



PATIENT

Ritz Diller

SPECIES

Canine

BREED

Retriever mix

SEX

Neutered male

AGE

4 years

WEIGHT

30 lbs

INTERPRETED BY

Bradley Harris, DVM,
DACVECC, DACVIM
(cardiology)

IMAGING PERFORMED BY

Dr. Mariusz
Chmielinski, DVM

HOSPITAL NAME

Apex Veterinary
Services Ltd.

REFERRING VET

SAVE Emergency/ER
Doctor

INVOICE

75300

DATE

5/12/26

PRESENTING CLINICAL SIGNS

History: Presented for investigation of chronic gastrointestinal disease characterized by intermittent vomiting, historical mucousy diarrhea, and weight loss beginning in fall of previous year. Diarrhea resolved after transition to hydrolyzed diet; however, vomiting persists intermittently despite dietary management. Vomiting occurs both post-prandially and on an empty stomach (clear bile), with one reported episode of pink-tinged vomitus.

Previous history includes Giardia infection as a puppy and prior low albuminemia (recently normalized). Addison's disease testing reportedly negative in October. Current medications include omeprazole, sucralfate, and B12 supplementation. Patient is a known scavenger when off leash and travels extensively in an RV environment including BC and Arizona.

BAR, adequately hydrated. Mild stress/panting during examination. No abdominal pain, mass effect, or organomegaly appreciated. Cardiovascular and respiratory examinations unremarkable. No peripheral lymphadenopathy noted.

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 pyelectasia is present. The capsules are uniform without significant irregularities noted. The left kidney measured 7.11 cm. The right kidney measured 6.11 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. The left adrenal gland measured 0.65 x 3.3 cm. The right adrenal gland measured 0.5 x 1.3 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 measured 1.77 cm at the hilus.



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

Gastrointestinal

The stomach is markedly distended with gas and echogenic luminal contents. The pylorus and pyloroduodenal junction appear patent. The small intestine is multi-focally minimally distended with a mild amount of gas and echogenic luminal contents. The small intestinal wall measure within normal limits for thickness. The duodenal wall has a prominent or thickened or muscularis layer that distorts the normal 1:3 muscularis to mucosa ratio. There are also similar regions of small intestine with a prominent muscularis, but less overt than the duodenum. The ileocecolic junction was patent and the colon contains normal shadowing feces.

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

There are severe prominent jejunal lymph nodes with normal length to width ratio. The parenchyma is isoechoic.

There is no significant free peritoneal effusion noted.

ULTRASONOGRAPHIC FINDINGS

- The intestinal submucosa is slightly irregular, thickened and hyperechoic suggestive of low grade, chronic disease. There is mild uniform prominence of the gastric mucosa as well as areas of "ropey" small intestinal wall with slight disruption of the normal 1:3 muscularis/mucosal ratio. This is most consistent with chronic enteropathy. No concerning lymphadenopathy or evidence of mechanical obstruction is present. Chronic inflammatory bowel disease is likely with a low possibility of an early neoplastic event such as lymphoma.
- The slightly prominent jejunal lymph nodes display no loss of parenchymal detail or change in echogenicity. This is most consistent with reactive lymphadenitis or lymphatic hyperplasia.



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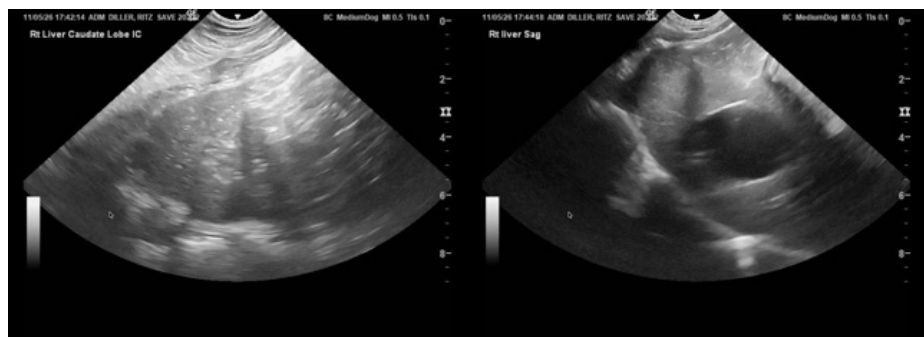
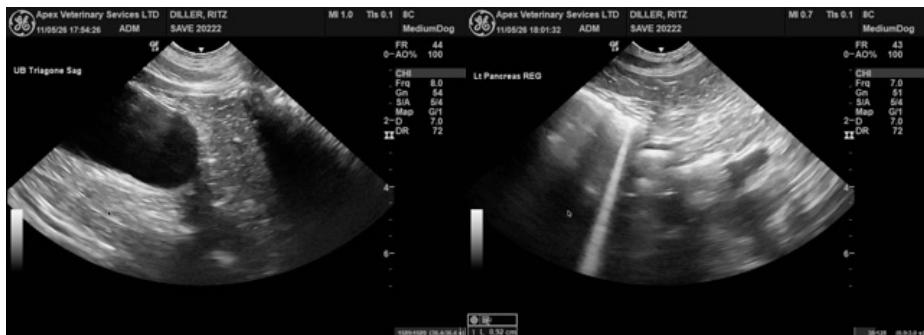
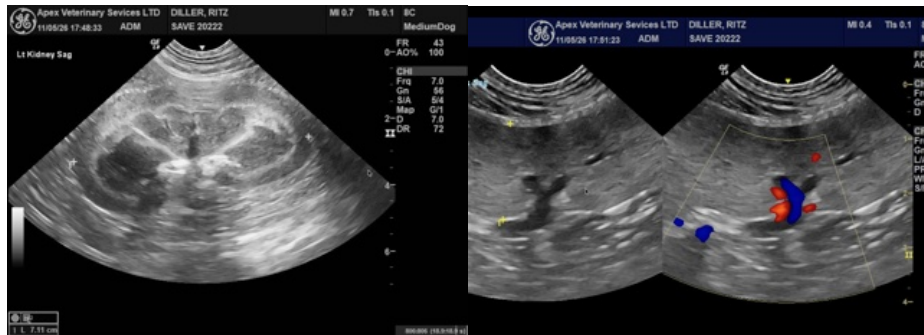
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A gastrointestinal panel (TLI, PLI, B12, folate) via Texas A&M gastrointestinal laboratory is indicated to further evaluate for potential chronic enteropathy. Ultimately, gastrointestinal biopsies may be required for a definitive diagnosis.

Continued supportive care is recommended pending results of the additional diagnostics.





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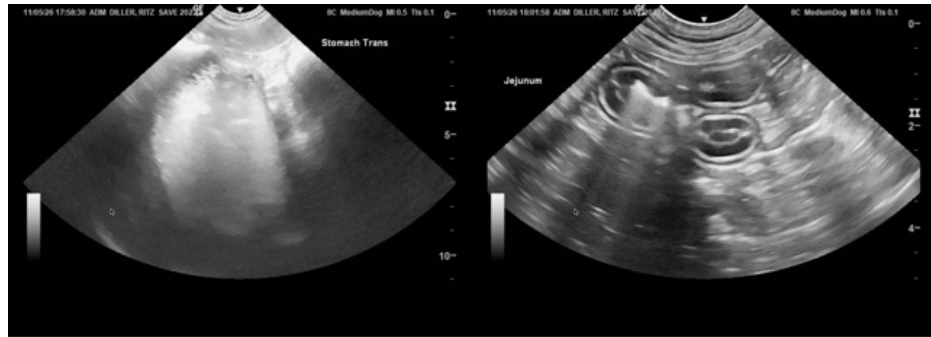
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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