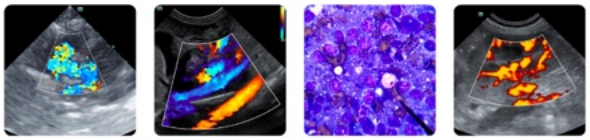


PATIENT

Lady McGinnis

SPECIES

Canine

BREED

Chihuahua

SEX

Spayed female

AGE

8 years

WEIGHT

14 lbs

INTERPRETED BY

Alicia Angosto Guerrero, DMV, PgDip, MSc.

IMAGING PERFORMED BY

Brandon

HOSPITAL NAME

Dillsburg VC

REFERRING VET

Dr. Pryor

INVOICE

78114

DATE

5/29/26

PRESENTING CLINICAL SIGNS

History: Lady has had chronic vomiting and has recently become pu/pd with inappropriate urination. Urinalysis via cysto is pending at Antech. She was started on Metoclopramide, Sucralfate, Cerenia, and Famotidine on 5/28. An echo was recently performed on Lady due to superventricular arrhythmia and showed normal cardiac structure/function.
Abnormal PE/Chem/CBC/UA Results: labs WNL and echo WNL. Urinalysis via cysto pending.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder lumen is moderately 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. There are no calculi and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size: 4.41x2.29 cm, and the thickness of the cortex is 0.35 cm, in the sagittal plane. The right kidney is normal in shape and size: 4.51x2.39 cm, and the thickness of the cortex is 0.40 cm, in the sagittal plane. Both renal cortices are isoechoic compared to the liver parenchyma. The corticomedullary ratio is normal and corticomedullary definition is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis.

Adrenal Glands

The left adrenal gland measures 0.49 cm at the cranial pole and 0.42 cm at the caudal pole in dorsoventral diameters of the sagittal plane. The right adrenal gland not confidently visualized.

Spleen

Splenic thickness is 1.15 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

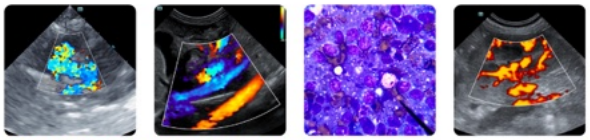
Liver

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 contain a moderate amount of biliary sludge. No evident dilation of the cystic duct or common bile duct is observed.

Gastrointestinal tract

The stomach is distended with ingesta, with mural thickness (3.20 mm) and preserved wall layering. The pylorus (5.09 mm). Duodenum: 2.88 mm. Jejunum: 3.18 mm. Within both the stomach and the partially



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corrugated duodenum, linear foreign material measuring approximately 2.0–2.5 cm in length is identified. These structures may represent plant fibers, sticks, grass, or other ingested fibrous material and should be correlated with the clinical history. Colon: 1.09 mm, with formed feces in the descending segment.

Pancreas

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

Free Abdomen

No abdominal effusion or peritonitis is observed. A gastric lymph node measures 0.48x0.73 cm and is rounded and hypoechoic in appearance. The cranial mesenteric lymph nodes are not visualized, although the surrounding mesentery appears unremarkable. The iliac trifurcation is normal.

PRIMARY FINDINGS

- Subjective diffuse gastric wall thickening.
- Mild duodenal corrugation.
- Linear intraluminal foreign material within the stomach and duodenum, favored to represent ingested plant material or other fibrous debris.

SECONDARY FINDINGS

- Moderate biliary sludge.
- Mild enlargement and rounding of a gastric lymph node.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Subjective diffuse gastric wall thickening is suspected, predominantly involving the mucosal and submucosal layers, although mural layering remains preserved. In conjunction with the mildly enlarged gastric lymph node, partial duodenal corrugation, and history of chronic vomiting, these findings support mild chronic inflammatory gastroduodenal disease. Differential considerations include chronic gastritis, dietary intolerance, food-responsive enteropathy, and early inflammatory enteropathy.
The linear intraluminal material identified within the stomach and proximal duodenum is favored to represent ingested plant or fibrous material. Correlation with the patient's ingestion habits is recommended, as this finding may be either a consequence of underlying gastrointestinal disease and nausea or a contributing factor to chronic gastric irritation.

No sonographic explanation for the recently reported PU/PD is identified. The kidneys are structurally normal, the visualized left adrenal gland is within normal limits, and there are no ultrasonographic findings suggestive of hyperadrenocorticism or steroid hepatopathy. The clinical significance of the reported PU/PD remains uncertain pending urinalysis results, as a urine concentrating abnormality has not yet been documented.

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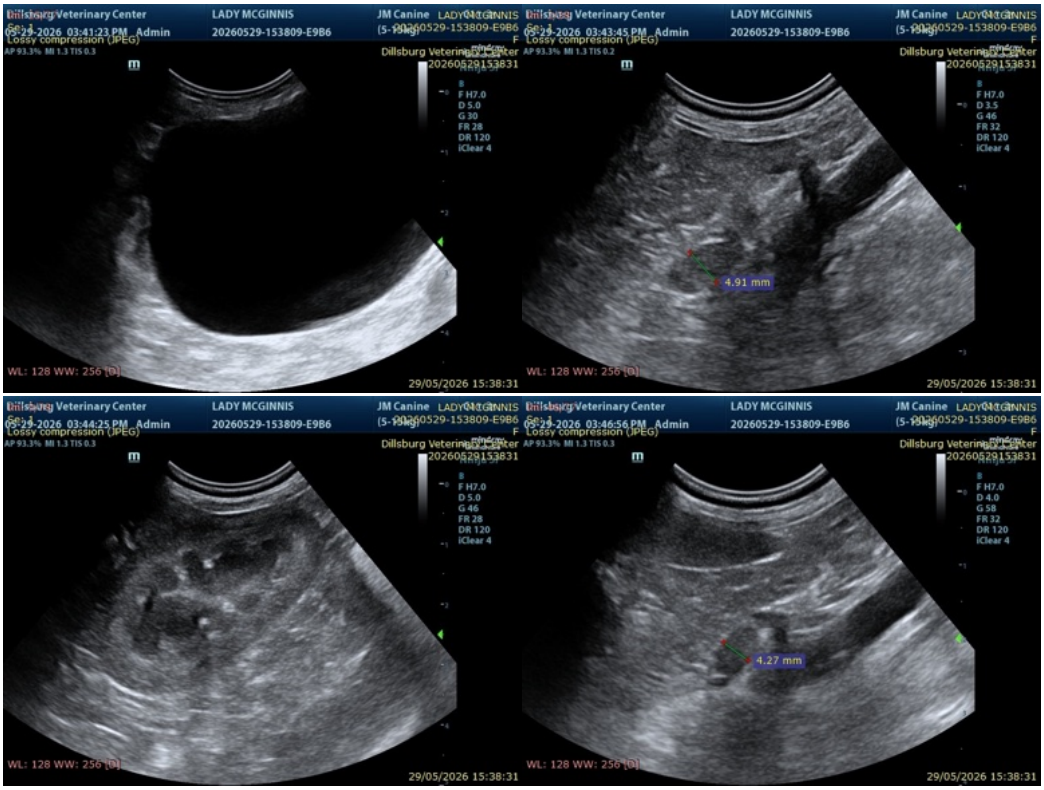
Recommendations

- Correlation with the pending urinalysis results is recommended before pursuing further investigation of the reported PU/PD.
- Measurement of daily water consumption is recommended to objectively quantify the reported polyuria/polydipsia.
- A strict dietary trial using a highly digestible, hydrolyzed, or novel protein diet may be considered if not previously performed.
- Correlation with the patient's ingestion habits is recommended. If the ingestion of grass, plants, sticks, or other fibrous material is suspected to be secondary to chronic nausea, optimization of antiemetic, gastroprotective, and dietary management may help reduce this behavior.
- If vomiting persists despite appropriate medical and dietary management, further investigation of chronic gastrointestinal disease may be considered, including serum cobalamin and folate concentrations, or endoscopic evaluation with gastric biopsies.
- Although hypoadrenocorticism is considered less likely based on the current ultrasonographic findings, resting cortisol screening may be considered if clinical suspicion persists.

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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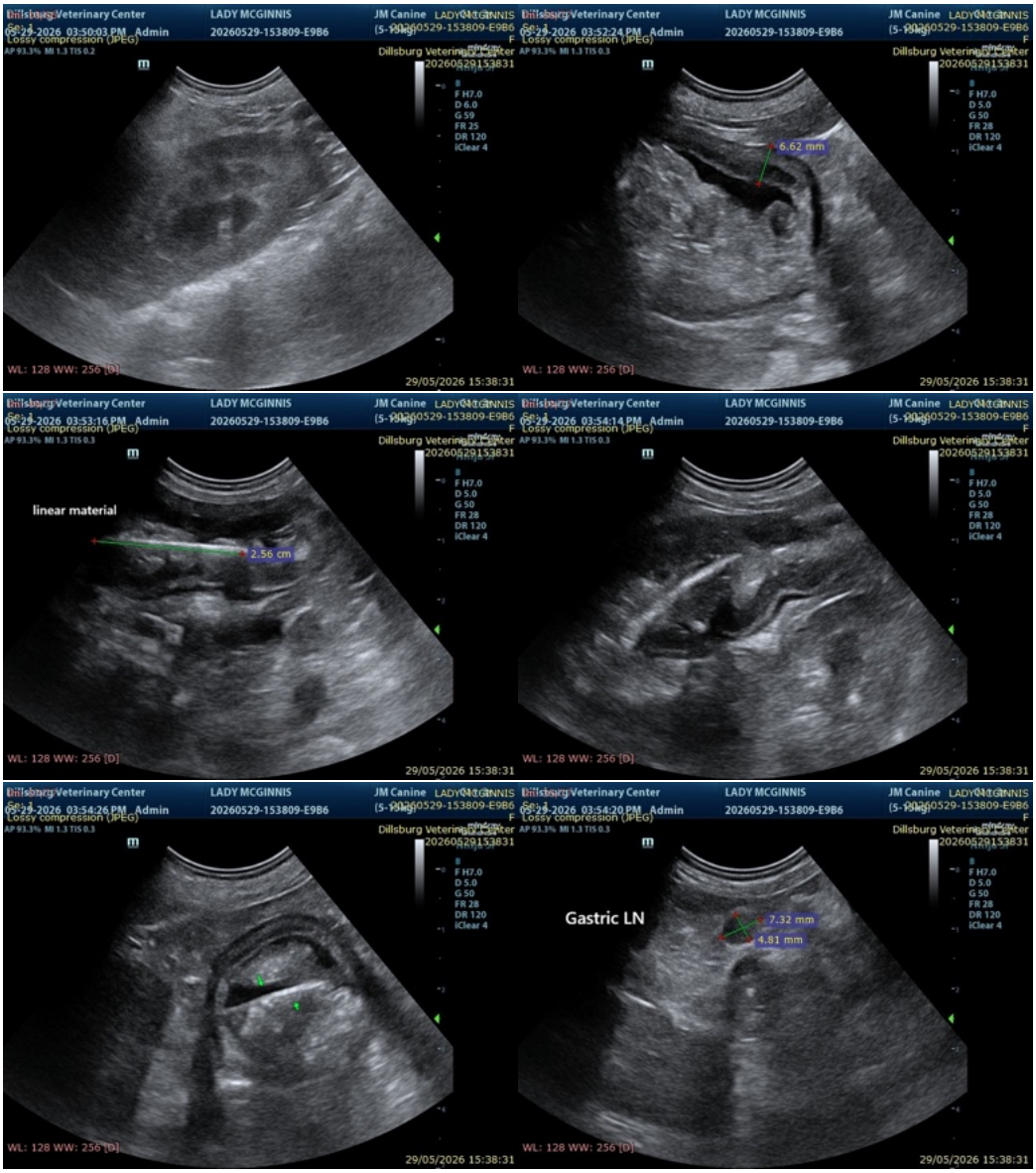

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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