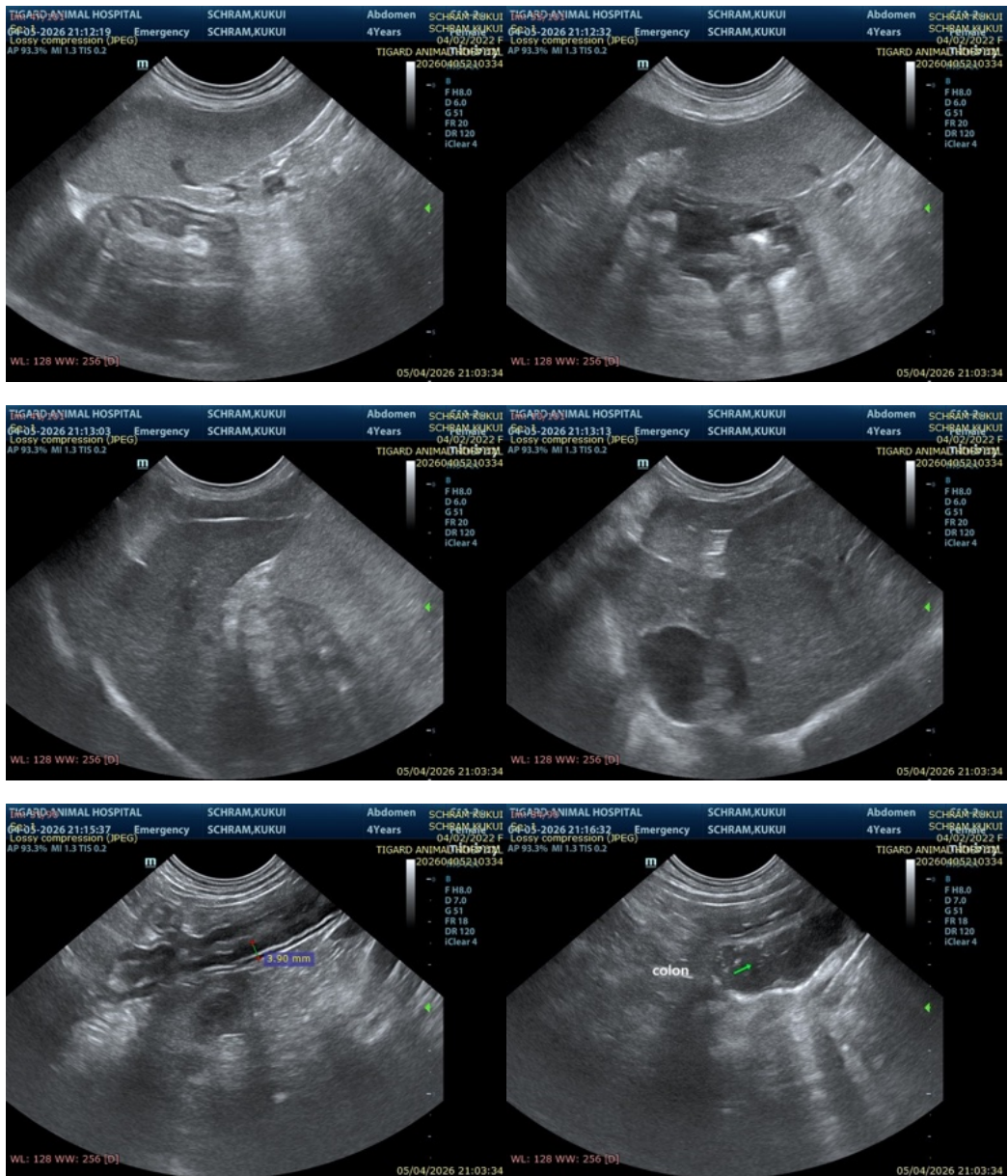
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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](mailto:info@SonoPath.com)