



PATIENT

Dakota Butterworth

SPECIES

Canine

BREED

Pitbull Terrier Mix

SEX

Spayed female

AGE

1 year

WEIGHT

78 lbs

INTERPRETED BY

Alicia Angosto
Guerrero, DMV,
PgDip, MSc.

IMAGING PERFORMED BY

Quinn Robinson RVT

HOSPITAL NAME

Hess Ridge AH

REFERRING VET

Dr. Vaccari

INVOICE

75549

DATE

5/14/26

PRESENTING CLINICAL SIGNS

History: Cyclical episodes (every 3-6 weeks) of vomiting and diarrhea that usually quickly resolve (12-24 hours). Current episode has persisted greater than 48 hours and has hematemesis and hematochezia.
Abnormal PE/Chem/CBC/UA Results: 5/12/26 CBC: Lymphs 1,020 (1,050-5,100), PDW 8.3 (9.1-19.4) Chem17: ALT 213 (10-125)

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 predominantly anechoic with scant suspended echoes. The bladder neck and proximal urethra appear normal. There are no calculi and no evidence of inflammatory or neoplastic changes.

The left kidney measures 5.56×2.64 cm, and the thickness of the cortex is 0.49 cm in the sagittal plane. The renal contour appears mildly irregular. The cortex is mildly hyperechoic compared to the hepatic parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. Mild pyelectasia measuring 1.91 mm is present. Multifocal small pinpoint hyperechoic foci with associated distal acoustic shadowing are present within portions of the medulla, compatible with mild mineralization. No nephrolithiasis or hydronephrosis is identified. Color Doppler demonstrates a normal vascular pattern.

The right kidney measures 9.63×4.61 cm, and the thickness of the cortex is 0.76 cm in the sagittal plane. The cortex is isoechoic compared to the hepatic parenchyma. The corticomedullary ratio and corticomedullary definition are preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler demonstrates a normal vascular pattern.

Adrenal Glands

Both adrenal glands demonstrate normal shape and echogenicity. The left adrenal gland is only partially visualized and measures approximately 0.52 cm. The right adrenal gland measures 0.57 cm at the cranial pole and 0.48 cm at the caudal pole.

Spleen

Splenic thickness is 1.33 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.



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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.

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The stomach is moderately distended with fluid and small amounts of residual ingesta. Gastric mural thickness measures 3.87 mm, with preserved wall layering.

The duodenum measures 3.43-3.80 mm. The jejunum measures 3.14 mm, with preserved wall layering.

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Multiple small intestinal loops contain fluid and small amounts of luminal ingesta and are mildly distended; however, no focal obstructive lesion, corrugation, plication, foreign material, or segmental obstructive pattern is identified. The patient's fasting status is unknown and may partially contribute to the luminal appearance.

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The colon measures approximately 1.98-2.23 mm in thickness and is relatively empty.

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Pancreas

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

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Free Abdomen

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

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PRIMARY FINDINGS

- Moderate fluid gastric distension
- Diffuse fluid-filled small intestinal distension without focal obstruction
- Marked asymmetry in renal size.
- Mild left renal contour irregularity, cortical hyperechogenicity, and pyelectasia. Subtle multifocal left renal medullary mineralization with associated pinpoint acoustic shadowing.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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The gastrointestinal tract demonstrates moderate fluid gastric distension and mild diffuse fluid-filled small intestinal distension with preserved intestinal motility and without ultrasonographic evidence of a discrete mechanical obstruction, foreign body, intussusception, plication, focal obstructive lesion, or clinically significant ileus. The overall appearance is considered more compatible with active gastroenteritis/enteropathy and a non-fasted digestive state.

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Given the patient's history of recurrent cyclical episodes of vomiting and diarrhea, the current findings are considered most supportive of recurrent inflammatory gastrointestinal disease/enteropathy with



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reactive gastrointestinal fluid accumulation and episodic hypomotility. Differential considerations include dietary-responsive enteropathy, inflammatory enteropathy, dysbiosis-associated disease, and episodic hemorrhagic gastroenteritis syndrome (AHDS-like episodes). Although no overt ultrasonographic evidence of pancreatitis is identified, mild or early pancreatitis cannot be completely excluded sonographically.

The reported hematemesis may reflect hemorrhagic gastritis and/or superficial mucosal erosive disease not detectable ultrasonographically, particularly in the setting of recurrent gastrointestinal inflammation. No sonographic evidence of gastric ulcer perforation, diffuse peritonitis, or abdominal mass lesion is identified.

The kidneys are markedly asymmetric in size, with the left kidney substantially smaller than the right and demonstrating mild cortical hyperechogenicity, contour irregularity, mild pyelectasia, and multifocal medullary mineralization. These findings are compatible with chronic unilateral renal injury/nephropathy, developmental hypoplasia/dysplasia, or sequelae of prior renal insult, with compensatory hypertrophy of the right kidney considered likely. Correlation with renal function testing is recommended, although these renal findings are not considered sufficient to fully explain the current gastrointestinal presentation based on the available information.

Recommendations

- Continued supportive management for acute gastrointestinal disease is recommended.
- Correlation with fasting status and dietary history.
- Correlation with pancreatic lipase testing (cPLI) may be considered if clinical suspicion for pancreatitis persists despite the relatively unremarkable pancreatic ultrasonographic appearance.
- If cyclical gastrointestinal episodes continue long term, further investigation for chronic inflammatory enteropathy, dietary-responsive disease, dysbiosis, or less likely intermittent mechanical disease may be warranted. Advanced diagnostics such as endoscopy and gastrointestinal biopsies could ultimately be considered if clinical signs become persistent or poorly responsive to empirical management.
- Correlation with renal values, SDMA, urinalysis, UPC ratio, urine culture, and blood pressure is recommended given the asymmetric renal appearance and chronic left renal abnormalities. Periodic monitoring of renal structure and function is advised.

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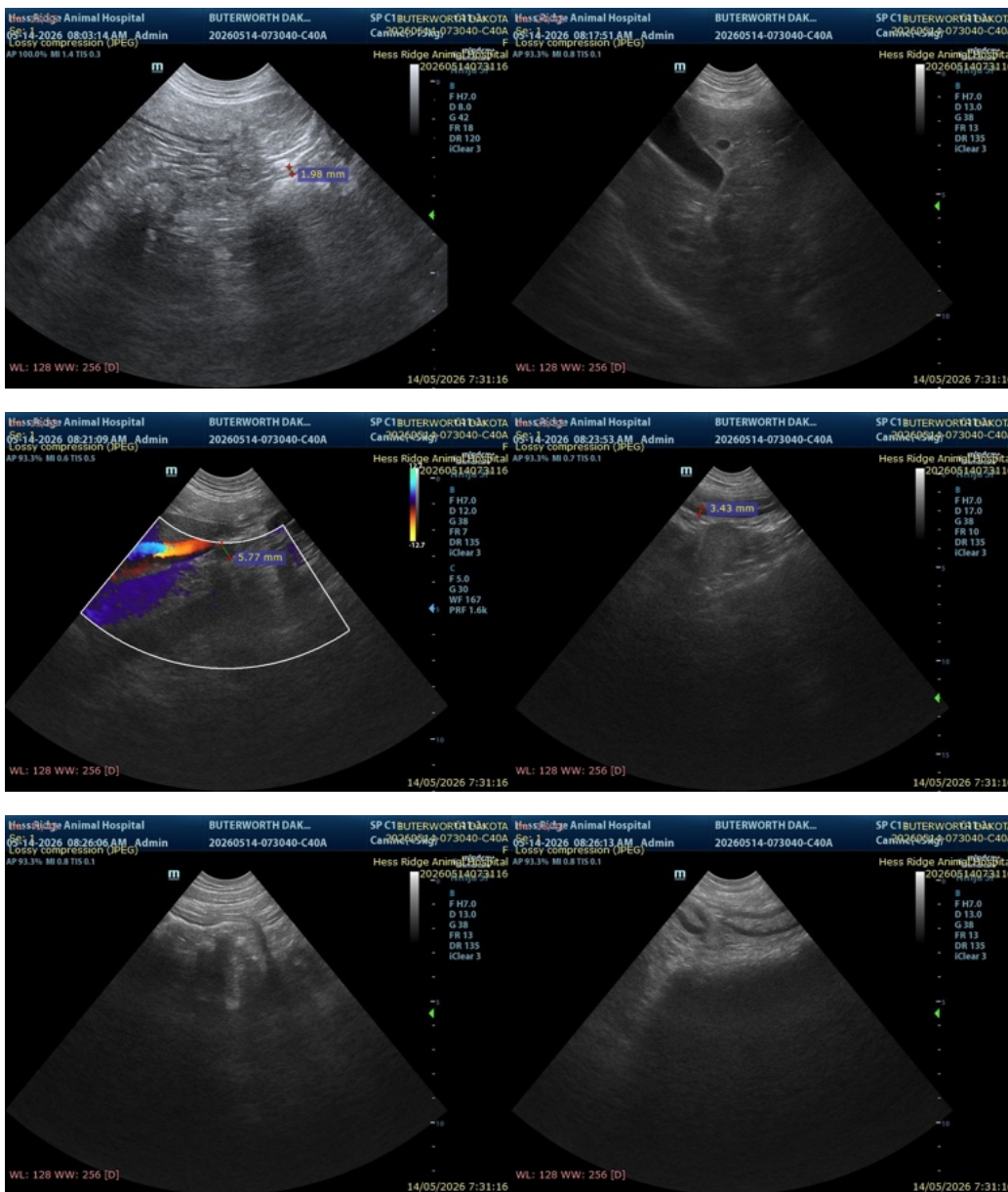
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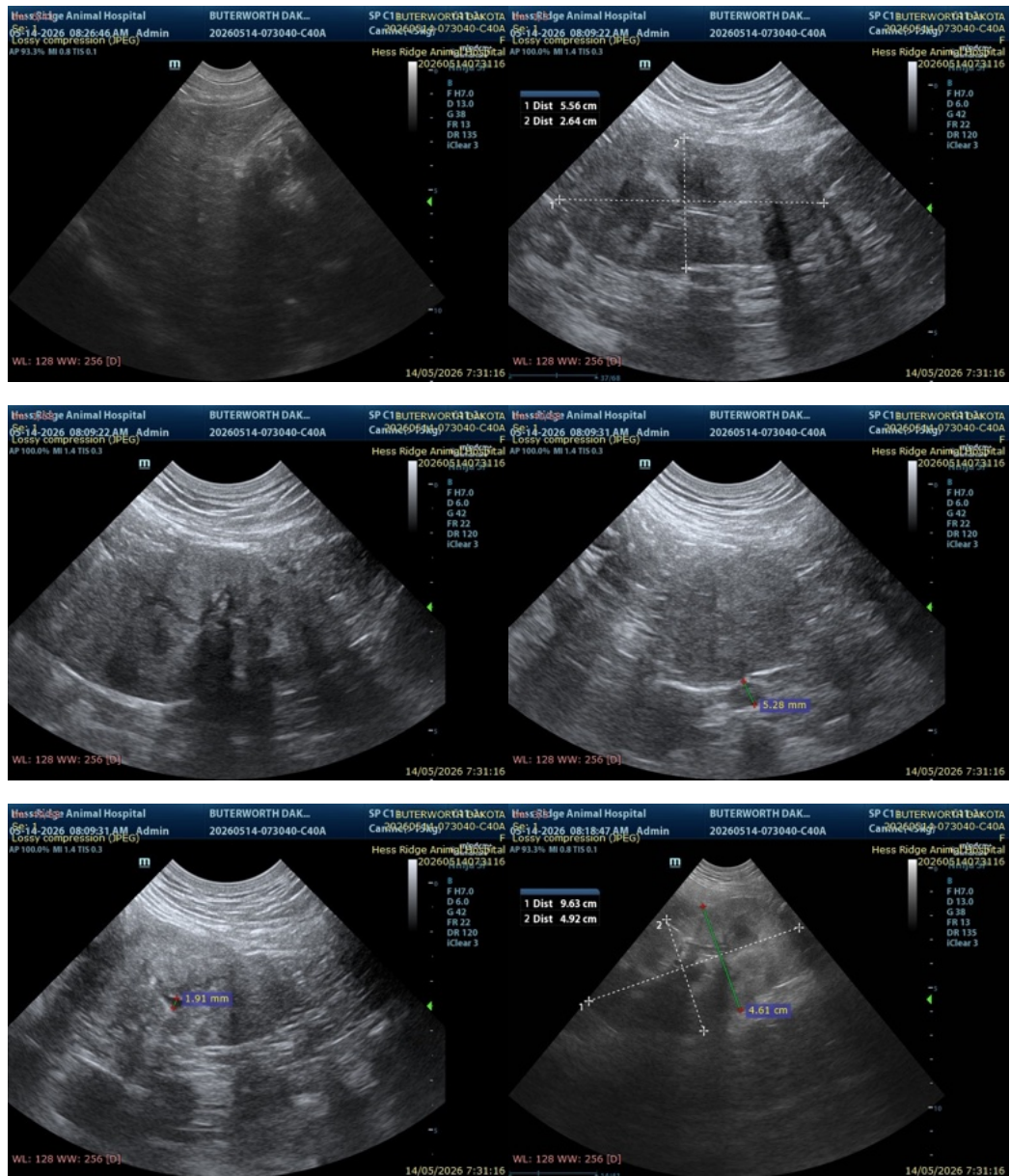
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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