

PATIENT

Penny Olson

SPECIES

Canine

BREED

Black Lab

SEX

Spayed Female

AGE

3.5 Years

WEIGHT

25.9 kg

INTERPRETED BY

Alicia Angosto
Guerrero, DMV,
PgDip, MSc.

IMAGING PERFORMED BY

Dr. Leah Richter

HOSPITAL NAME

Allied VE & R

REFERRING VET

Dr. Leah Richter

INVOICE

37269

DATE

5/28/26

PRESENTING CLINICAL SIGNS

History: 5/19 a 5ish day hx diarrhea and 1 episode vomiting. Diarrhea- large volume, very liquid, mucous-ey, occasional stick fragments (5/14). Treated with OP supportive care (SQF, cerenia, proviable, Hill's Biome) pending BW. Elected to hold on AXR. Blood work unremarkable apart from mildly elevated SDMA. 5/22 PM tried transitioning to normal diet had more diarrhea. 5/23 AM back to bland diet. Ate cat vomit (food material) 5/24, straining and small volume liquid stools. 5/25 AM very soft stool, small amounts diarrhea. 5/26 AM more diarrhea, small amounts of raspberry red blood and jam consistency. Treated OP supportive care, ran fecal testing. Elected to hold on AXR, hold GI panel pending AUS. Giardia SNAP negative, fecal antigen ova and parasites negative. Cortisol baseline above 2. 5/27 AM had 9-10 large, liquid, clear stools, little control over bowels. Drooling copiously, straining with no bowel movements. Perked up with 2nd dose oral cerenia, given one can of Hill's Biome, still notably lethargic. Improved in mentation, little quieter than normal, no bowel movements since 5/27 AM. Gave ~1 cup of white rice and 1 Hill's GI Biome can 6:45am morning. Concern initial sedation from broken toenail (5/11) may contributed to onset diarrhea, received carprofen for broken toenail)

Abnormal PE/Chem/CBC/UA Results: 5/19/26 CBC: WNL Chem: SDMA 17.0 (H), otherwise WNL 4DX Negative x4 5/26/26 Giardia: Negative Fecal ova and parasite antigen panel: Negative Cortisol: >2.

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 ultrasonographic appearance. No calculi or sonographic evidence of inflammatory or neoplastic disease are identified.

The left kidney is normal in shape and size, measuring 5.90 × 3.05 cm. The cortical thickness measures 0.51 cm in the sagittal plane.

The right kidney is normal in shape and size, measuring 5.63 × 3.26 cm. The cortical thickness measures 0.55 cm in the sagittal plane.

The renal cortices are isoechoic relative to the hepatic parenchyma. The corticomedullary ratio is normal, and corticomedullary definition is preserved. No evidence of pyelectasia, nephrolithiasis, or hydronephrosis is identified.

Adrenal Glands

The left adrenal gland measures 0.49 cm at the cranial pole and 0.50 cm at the caudal pole. The right adrenal gland is not confidently visualized.

Spleen

Splenic thickness is 1.65 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver



PATIENT	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.
Penny Olson	
SPECIES	The gallbladder lumen is normally distended. The wall is thin and the contents are primarily anechoic. No evident dilation of the cystic duct or common bile duct is observed.
Canine	
BREED	<i>Gastrointestinal tract</i>
Black Lab	The stomach is mildly distended with ingesta. Gastric wall thickness measures 2.97 mm, with preserved wall layering.
SEX	The duodenal wall measures 3.07 mm.
Spayed Female	The jejunal wall measures 2.63–3.05 mm, with preserved wall layering.
AGE	No evidence of gastrointestinal obstruction, ileus, mural thickening, plication, foreign material, or other significant intestinal abnormality is identified.
3.5 Years	The ascending colonic wall measures 0.70 mm, the transverse colon 0.85 mm, and the descending colon 1.32 mm. Formed fecal material producing distal acoustic shadowing is present throughout the colon.
WEIGHT	<i>Pancreas</i>
25.9 kg	The evaluated pancreatic regions do not show evidence of overt inflammation or neoplastic disease.
INTERPRETED BY	<i>Free Abdomen</i>
Alicia Angosto Guerrero, DMV, PgDip, MSc.	No sonographic evidence of abdominal effusion, peritonitis, or lymphadenomegaly is identified. The iliac trifurcation is normal.
IMAGING PERFORMED BY	PRIMARY FINDINGS
Dr. Leah Richter	<ul style="list-style-type: none">No clinically significant ultrasonographic abnormalities identified.
HOSPITAL NAME	<u>INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS</u>
Allied VE & R	No sonographic evidence of gastrointestinal obstruction, foreign material, intussusception, pancreatitis, focal gastrointestinal mass lesion, significant enterocolitis, abdominal lymphadenopathy, or other clinically significant abdominal abnormality is identified.
REFERRING VET	Despite the absence of significant ultrasonographic abnormalities, the reported history of acute severe diarrhea, hematochezia, mucus production, tenesmus, and frequent small-volume bowel movements remains most compatible with an acute large bowel inflammatory process. Acute dietary indiscretion, transient infectious enterocolitis, acute colitis, typhlocolitis, or self-limiting inflammatory gastrointestinal disease remain reasonable clinical considerations despite the lack of specific ultrasonographic changes.
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DATE	Recommendations:
5/28/26	The absence of significant ultrasonographic abnormalities does not exclude clinically important inflammatory, infectious, or functional gastrointestinal disease. Given the severity and persistence of



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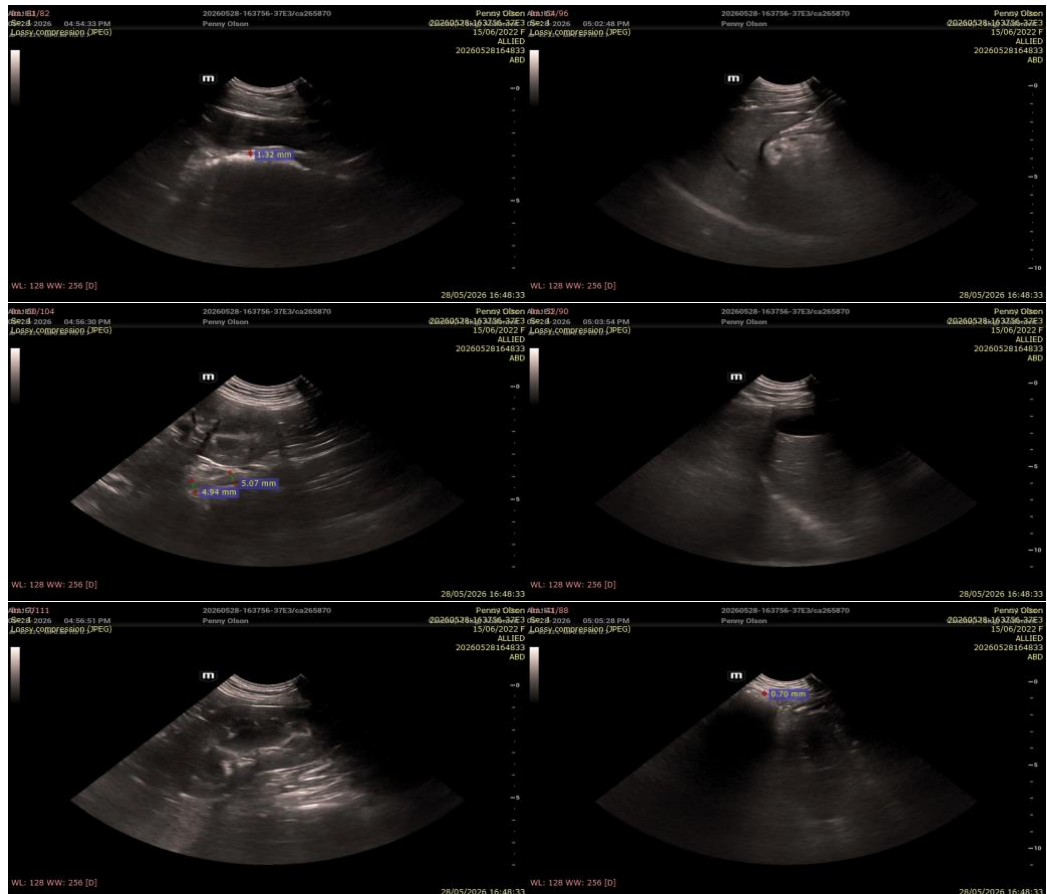
DATE

5/28/26

the clinical signs, further gastrointestinal investigation is warranted:

- Given the negative fecal screening results, additional fecal PCR testing may be considered if clinical signs fail to improve as expected or if concern for infectious enterocolitis persists.
- Continued gastrointestinal dietary management and probiotic therapy are recommended, as acute inflammatory colonic disease may require time for complete mucosal recovery and normalization of bowel function.
- Consideration of soluble fiber supplementation may be beneficial while colonic mucosal recovery.
- Empiric fenbendazole therapy may be considered despite negative fecal testing, depending on regional parasite prevalence and clinical suspicion.
- Additional microbiome-directed or anti-inflammatory gastrointestinal therapies may be considered if clinical signs persist despite current management.
- Fecal microbiota transplantation may be considered in refractory cases where intestinal dysbiosis remains a concern.
- If clinical signs persist, colonoscopy and/or intestinal biopsy may be considered.

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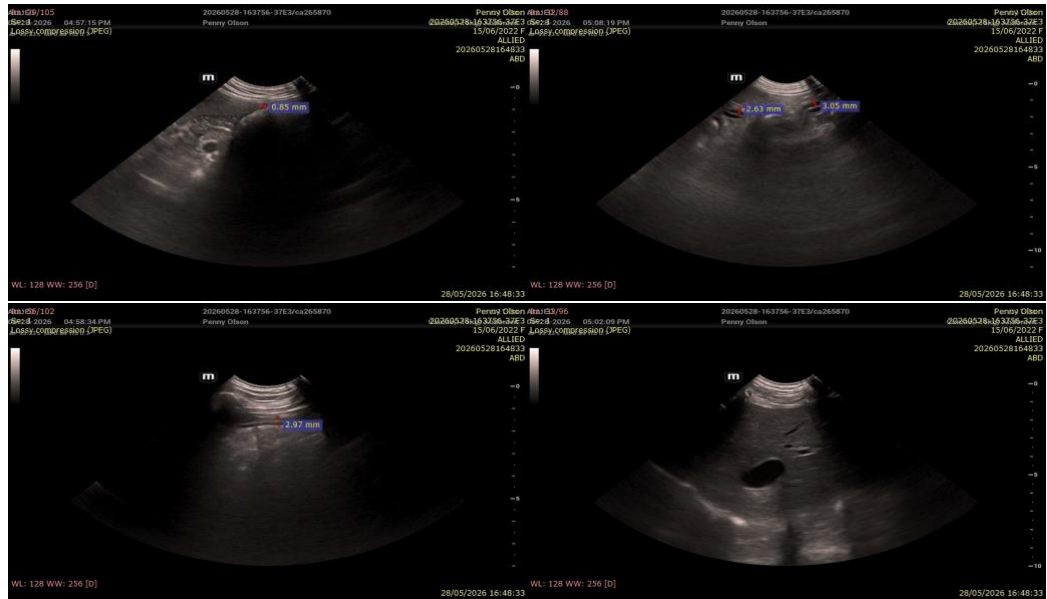
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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