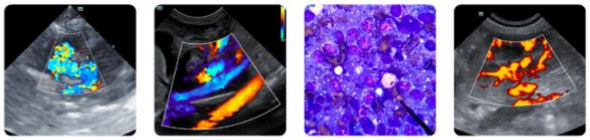


PATIENT

Cooper Buckman

SPECIES

Canine

BREED

Poodle Mix

SEX

Neutered Male

AGE

4 Years

WEIGHT

4.9 kg

INTERPRETED BY

Bradley Harris, DVM, DACVECC, DACVIM (cardiology)

IMAGING PERFORMED BY

Dr. Mariusz Chmielinski DVM

HOSPITAL NAME

Apex Veterinary Services LTD

REFERRING VET

Alpine 24/7 ER Doctor

INVOICE

16013

DATE

05/09/26

PRESENTING CLINICAL SIGNS

4-year-old MN Cavalier King Charles Spaniel mix, 5.0 kg, presented for progressive vomiting of approximately 2–3 weeks duration, initially occurring only in the mornings as clear bile, now progressing to vomiting throughout the day. Appetite reduced in mornings with intermittent anorexia; owner reports persistent grass ingestion. Normal bowel movements reported. Initially managed medically for suspected reflux/GERD with famotidine and sucralfate without improvement. Presented to referral hospital May 9, 2026 for further investigation. On presentation: mildly tacky mucous membranes (~5% dehydrated), QAR, mild cranial abdominal discomfort on palpation (first and second quadrants). No diarrhea. Weight loss of approximately 200 g over 3 weeks

Abnormal PE/Chem/CBC/UA Results: Recent CBC/Chemistry largely unremarkable. Mildly concentrated urine previously noted with trace bilirubin/proteinuria. Baseline cortisol and ACTH stimulation testing performed to rule out hypoadrenocorticism; results within normal limits making Addison's disease unlikely. Abdominal radiographs and barium study performed May 8, 2026. Initial radiographs demonstrated gas accumulation within portions of the small intestine; obstruction could not be ruled out. Barium transit reportedly progressed through the GI tract appropriately; however concern remained for an abnormality within the stomach and possible gastric foreign material/partial obstruction

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic urine. The 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. 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. The left kidney measures 3.72 cm. The right kidney measures 4.16 cm.

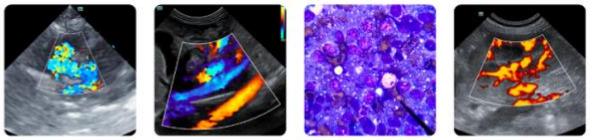
Adrenal Glands

The adrenals are slightly thinned and flattened with an isoechoic parenchymal echotexture. The phrenic vasculature is normal. The left adrenal gland measures 0.3 cm x 1.3 cm. The right adrenal gland measures 0.30 cm x 0.77 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 0.99 cm at the hilus.

Liver



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

Gastrointestinal

The stomach is moderately to markedly distended with mixed gas and fluid contents. The visual portions of the pylorus and pyloroduodenal junction appear patent, however a partial or occult pyloric outflow obstruction can't be excluded given the degree of gas accumulation and dilation within the stomach.

The small intestine is multifocally distended with echogenic luminal contents. There's no significant shadowing foreign material or evidence for small intestinal mechanical obstruction identified. The ICJ is patent, and the colon contains normal shadowing feces.

Pancreas

The pancreas is slightly prominent and mildly remodeled with no evidence of regional hyperechoic mesentery or omental fat.

Free Abdomen

There are several mildly prominent sublumbar lymph nodes with normal length-to-width ratios and isoechoic parenchyma. No significant free perineal effusion is noted.

ULTRASONOGRAPHIC FINDINGS

- Both adrenal glands are flattened and isoechoic. This may be normal for this patient or potentially secondary to hypoadrenocorticism or adrenal burnout from chronic disease.
- There's no overt evidence of a pyloric outflow obstruction noted in this study, however a partial or intermittent obstruction can't be definitively excluded given the degree of gas dilation within the gastric lumen.
- The changes to the pancreas indicate likely previous or historic pancreatitis given the lack of evidence for active regional inflammation, however an early or occult pancreatic inflammation can't be completely excluded.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Symptomatic or supportive care as clinically indicated is recommended given the previously performed additional diagnostics. If clinical signs do not resolve, consider a gastroscopy to further evaluate the gastric lumen for potential foreign material and partial obstruction.

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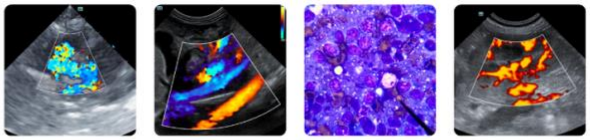

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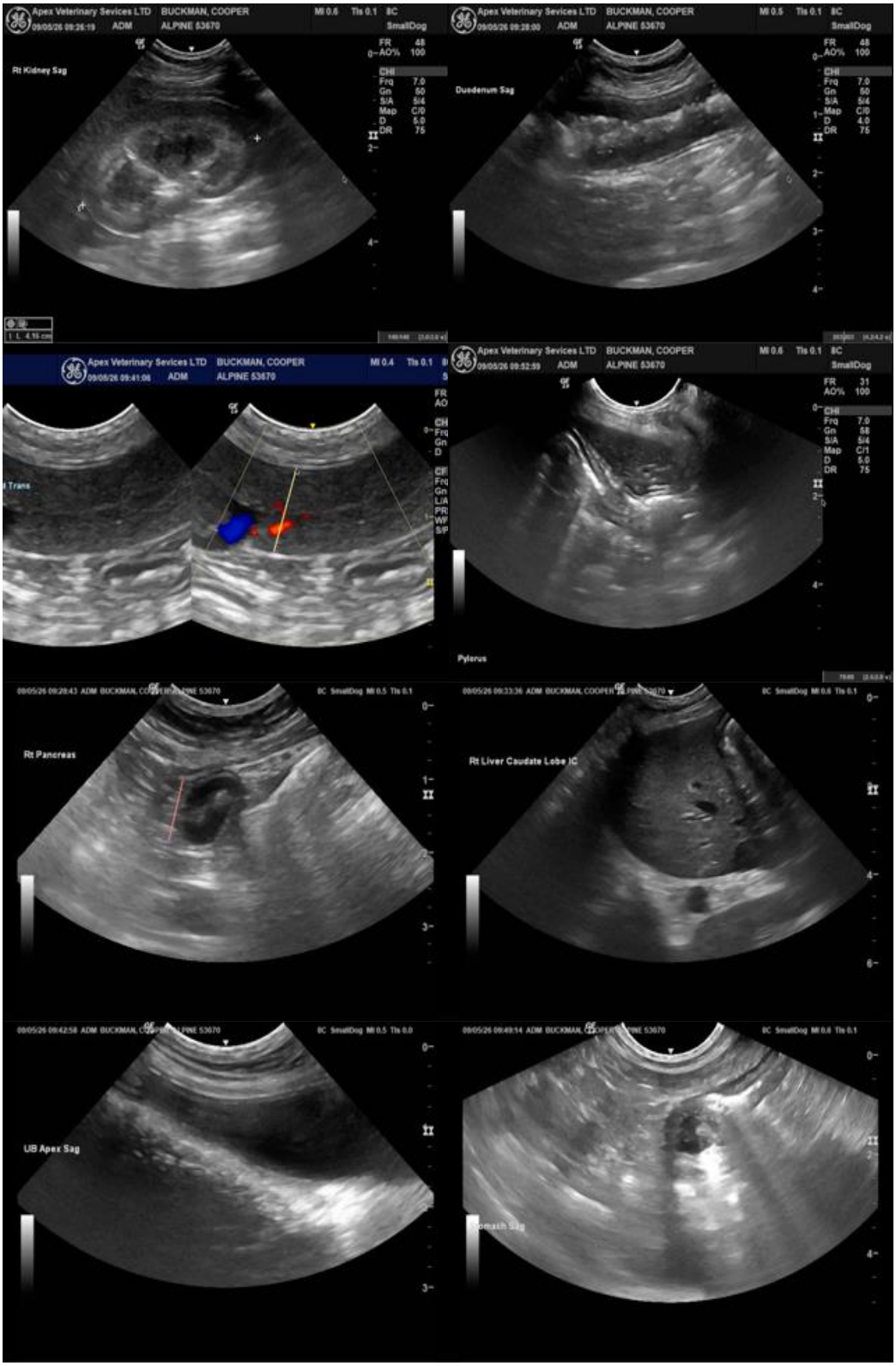

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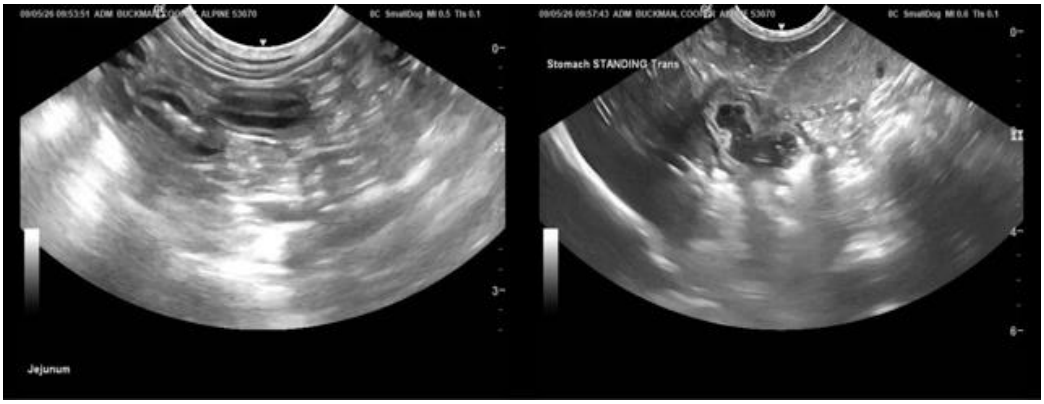

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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