PATIENT

Cider Chaz

SPECIES

Canine

BREED

Pitbull

SEX

MN

AGE

9 years

WEIGHT

16.6 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Roundhill Animal Hospital

REFERRING VET

Dr. Carl Kelly

INVOICE

11698

DATE

4/13/2026

PRESENTING CLINICAL SIGNS

Abdominal. Sedated with 1.5 cc dolorex/10mg xylazine. Emesis 2-3 times a week for the past several months. Appetite and energy levels are normal. Vomit is usually bile but will occasionally vomit after eating. Owner reports unexplainable "whining" as a new behavior. Had diarrhea in early February for about a week, has resolved since then. Bloodwork from Alpine Animal Hospital sent.

Abnormal PE/Chem/CBC/UA Results: LABS attached.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is only mildly distended (empty). Visible contents are anechoic. Urinary bladder wall is unable to be fully assessed for pathology without further distension. No visible masses or definitive cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface. In the face of urinary signs and/or suspected urinary bladder pathology, reassessment after complete filling is recommended.

The area of the prostate is examined without evident prostatic pathology.

The right kidney is normal is size (5.0 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal is size (6.5 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

The right adrenal gland is normal in size (0.83 cm at cranial pole and 0.88 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.76 cm at cranial pole and 0.74 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). Multifocal well-demarcated hyperechoic homogenous nodules are noted. Splenic vasculature appears normal. Additionally, there's a very subtle, approximately 1.0 cm in diameter, non-capsular disrupting hypo- to anechoic nodule mid-spleen.

Liver

The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.

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Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The stomach is moderately distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. If patient was appropriately fasted, delayed gastric emptying could be considered. Non-shadowing foreign material is considered less likely but cannot be definitively ruled out.

If clinical signs are consistent (vomiting, etc.), recommendations include supportive medical care, 24 hours fasting and re-image.

Diffusely, but most significantly visible within the jejunum, the small intestine is diffusely mildly thick with a relatively thick mucosa compared to other layers. Normal wall layering is preserved; however, the mucosa is more echogenic than normal and contains hyperechoic striations perpendicular to the lumen. The lumen of the small intestine is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction or foreign material noted. Focally, in the mid abdomen there's an area of jejunum, however, that's focally thicker measuring approximately 1.0 cm thick with loss of layering, and this loop of bowel is surrounded by enhanced hyperechoic fat, mesentery, and a trace amount of anechoic free fluid.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

There is a trace amount of anechoic free fluid adjacent to the focal bowel described above.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- The focal bowel changes could represent a focal infiltrative process with both benign inflammatory processes as well as infiltrative neoplastic disease being differentials, that are unable to be differentiated without tissue sampling. Alternative etiologies include potentially chronic foreign body, necrosis of the bowel wall, other. Diffusely, suspect lymphangiectasia – Small bowel findings are most consistent with lacteal dilation. These findings can be observed with protein-losing enteropathies caused by either primary lymphangiectasia or primary infiltrative inflammatory disease with secondary lymphangiectasia. Infiltrative neoplasia is possible but considered less likely. Histopathology is necessary to definitively determine underlying cause.

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- Hyperechoic splenic nodules – most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation, granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.
- Hypoechoic splenic nodules – likely represents a benign lesion such as a cyst, hematoma, nodular hyperplasia, extramedullary hematopoiesis, etc., however while considered less likely, infiltrative neoplasia can mimic benign lesions, and cannot be ruled out.
- Moderate gallbladder debris - Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A routine fecal/giardia exam is recommended if not recently evaluated.

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

Ultimately, however, regardless of the underlying cause given the concern for focal peritonitis adjacent to the bowel loop described above, an exploratory laparotomy for resection and anastomosis with submission of bowel wall for histopathology is likely indicated/warranted both as a therapeutic and additional diagnostic step.

Other than supportive/symptomatic medical management of clinical signs, further treatment recommendations are largely dependent on results of the above.

Imaging performed by

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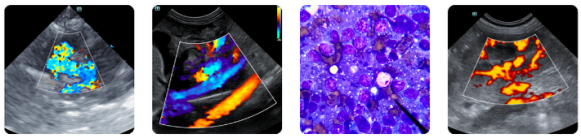

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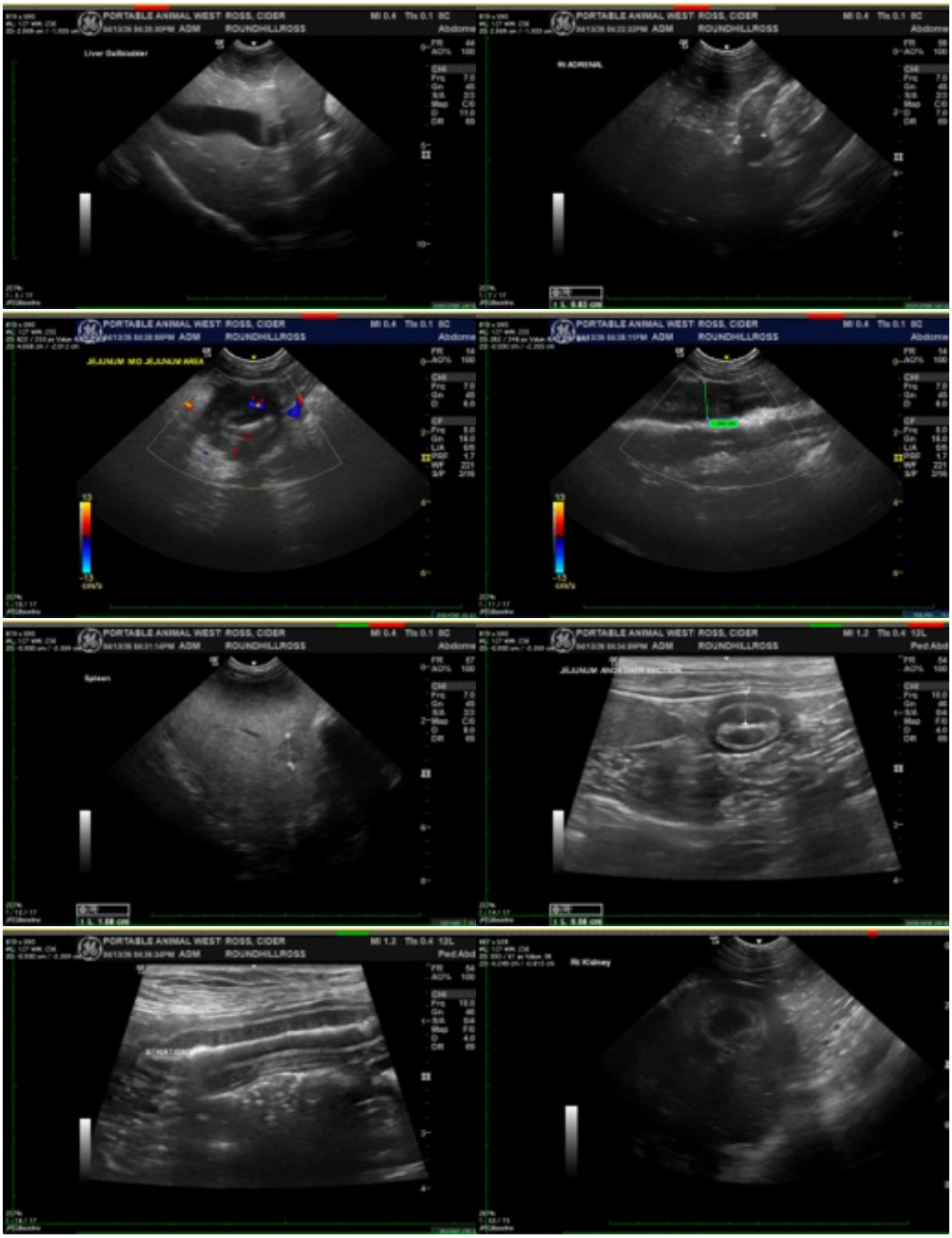

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
info@sonopath.com

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