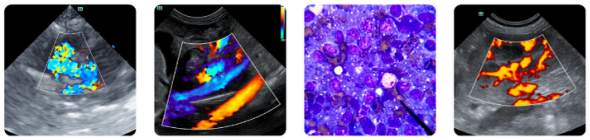


PATIENT

Diesel Yarborough

SPECIES

Canine

BREED

American Bully

SEX

Male

AGE

1 year 7 months

WEIGHT

56.5

INTERPRETED BY

Bradley Harris, DVM, DACVECC, DACVIM (cardiology)

IMAGING PERFORMED BY

Dr. Celia Grant

HOSPITAL NAME

Craig Road Animal Hospital

REFERRING VET

Dr. James Quintana

INVOICE

11203

DATE

1/30/2026

PRESENTING CLINICAL SIGNS

- Presented for 1.5 day history of anorexia, vomiting and inappetence. No recent travel history. Not current on vaccines. Approximately 5-7% dehydration, non-painful on abdominal palpation. Only one testicle descended. Dull mentation on presentation, regurging bile.

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 prostate is minimally enlarged with smooth and symmetrical capsular margins. The parenchyma is of appropriate echogenicity with no significant irregularities. The prostatic urethra appears patent with no evidence of urethral obstruction.

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 6.11 cm, and the right kidney measures 5.60 cm.

Adrenal Glands

Both adrenal glands are visualized and have normal shape, size, position and echogenicity for this breed. The phrenic vasculature, glandular echogenicity and detail were unremarkable. Capsule, cortex, and medullary definition were normal for this age patient. Left adrenal gland measures 0.6 cm x 2.3 cm. The right adrenal measures 0.66 cm x 2.6 cm.

Spleen

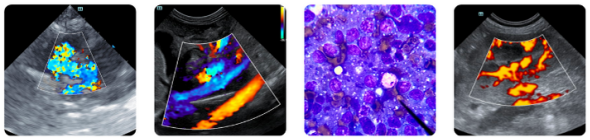
The spleen is smooth with homogeneous parenchyma and hyperechoic to liver and renal cortical parenchyma. The capsule is without noticeable irregularity or deformation. The splenic vasculature is normal without signs of congestion, spontaneous echo contrast, or thrombosis. No evidence of acute or chronic inflammatory, neoplastic, or infarct are documented. The spleen measures 1.43 cm at the hilus.

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 is mild to moderately distended with minimally echogenic bile and suspended echogenic debris. The cystic duct is mildly distended with no overt intra- or extra-hepatic biliary dilation. The common bile duct is not discretely visualized.

Gastrointestinal



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The stomach is moderately distended with echogenic fluid and hyperechoic marginally shadowing ingesta. The pylorus and pyloroduodenal junction appear patent with no evidence of obstruction. Small intestine is multifocally distended with echogenic luminal contents. There is no discrete shadowing foreign material or evidence for mechanical small intestinal obstruction. Ileocecal colic junction is patent, and the colon contains normal shadowing feces.

Pancreas

The pancreas is prominent and hypoechoic with irregular margins and mixed hyper- and hypoechoic nodular changes. The pancreatic duct appears normal.

Free Abdomen

There are several prominent mesenteric and jejunal lymph nodes with normal length to width ratio and isoechoic parenchymal detail. There's a mild volume of anechoic free peritoneal effusion noted.

ULTRASONOGRAPHIC FINDINGS

- There are areas of minor gastrointestinal luminal fluid noted with echogenic contents and a to-fro motion consistent with ileus. There was no evidence of an obstructive pattern, and normal wall thickness and layering is retained throughout the gastrointestinal tract. This is a consistent response to irritation or inflammation. Gastroenteritis or pancreatitis should be considered.
- The prominent, hypoechoic pancreas with an irregular contour and mixed ill-defined hyper and hypoechoic changes is most consistent with pancreatic remodeling and nodular hyperplasia. This may be secondary to active or acute-on chronic inflammatory disease or pancreatitis.
- The slightly prominent mesenteric and jejunal lymph nodes display no loss of parenchymal detail or change in echogenicity. This is most consistent with reactive lymphadenitis or lymphatic hyperplasia.
- The free peritoneal effusion is suspected to be secondary to pancreatitis or some other occult source of peritonitis.
- The absence of a definitive mechanical small intestinal obstruction does not completely rule out the possibility of an occult mechanical obstruction despite significant small intestinal dilation.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A cPLI is recommended to further evaluate the pancreas for potential active inflammation or pancreatitis.

Consider an abdominocentesis with fluid analysis and evaluation of electrolytes, total bilirubin, and creatinine as well as cytology.

Abdominal radiographs are also recommended to further evaluate the gastrointestinal tract for evidence of potential occult mechanical obstruction. Pending results of additional diagnostics, hospitalization with supportive care and supplemental enteral feeding is indicated. Consider nasogastric tube placement for removal of gastric fluid to help stimulate gastric motility and reduce risk of aspiration.

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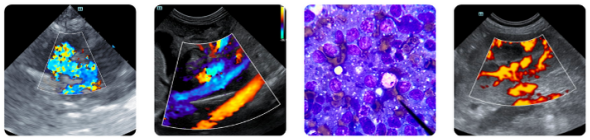

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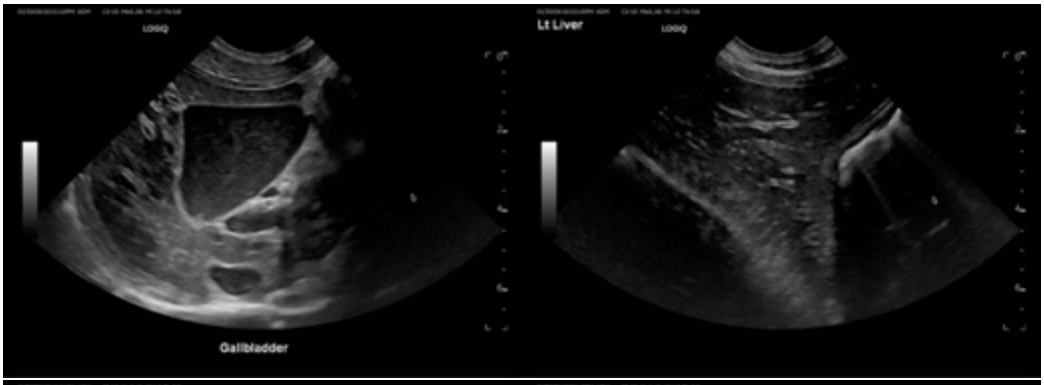

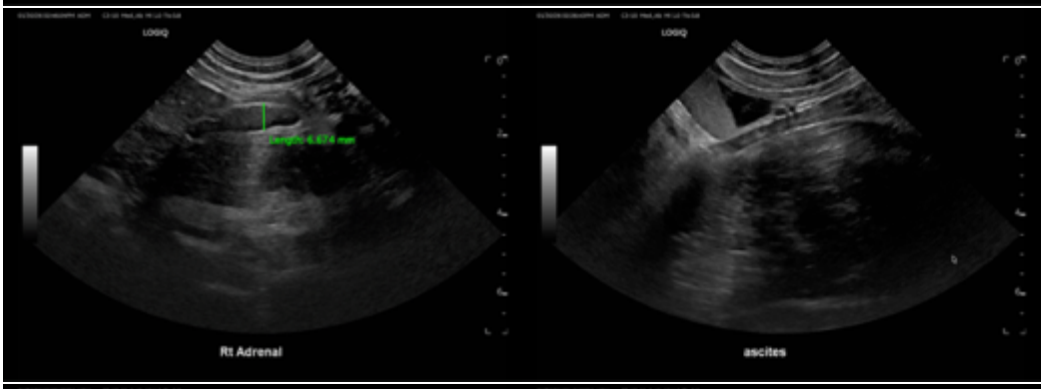

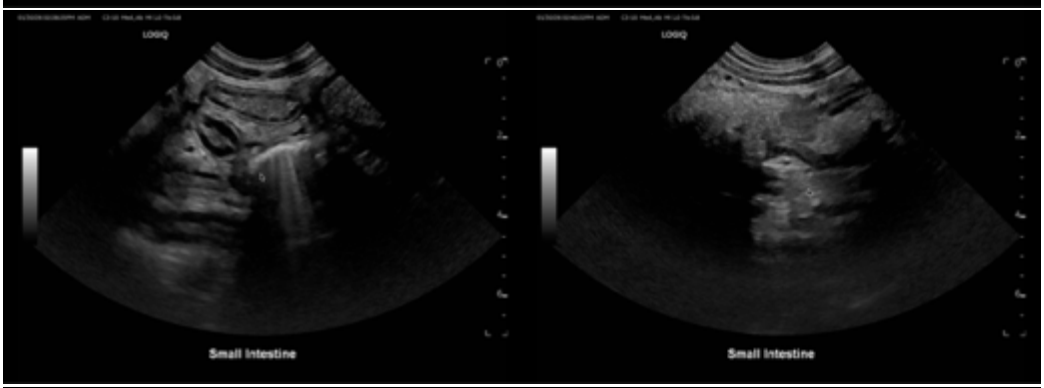

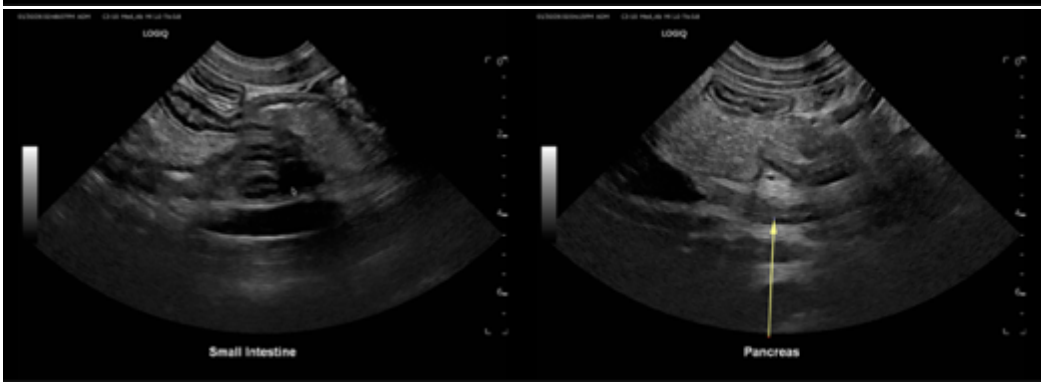

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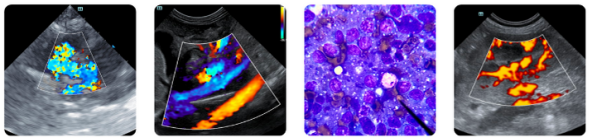

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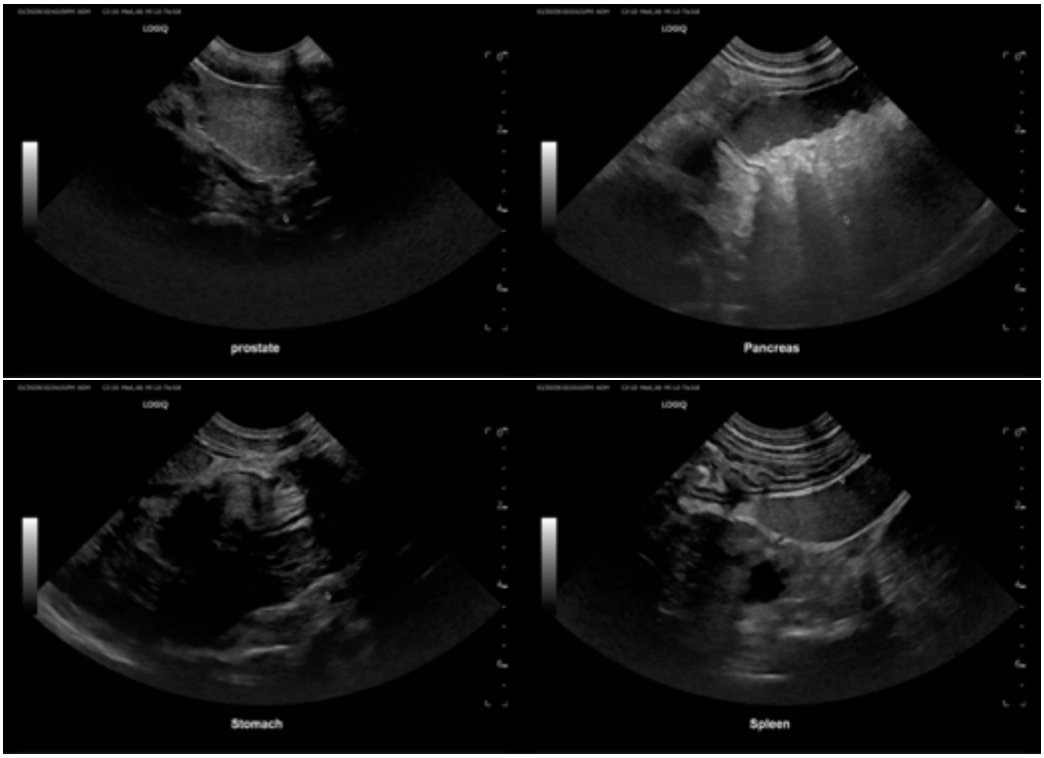

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Bradley Harris, DVM, DACVECC, DACVIM (cardiology)

info@SonoPath.com