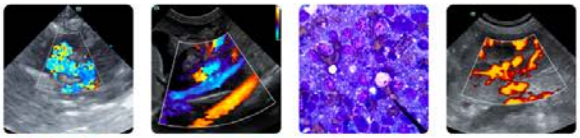


PATIENT

Buttercup DSurney

SPECIES

Canine

BREED

Golden Retriever

SEX

Spayed Female

AGE

7 Years 8 Months

WEIGHT

63.4 lbs

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Kathleen Byrnes

HOSPITAL NAME

Stoney Creek Veterinary Hospital

REFERRING VET

Dr. Eldred

INVOICE

73305

DATE

2/26/26

PRESENTING CLINICAL SIGNS

P presented for US due to vomiting on and off for two weeks. Radiographs: Rounded soft tissue opacity noted in area of caudal hepatic margin.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (5.9 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (6.21 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.50 cm at the cranial pole and 0.54 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.92 cm at the cranial pole and 0.72 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

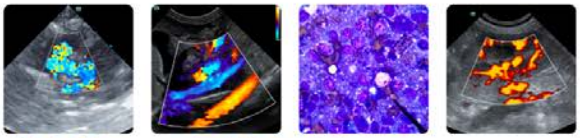
Spleen

The spleen is subjectively normal in size (1.93 cm), echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and likely incidental at this time. The cystic and common bile ducts are normal/not visible.



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Gastrointestinal

The stomach contains a large amount of shadowing ingesta. The visualized areas of gastric wall measure at a normal thickness of <0.7cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity. Shadowing ingesta interferes with full evaluation of the stomach and the cranial abdomen, the pyloroduodenal junction was not clearly visualized.

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. The duodenum is poorly visualized due to gas interference from the stomach and the jejunum measured as normal (between 0.2-0.47cm.) Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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 area of the pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Large, shadowing ingesta visualized within the gastric lumen – Correlate with feeding history. If the patient was adequately fasted, consider such differentials as delayed gastric emptying or partial outflow tract obstruction (PDJ obscured by gas).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No obvious mass lesions were observed on today's exam. The stomach had a significant amount of shadowing ingesta and gas, which interfered with evaluation of much of the cranial abdomen. The region of the pyloroduodenal junction was not clearly visualized to rule out an outflow tract obstruction. Additionally, the right caudal liver, right cranial abdomen, region of the pancreas, duodenum, etc. were also obscured. The remainder of the abdomen appeared within normal limits.

Initial diagnostics and treatment for chronic vomiting could include the following:

- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend chronic probiotic therapy.
- Recommend full biochemical evaluation including a baseline cortisol.

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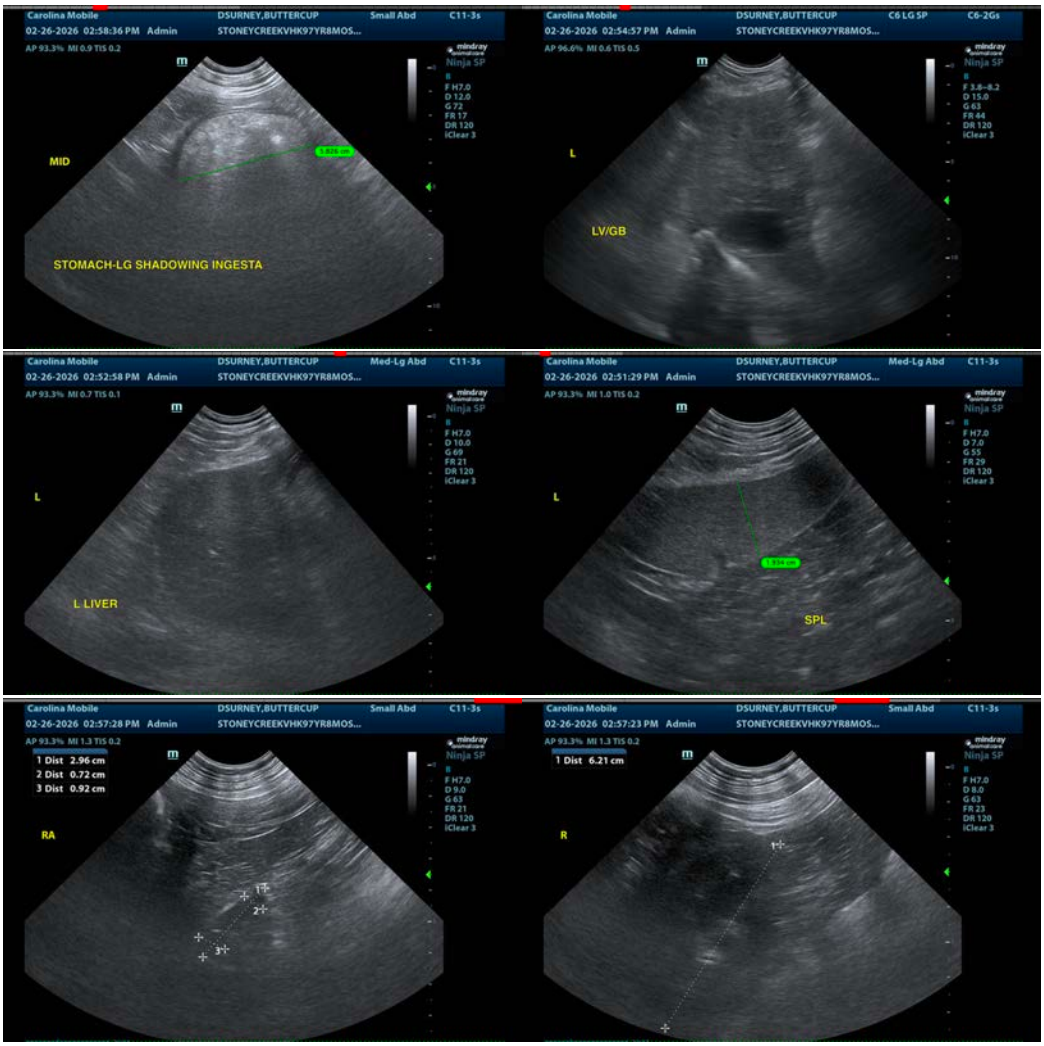
- If not already done, you could consider parasite screening and empirical deworming.

If vomiting is persistent despite taking these measures (or sooner if concerned), recommend a prolonged fast (at least 12-16 hours) and repeat imaging with sedation to determine if the stomach empties normally and to see if some of the cranial abdominal regions can be further evaluated. If vomiting is persistent, eventually surgical evaluation and biopsies of the GI tract may be warranted.



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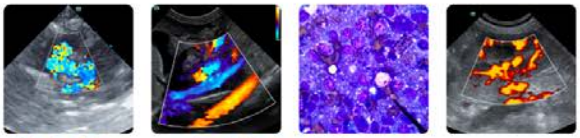

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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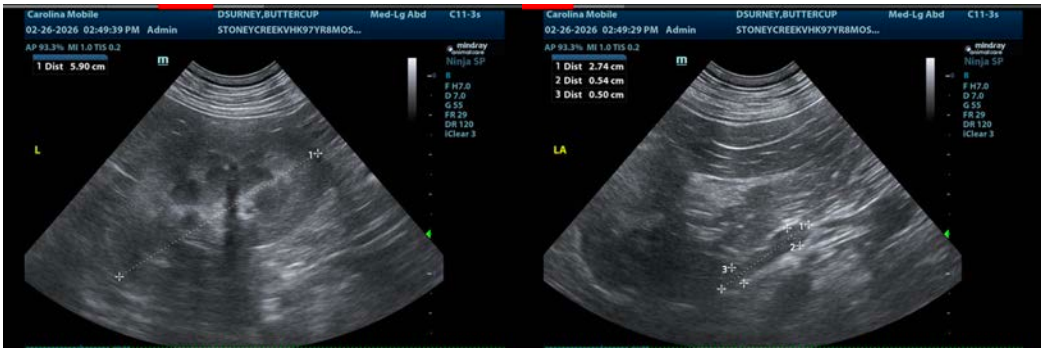

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)

info@sonopath.com