



**PATIENT**

Whiskey Haynes

**SPECIES**

Canine

**BREED**

Australian Shepherd  
Mix

**SEX**

Intact male

**AGE**

4 years

**WEIGHT**

23 kg

**INTERPRETED BY**

Eric Lindquist, DMV  
DABVP, Cert. IVUSS

**IMAGING PERFORMED BY**

Kathleen Byrnes

**HOSPITAL NAME**

Animal Emergency  
Clinic of High Country

**REFERRING VET**

Dr. Wolverton

**INVOICE**

69791

**DATE**

1/6/26

**PRESENTING CLINICAL SIGNS**

History: Recheck US from yesterday- originally presented for vomiting, stomach dilated with fluid and linear material, PDJ patent, scant free fluid, prostate enlarged, improved today no regurgitation, ate at 8pm last night.

**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 **kidneys** 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.

**Adrenal Glands**

Both **adrenal glands** were 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.

**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 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.



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**Gastrointestinal**

Retention of ingesta was noted in the **stomach** with patent pyloric outflow. However, the amount of free fluid has increased and a distal small intestinal 3.0 cm, sharp, dense foreign body structure appeared to be present and was preceded by intestinal stasis and empty small intestine. There was reactive mesentery associated with the foreign body obstruction. The foreign body appeared to be bilobed and combined, two separate structures measuring approximately 3.0 cm.

**Pancreas**

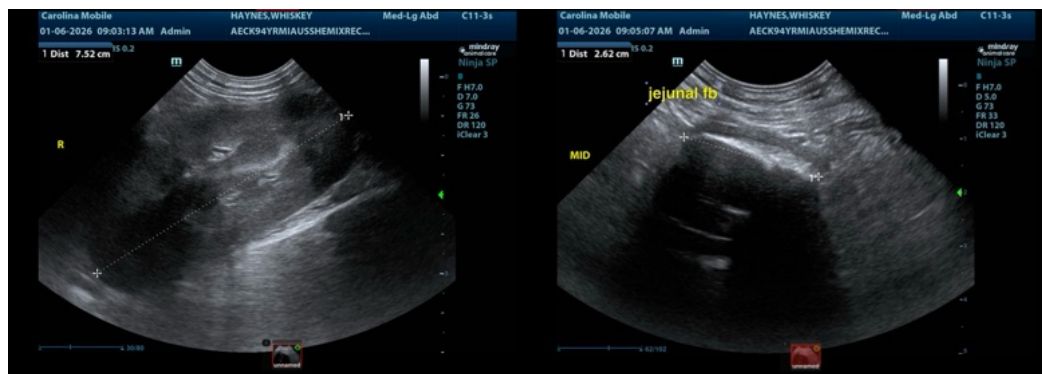
The base and limbs of the **pancreas** were observed to be largely isoechoic to surrounding omental fat. Pancreatic duct and capsular contour were acceptably normal and parenchyma respected normal curvilinear patterns. No overt evidence of active inflammatory or neoplastic disease was noted.

**ULTRASONOGRAPHIC FINDINGS**

- Distal small intestinal foreign body obstruction with emerging peritonitis.
- Unhealthy portion of small intestine where the foreign body is embedded.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

There was significant improvement regarding interfering artifact noted compared to the prior sonogram. Immediate exploratory surgery is indicated. GI biopsies are warranted to rule out underlying disease. Resection of a portion of the small intestine where the foreign body is embedded may be necessary in this patient. I do not recommend simple enterotomy at the area of the intestinal foreign body obstruction as mural changes within the small intestine in this region would lead to potential poor healing and dehiscence. I do not suspect neoplasia; however, intestinal necrosis or chronic inflammatory changes are likely. This may be an underlying primary intestinal pathology with secondary embedded foreign matter.





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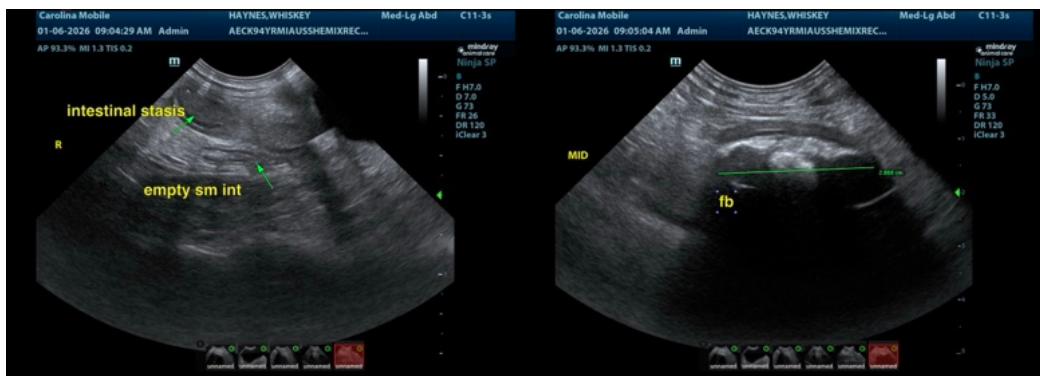
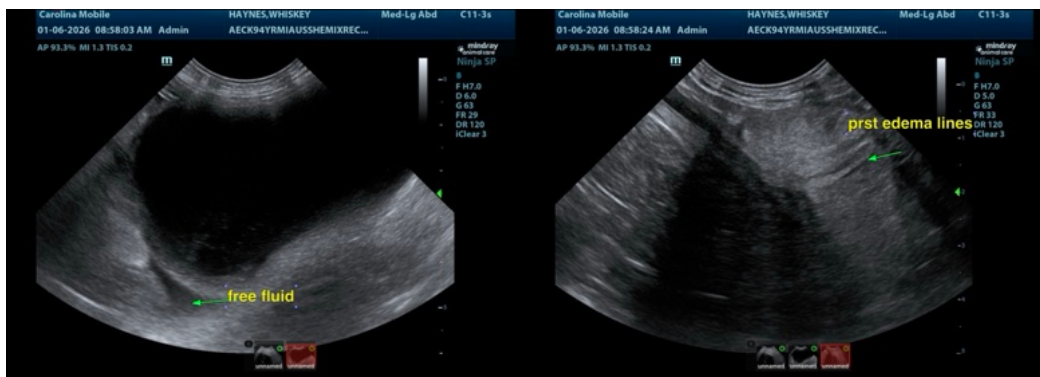
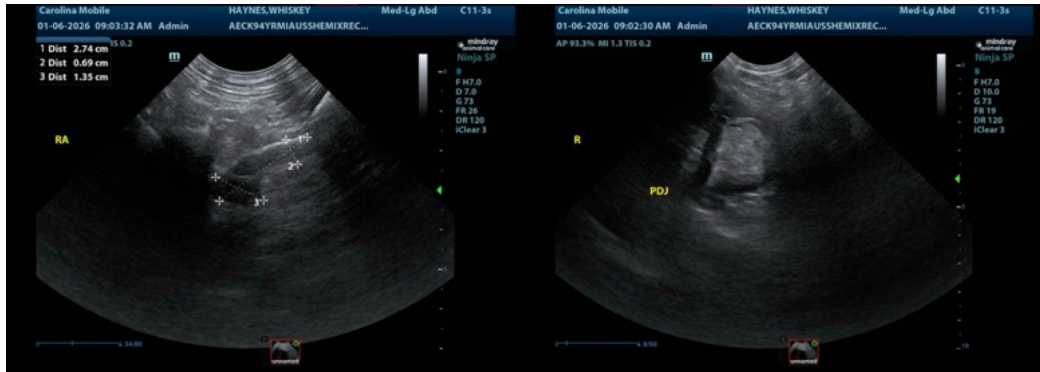
Dr. Wolverton

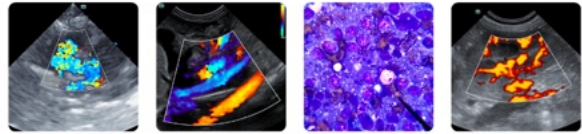
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**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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, Cert. IVUSS, CEO of SonoPath.com**

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