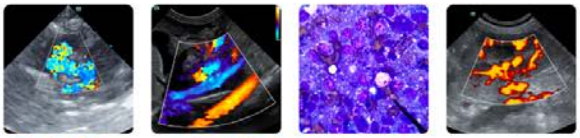

SonoPath www.thefocalzone.com info@thefocalzone.com 289.808.2608

PATIENT

Boomer Kirkup

SPECIES

Canine

BREED

Golden Retriever

SEX

Neutered Male

AGE

11 Years

WEIGHT

28.7 kg

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Buck Animal Hospital

REFERRING VET

Dr. Galbraith

INVOICE

75960

DATE

6/17/26

PRESENTING CLINICAL SIGNS

Dull, lethargic, mild dehydration. Vomiting for 1.5 weeks, multiple times per day (after small meals, on empty stomach), cerenia did not help at all. Current Medications: cerenia

Abnormal PE/Chem/CBC/UA Results: Values BW WNL Radiographic Findings not done Primary Question to Be Answered in This Exam FB? stomach?

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The kidneys were both normal size and structure, with smooth capsule and normal corticomedullary definition and ratio. Medullary structure differed distinctly from that of the cortex. No evidence of pelvic dilation was present. Left kidney measured 6.77 cm. Right kidney measured 6.26 cm.

Adrenal Glands

Both adrenal glands were visualized and recognized as having normal shape, size, position and echogenicity for this breed and age. The visible phrenic vasculature was unremarkable. Left measured 2.68 cm in length x 0.59 cm at the caudal pole and 0.49 cm at the cranial pole. Right measured 2.95 cm in length x 0.55 cm at the caudal pole and 1.34 cm at the cranial pole.

Spleen

The spleen was normal with age appropriate homogeneous parenchyma and a smooth capsule with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

Liver

The liver is subjectively normal in size with normal contours and structure. There is age appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion.

Gall bladder is moderately distended with normal wall thickness and anechoic contents. Common bile duct is non-distended and tapers normally.

Gastrointestinal

The stomach contains minimal luminal contents. It is subjectively mildly thickened diffusely with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate. No masses or focal lesions were observed

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. There were no focal lesions consistent with obstruction or a mass effect observed.

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Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The visible pancreas was observed to be largely isoechoic to surrounding omental fat.

Free Abdomen

No clinically significant lymphadenopathy or abnormalities noted. No free fluid noted.

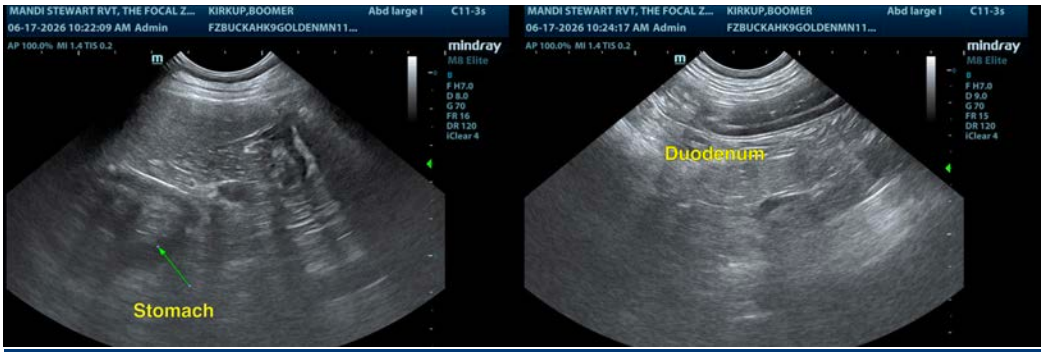
ULTRASONOGRAPHIC FINDINGS

- Mild gastric wall thickening, otherwise normal abdomen.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Gastric thickening with maintenance of wall layering is mild and is likely secondary to reported chronic vomiting. Mural disease cannot be definitively ruled out, and given the severity of vomiting, biopsy is indicated.

There is no other ultrasonographically evident cause of reported GI signs in this abdominal study. Pancreas and GI tract are otherwise within normal limits. Consideration for dietary indiscretion, infectious etiologies (bacterial, viral, parasitic), food sensitivity/allergy or mild inflammatory bowel disease is reasonable. While not sonographically evident, pancreatitis cannot be completely ruled out. Empiric treatment for GI signs including anti-nausea, appetite stimulant and fluid support as clinically indicated is warranted. A diet trial with hydrolyzed protein or select protein diet could be considered if food sensitivity is suspected clinically. Additional diagnostics to be considered include current chem lyte/CBC, baseline cortisol +/- ACTH stimulation test, GI panel (TLI/PLI/cobalamin/folate), fecal pathogen panel, thyroid testing, bile acid profile, and thoracic radiographs to rule out occult neoplasia, cardiac disease and esophageal disease as potential causes. Ultimately GI biopsy may be required for more definitive diagnosis if the patient is not responsive to medical treatment.



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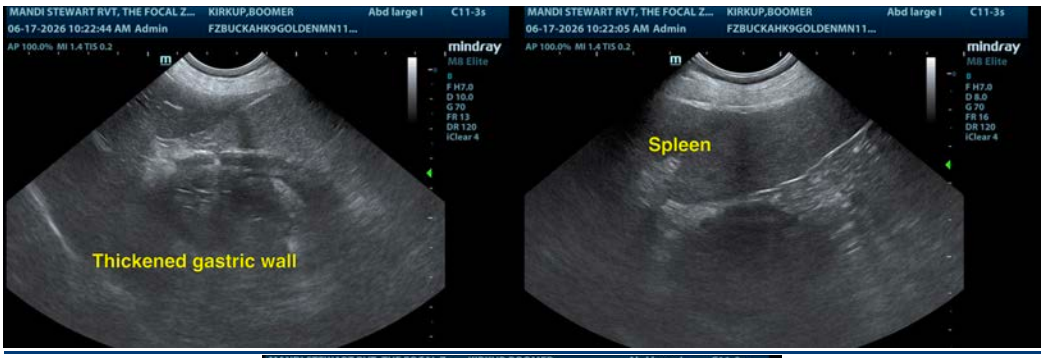

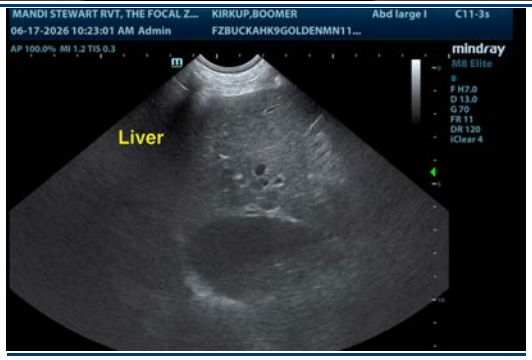

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC

info@SonoPath.com