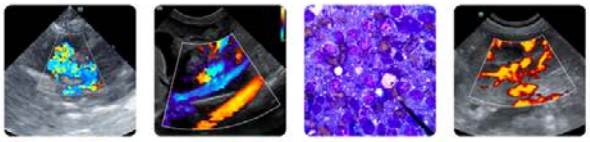


PATIENT

Atlis Finlay

SPECIES

Canine

BREED

Labrador

SEX

Neutered Male

AGE

5 Years

WEIGHT

49 kg

INTERPRETED BY

Brad Harris, DVM, DACVECC, DACVIM (cardiology)

IMAGING PERFORMED BY

Brittany Schneider, DVM

HOSPITAL NAME

Wilvet Salem

REFERRING VET

Brittany Schneider, DVM

INVOICE

72455

DATE

1/25/26

PRESENTING CLINICAL SIGNS

P has been vomiting off and on over the past few months. a few times a week for 2 months. Today o said p was drooling and had vomited 5 times only liquid no food. 1 pile of food. Was eating and drinking today but will vomit it right back up. Did have diarrhea in the house a few days ago but unsure if he is still having it. He seemed lethargic today. No change in food, no toxins/plants. Went to pDVM about 1-1.5 months ago due to vomiting. Switched up when he was fed and started a anti-acid, did seem to help but today was excessive for him. No Xrays or BW performed

CBC: HCT 61.8 WBC 18.60 neuts 17.08 plts 205. Chem 17: wnl. EPOC: HCT 56 gluc 125 lytes wnl PH 7.466. Cpli: 31- wnl

Abnormal PE/Chem/CBC/UA Results: Radiograph results. There is a small amount of heterogenous material present in the stomach. Radiographic differentials include ingesta versus foreign non-digestible material which often cannot be differentiated radiographically. There is no evidence of obstruction the small intestine, therefore as well as the above gastric differentials, consider any the various causes of nonspecific gastroenteropathy such as; dietary discretion, pancreatitis, infectious or inflammatory bowel disease, multiple other systemic differentials. Atypical gas accumulation in the mid right abdomen. Consider full abdominal ultrasound for a more definitive parenchymal assessment.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and pelvic urethra are unremarkable with normal wall thicknesses and normal tone. The ureters were not visualized, which is a normal finding. There are no uroliths or sediment noted, and anechoic urine is present. The ureteral papillae appear normal. There is no evidence of inflammatory, infiltrative, or neoplastic disease.

The kidneys are normal in size and structure, with appropriate corticomedullary definition and cortex to medulla ratio. The cortices are uniform in texture with normal echogenic relationship to liver and spleen. The medullary structure differed distinctly from the cortex and no evidence of pyelectasis is present. The capsules are uniform without significant irregularities noted. Left kidney measures 6.3 cm. Right kidney measures 7.9 cm.

Adrenal Glands

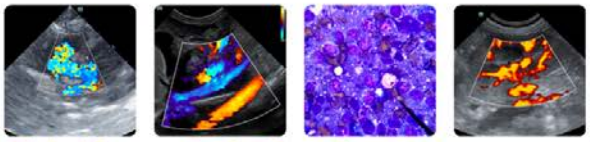
The adrenal glands are not visualized.

Spleen

The spleen measures 2.2 cm at the hilus. It is smooth with homogeneous parenchyma and hyperechoic to liver and renal cortical parenchyma. The capsule is without noticeable irregularity or deformation. The splenic vasculature is normal without signs of congestion, spontaneous echo contrast, or thrombosis. No evidence of acute or chronic inflammatory, neoplastic, or infarct are documented.

Liver

The liver is subjectively normal liver size, contour, and structure. Parenchymal echogenicity is naturally coarse and hypoechoic to the spleen. Vasculature is within normal limits with no evidence of congestion. The gallbladder has thin walls which contain anechoic bile. There is no evidence of intra- or extra-hepatic biliary dilation. The cystic and common bile ducts were normal. No hepatic lymphadenopathy is



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documented. There is no overt structural evidence of inflammatory, infiltrative or regenerative pathology evident.

Gastrointestinal

The stomach is moderately distended with echogenic fluid as well as hyperechoic shadowing contents. The pylorus and pyloroduodenal junction are not visualized. The small intestine has multiple loops that are moderately distended with echogenic fluid and a to-fro motion consistent with ileus. There are multiple loops that contained hyperechoic shadowing material, concerning for potential foreign body. An overt mechanical obstruction is not discretely visualized. However, given the appearance of the gastrointestinal tract, an occult obstruction is of concern at this time. The colon contains normal shadowing feces. The gastrointestinal walls are normal in thickness with maintenance of normal wall layering.

Pancreas

The base and limbs of the pancreas are isoechoic to surrounding omental fat. The pancreatic duct and capsular contour are normal. There is no overt evidence of active inflammatory or neoplastic disease.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Moderate gastric dilation with echogenic fluid and shadowing gastric contents.
- Multiple loops of small intestinal dilation with echogenic fluid and mild to moderate ileus.
- Hyperechoic shadowing small intestinal material that is not overtly obstructive. However, given the appearance of the small intestinal tract, an occult mechanical obstruction is of concern.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the ileus and dilation of the small intestinal tract. consider an exploratory laparotomy with potential enterotomy if foreign material is detected. The potential for a negative explore should also be discussed with the owners, and if this is the case, gastrointestinal biopsies should be obtained for histopathology, given the patient's chronic lower gastrointestinal signs. Alternatively, hospitalization with supportive care and serial imaging could be considered to monitor for progressive ileus and the presence of a mechanical obstruction. Also consider a spec cPLI to evaluate for potential occult pancreatitis as an underlying cause of the acute clinical signs.

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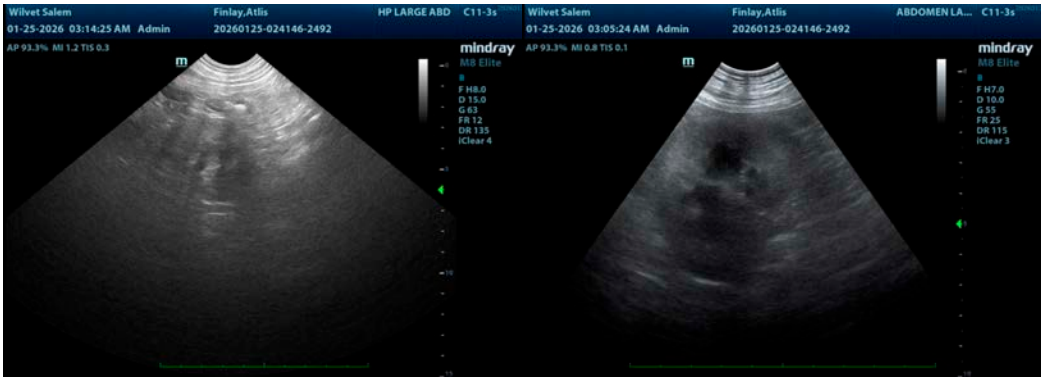

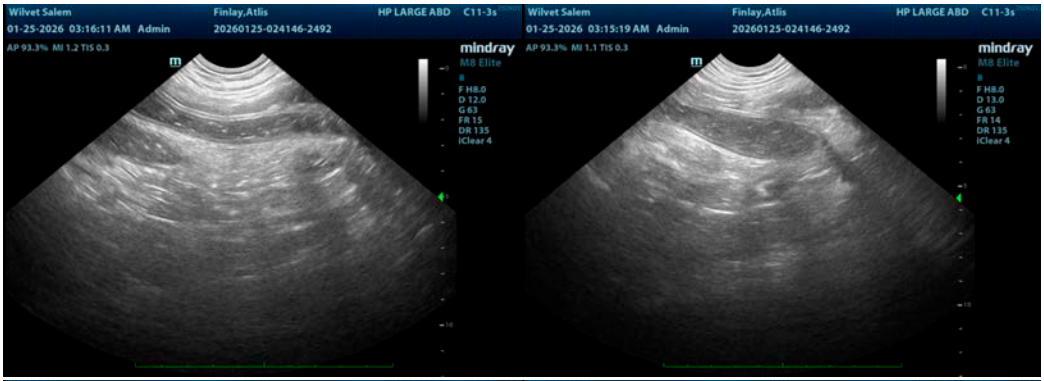

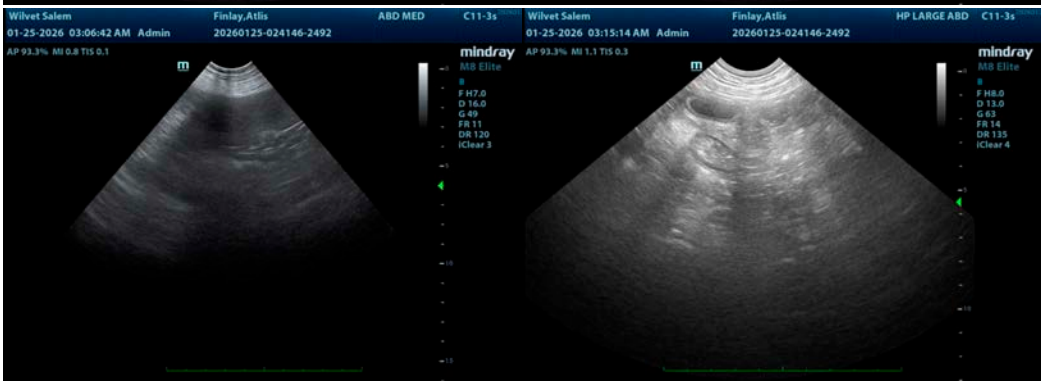

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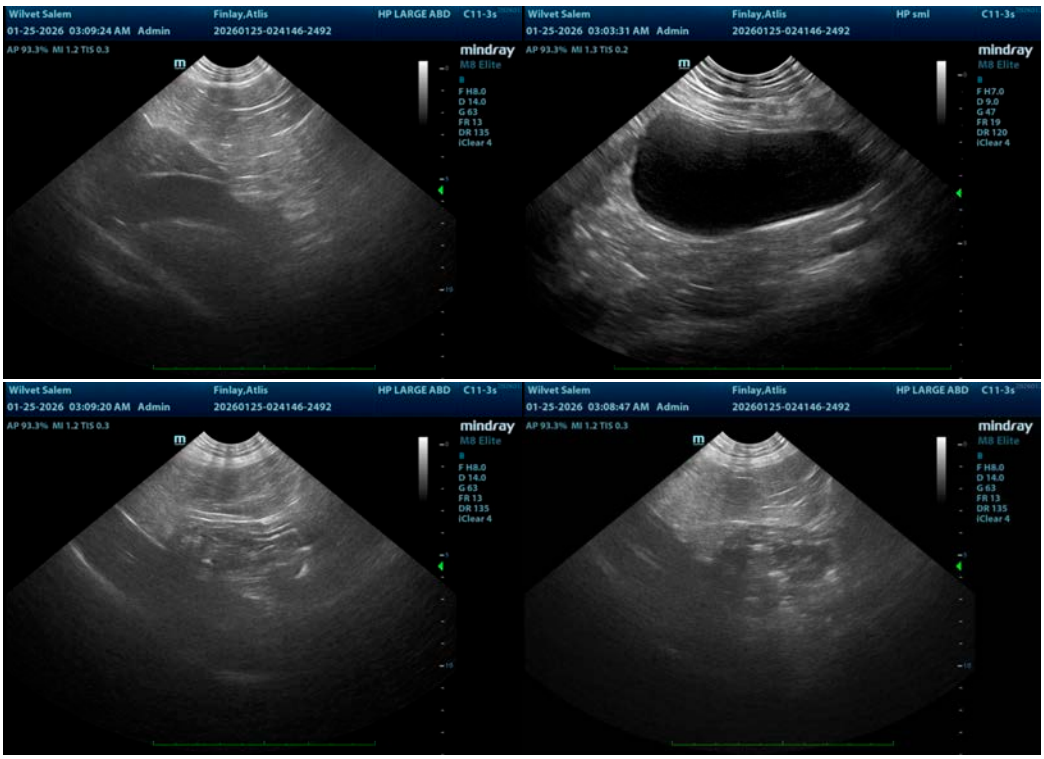

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Brad Harris, DVM, DACVECC, DACVIM (cardiology)

info@SonoPath.com