



PATIENT

Sprinkles Svenrou

SPECIES

Canine

BREED

Beagle

SEX

Spayed Female

AGE

4 Years

WEIGHT

11.4 kg

INTERPRETED BY

Eric Lindquist, DMV,
DABVP(CFM), Cert.
IVUSS

IMAGING PERFORMED BY

Dr. Manes

HOSPITAL NAME

Wilvet South

REFERRING VET

Dr. Manes

INVOICE

12818

DATE

12/23/25

PRESENTING CLINICAL SIGNS

Hospitalized on 12/21 for acute onset vomiting, hematochezia and severe dehydration. Initial imaging was not concerning for FB obstruction. P received fresh frozen plasma transfusion on 12/22. Regurgitation started the night of 12/22 and has continued throughout the day on 12/23 with NG tube in place and while on metoclopramide. P also developed low grade heart murmur on the morning of 12/23. Goal of study is to look for cause of acute gastric distress, rule out partial or full obstruction vs severe ileus.

Abnormal PE/Chem/CBC/UA Results: Intake diagnostics: EPOC: respiratory acidosis pH 7.207 (L), pCO₂ 57.3 (H), Na 137 (L), Cl 103 (L), LAC 7.71 (H), Glu 134 (H), rest WNL. CBC: Hct 39.3%, WBC 7.89k (N), Mono 1.25k (H), rest WNL. PLT 169k Chem17: ALKP 225 (H), rest WNL. PT: 13 sec (N) SNAP Giardia: Negative Imagyst Fecal: All negative, no parasites seen. Three-view abdominal rads: Fluid dilated small and large bowel loops throughout abdomen. No obvious obstructive pattern noted. Recheck diagnostics 12/22: PCV/TS 22%, 4 g/dL recheck EPOC: pH 7.324 (L), Na+ 138 (L), K+ 3.0 (L), Cl- 105 (L), Glu 182 (H), Hct 20% (L) Albumin: 1.6 g/dL (L) FU EPOC: K+ 3.4 (L), Glu 153 (H), Hct 17% (L) PCV/TS: 22%, 5.4 Recheck diagnostics 12/23: -PCV/TS 24%, 5g/dL -EPOC: K 3.0, Glu 193, Hct 19% -Albumin: 2.0 g/dL (L)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The **urinary bladder**, trigone, and pelvic urethra presented normal thicknesses and normal tone. The ureters were not visible which is normal. No uroliths or sediment were visualized, and anechoic urine was present. No evidence of inflammatory or neoplastic changes were noted. Ureteral papillae were normal.

The iliac trifurcation was unremarkable.

The **left kidney** revealed normal size and structure, corticomedullary definition and ratio for this age. The cortices presented largely uniform texture with normal echogenic relationship to liver and spleen. Medullary structure differed distinctly from the cortex and no evidence of pelvic dilation was present. The capsules were acceptably uniform without significant irregularities. The left kidney measured 5.1 cm in length.

The **right kidney** was not visualized.

Adrenal Glands

The **left adrenal gland** was visualized and recognized as having 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 0.56 cm width at the caudal pole and 0.60 cm width at the cranial pole.

The **right adrenal gland** was not visualized.

Spleen

The **spleen** presented a smooth homogeneous parenchyma hyperechoic to liver and renal cortical parenchyma. The capsule was smooth without noticeable expansion or deviation from within the spleen or adjacent pathology. The splenic vasculature demonstrated normal volume without signs of



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congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarctual changes were noted.

Liver

The **liver** images submitted revealed subjectively normal liver size, contour, and structure. Parenchymal echogenicity was naturally coarse and hypoechoic to the spleen. Vascular and biliary tracts were of normal volume with no evidence of congestion. The gallbladder presented acceptably thin walls with primarily anechoic content. The cystic and common bile ducts were normal. No pathological hepatic lymphadenopathy was evident. No overt structural evidence of inflammatory, infiltrative or regenerative pathology was evident.

Gastrointestinal

The **gastrointestinal tract** revealed variable wall thickening measuring up to 0.73 cm. A minor amount of ingesta was noted in the stomach. Gastric wall thickness measured up to 1.2 cm with thickening primarily in the pyloric outflow tract. Soft stool was noted in the colon. Areas of dilated upper small intestine were noted followed by an empty small intestine. Entrapped foreign matter was noted in the distal small intestine, however, concurrent diffuse gastrointestinal thickening noted is suggestive of underlying disease.

Pancreas

The **pancreas** revealed minor heterogenous parenchymal changes suggestive of inflammation.

Heart

Rapid view of the **heart** revealed no evident pathology other than tachycardia. Normal volumes and contractility were noted.

ULTRASONOGRAPHIC FINDINGS

- Distal small intestinal partial foreign body.
- Tachycardia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommend exploratory surgery in this patient with the objective of liberating the distal small intestine and obtaining GI biopsies. Suspect GI blood loss with potential bone marrow disease as the cause of the anemia. Concurrent protein losing enteropathy is likely. Prognosis is guarded. The echotexture of the material in the distal small intestine suggests for soft foreign matter, however, diffuse GI disease appears to be present. Inflammatory bowel versus emerging round cell neoplasia are primary concerns.

According to SonoPath research presented at ECVIM 2016 (Stockholm, Sweden), Advances in Small Animal Medicine and Surgery (May 2017), and EVDI 2017 (Verona, Italy), concurrent underlying chronic inflammatory neoplastic intestinal disease can often reside in PICA patients. Therefore, surgical biopsies are essential in this case regardless of the exploratory findings.



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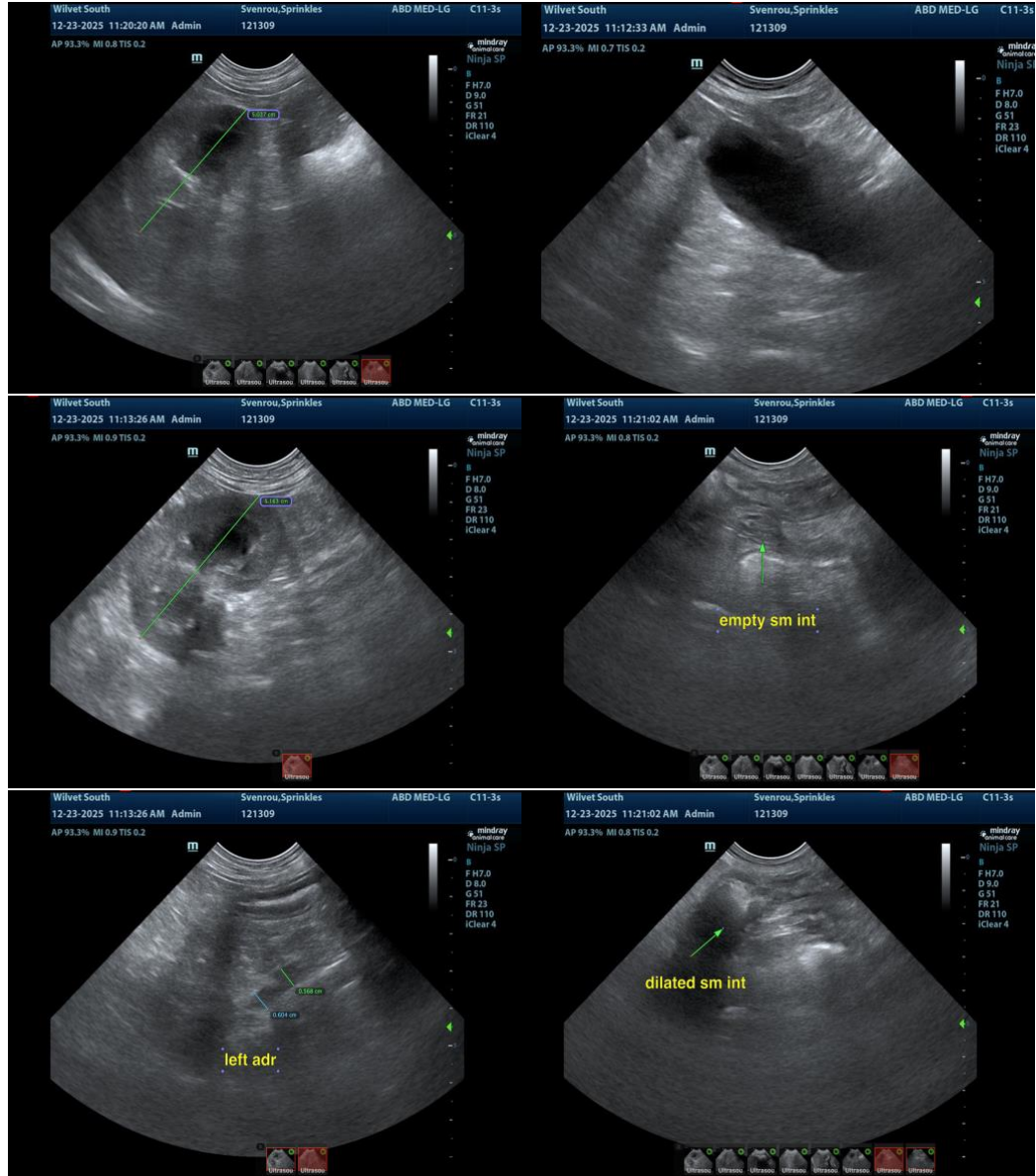
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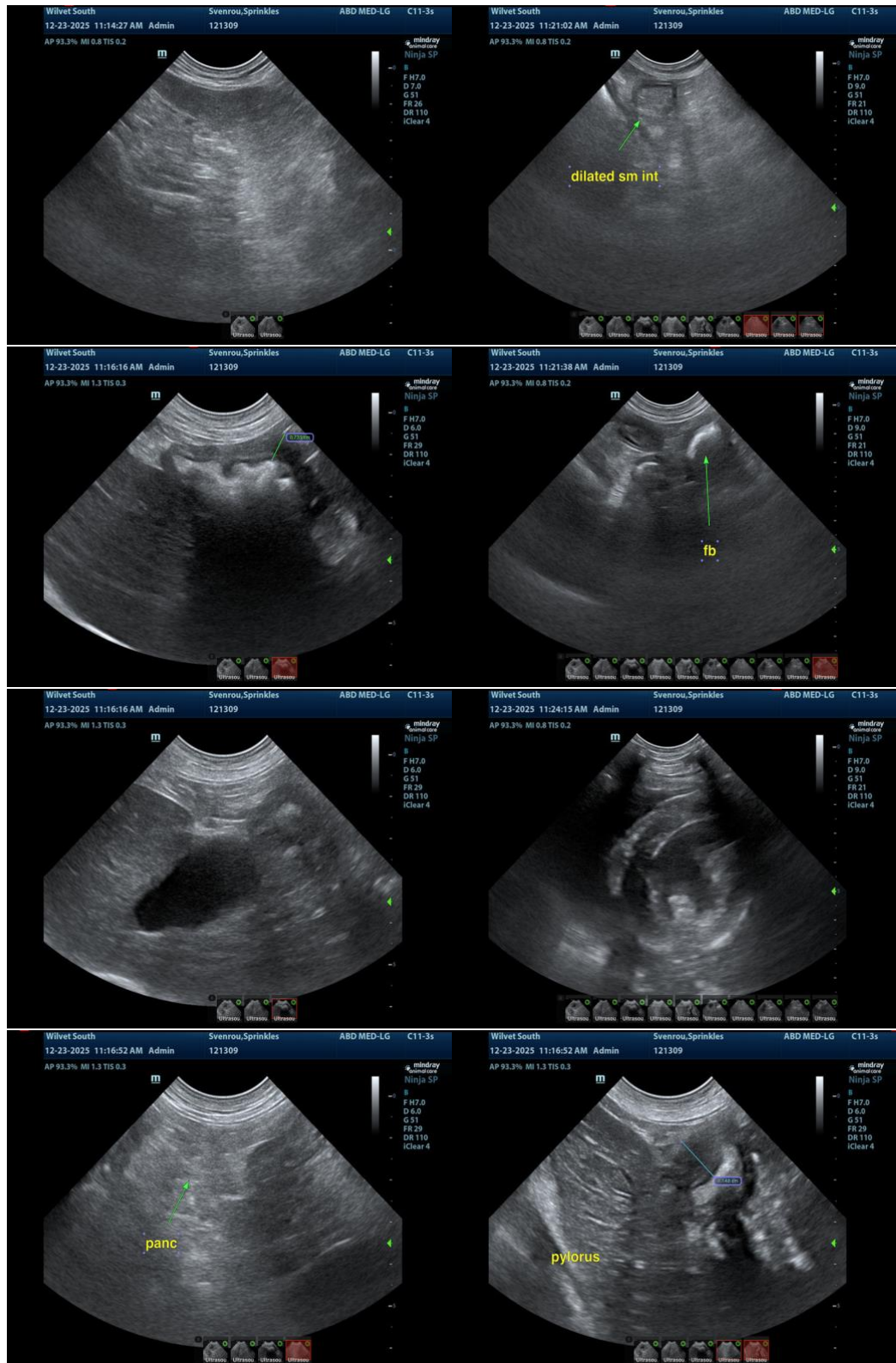
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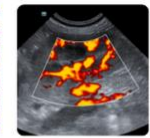
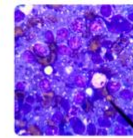
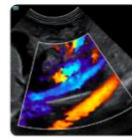
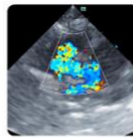
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Eric Lindquist, DMV, DABVP(CFM), Cert. IVUSS,

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