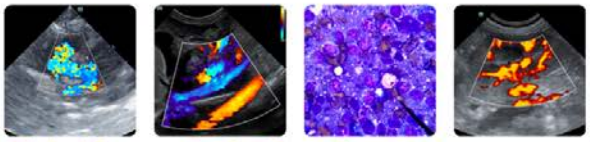

PATIENT

Nyx Schleeter

SPECIES

Canine

BREED

Anatolian Shepherd Dog x

SEX

Spayed Female

AGE

2 Years

WEIGHT

28.5 kg

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Dr. Leah Richter

HOSPITAL NAME

Allied Veterinary Emergency & Referral

REFERRING VET

Dr. Leah Richter

INVOICE

75304

DATE

5/11/26

PRESENTING CLINICAL SIGNS

Healthy Adult.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended, and the wall of the urinary bladder appears thin and smooth. The urine is anechoic. Normal appearance of the bladder neck and proximal urethra. No calculi are identified, and there is no ultrasonographic evidence of inflammatory or neoplastic change.

The left kidney is normal in shape and size, measuring 6.32×3.32 cm, with a cortical thickness of 0.49 cm in the sagittal plane. The renal cortex is isoechoic compared to the hepatic parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. No evidence of pyelectasia, nephrolithiasis, or hydronephrosis is identified. Color Doppler demonstrates a normal vascular pattern.

The right kidney is normal in shape and size, measuring 5.95×2.93 cm, with a cortical thickness of 0.50 cm in the sagittal plane. The renal cortex is isoechoic compared to the hepatic parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. No evidence of pyelectasia, nephrolithiasis, or hydronephrosis is identified. Color Doppler demonstrates a normal vascular pattern.

Adrenal Glands

The left adrenal gland is partially visualized and measures 0.56 cm at the caudal pole. The right adrenal gland is not confidently visualized.

Spleen

Splenic thickness is 1.66 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 moderately 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 Tract

The stomach is empty and folded, with mural thickness measuring 2.70–3.70 mm and preserved wall layering. No videos of the pyloroduodenal junction were provided for evaluation. No convincing ultrasonographic evidence of gastric ulceration is identified. No abnormal fluid accumulation is present within the gastric lumen to specifically explain the reported nausea/reflux-type episodes, and no convincing sonographic evidence of delayed gastric emptying is identified on the submitted images/videos.

The duodenum measures 3.45 mm in thickness.

The jejunum measures 3.25 mm in thickness, with preserved wall layering.

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The ileocecocolic junction is not visualized.

The colon measures 1.06 mm in thickness with normal luminal contents.

Pancreas

The evaluated pancreatic regions 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 is normal.

PRIMARY FINDINGS

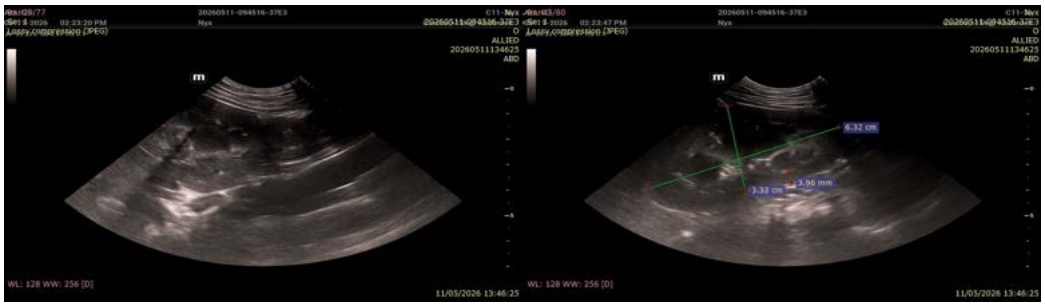
- No clinically significant ultrasonographic abnormalities identified

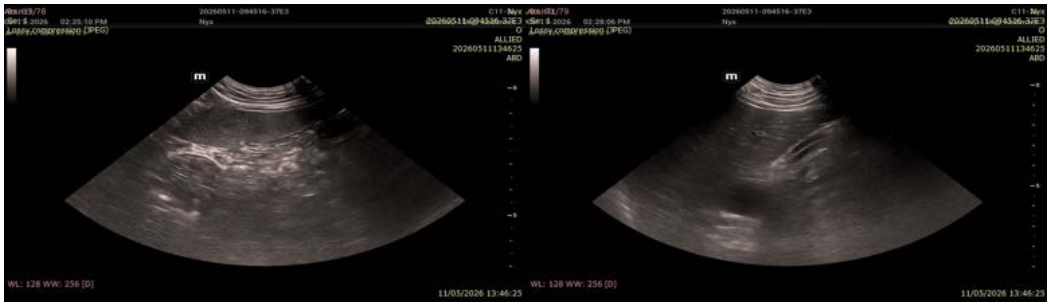
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Overall, no clinically significant abdominal ultrasonographic abnormalities are detected on the current study.

Given the updated history of chronic intermittent reflux-type episodes, nausea/heaving behavior, and episodic vomiting despite the relatively unremarkable abdominal ultrasonographic appearance, upper gastrointestinal/esophageal disease remains a reasonable clinical consideration. Gastroesophageal reflux, esophagitis, intermittent hiatal hernia, functional gastric disorder, or subtle upper gastrointestinal inflammatory disease cannot be excluded based on abdominal ultrasound alone.

If clinical signs persist or progress, further upper gastrointestinal evaluation may be considered, including endoscopic assessment to evaluate for esophagitis, reflux-associated change, hiatal hernia, pyloric abnormalities, or other subtle mucosal disease not detectable ultrasonographically.





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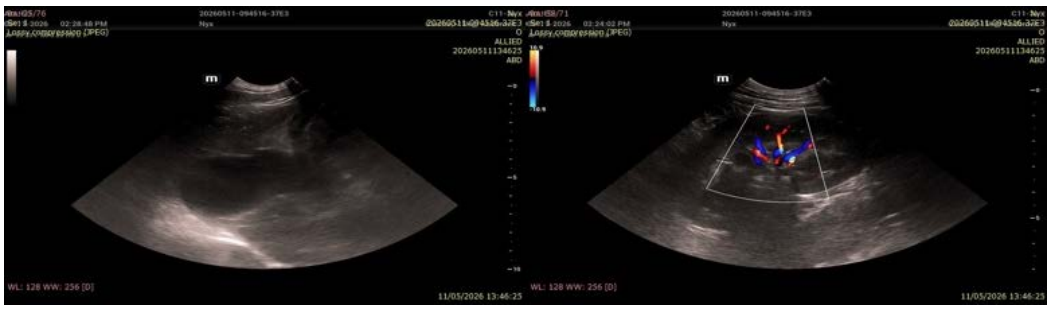

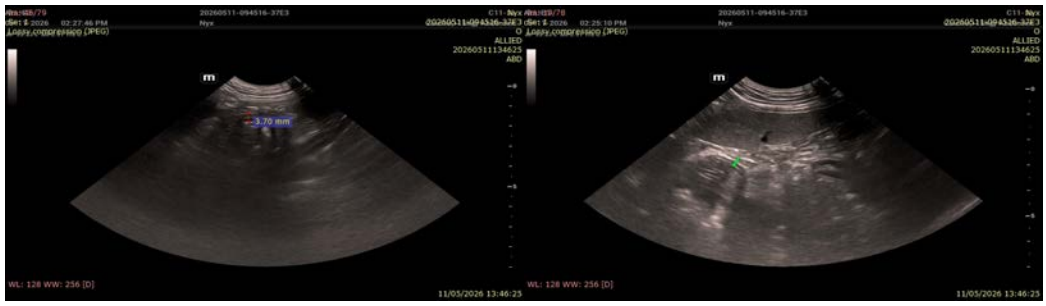

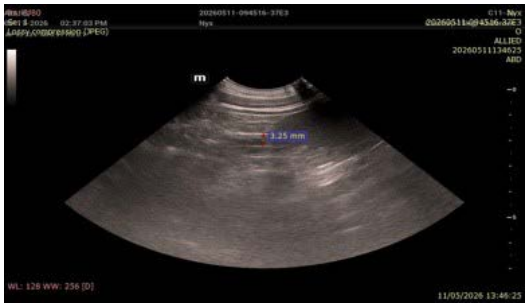

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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