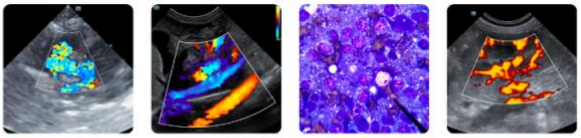


PATIENT

Frank Delmore

SPECIES

Canine

BREED

Poodle Mix

SEX

Neutered Male

AGE

1 Year 5 Months

WEIGHT

109.6 pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Shari Reffi CVT

HOSPITAL NAME

Harmony Animal Hospital

REFERRING VET

Dr. Gruber

INVOICE

15131

DATE

04/16/26

PRESENTING CLINICAL SIGNS

Hx of GI upset believed to be FB/FBO. AUS to R/O FB/FBO due to regurg + diarrhea. Currently on hypoallergenic diet; Metronidazole (6p last dose); Famotidine (6p) (Torb/Midaz sedation for scan)

Abnormal PE/Chem/CBC/UA Results: WNL; Barium study -NSF

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 2.0 cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The prostate is normal in size (0.94 cm) and shape for this neutered male dog. The parenchyma is homogenous and the external margins are smooth. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (7.49 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of 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 (6.84 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of 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 0.41 cm at the cranial pole and 0.55 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.

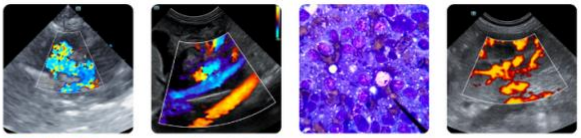
The right adrenal gland is normal in size measuring 0.84 cm at the cranial pole and 0.55 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. The spleen measured 2.86 cm. The spleen appears slightly curled/folded in position.

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 primarily anechoic. The cystic and common bile ducts are normal/not visible.



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Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.7 cm 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. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal to moderate fluid. 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 measured as normal (between 0.3 - 0.5 cm in wall thickness) and the jejunum measured as normal (0.27 cm). In the caudal abdomen, there is segmental fluid and gas distension of the bowel. No definitive obstruction is observed.

There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The pancreas is visible and mildly mottled in the left limb compared to the surrounding isoechoic 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. There a mild mesenteric lymphadenopathy with a large mesenteric lymph node measuring 1.26 cm x 2.66 cm and another measuring 0.50 cm x 2.54 cm. The omentum is generally of normal echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Visible/mildly mottled pancreas- No evidence of overt inflammation is noted at this time. Mild pancreatitis is possible.
- Population of fluid and gas distended bowel in the caudal abdomen- findings could be consistent with enteritis or an unseen small focal lesion/partial obstruction.
- Prominent mesenteric lymph nodes- the changes observed are most consistent with reactive lymph nodes although an early neoplastic change is unlikely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of a definitive focal obstruction is visualized on today's exam. The cranial abdomen appears relatively quiet. In the caudal abdomen, there is a population of bowel which appears mildly fluid and gas distended, possibly consistent with focal enteritis/ileus, although partially obstructive foreign material cannot be ruled out. Correlate with serial radiographs and continued treatment for gastroenteritis/ mild pancreatitis.

If symptoms are persistent (particularly if radiographs are supportive of an obstructive pattern), and you are highly suspicious for ingested foreign material you could consider explore with the intent to obtain biopsies of the GI tract and look for any foreign material.

If the patient is regurgitating, recommend three view thoracic radiographs to evaluate the esophagus

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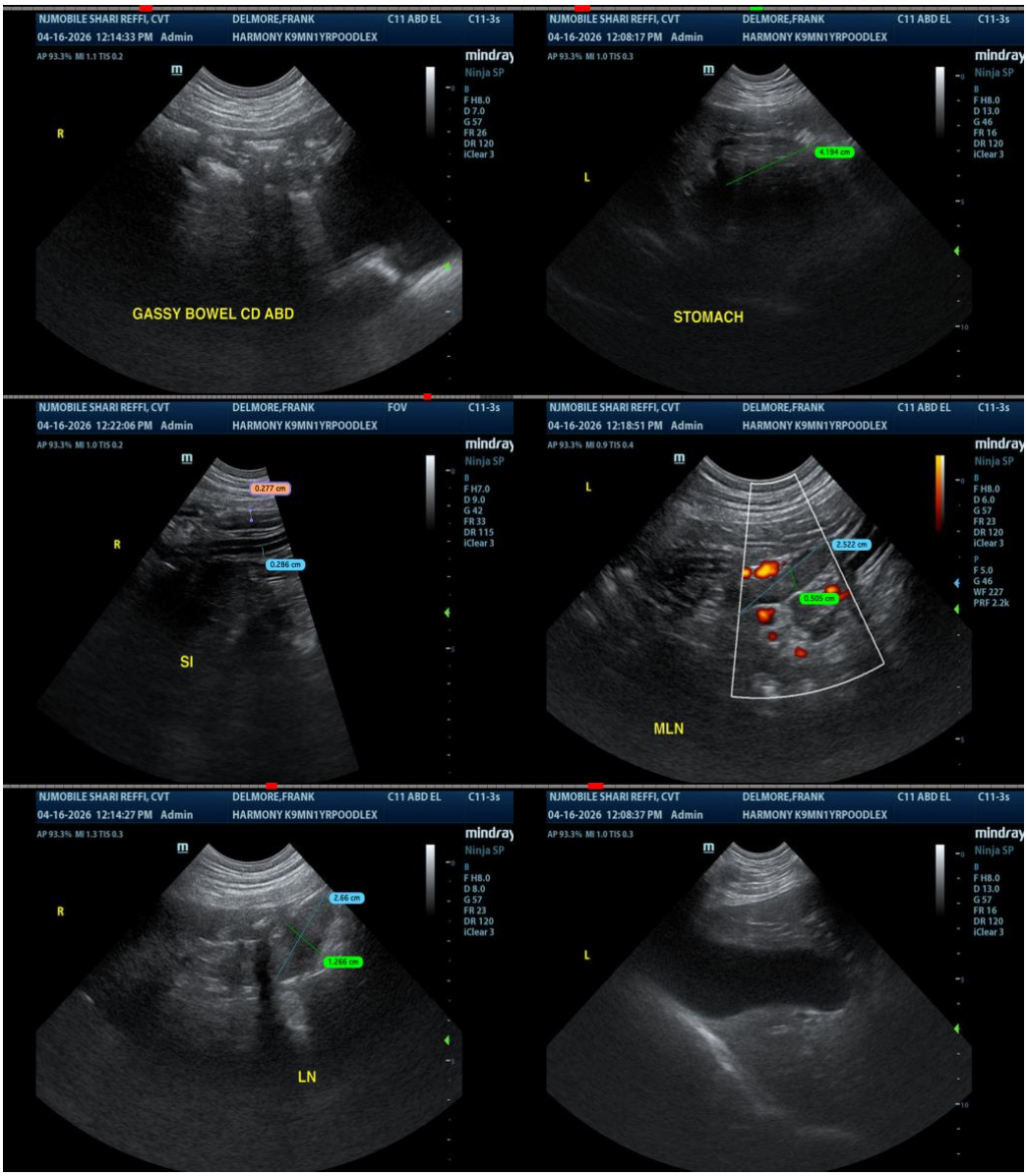
for dilation, foreign body structure, etc., and the lungs for aspiration pneumonia. Additionally, you could consider upper GI endoscopy to evaluate the esophagus, stomach, and proximal GI tract and obtain biopsies.

If not already done, consider a baseline cortisol to screen for Addison's. Serial ultrasound can also be considered over time looking for progression of lesions.



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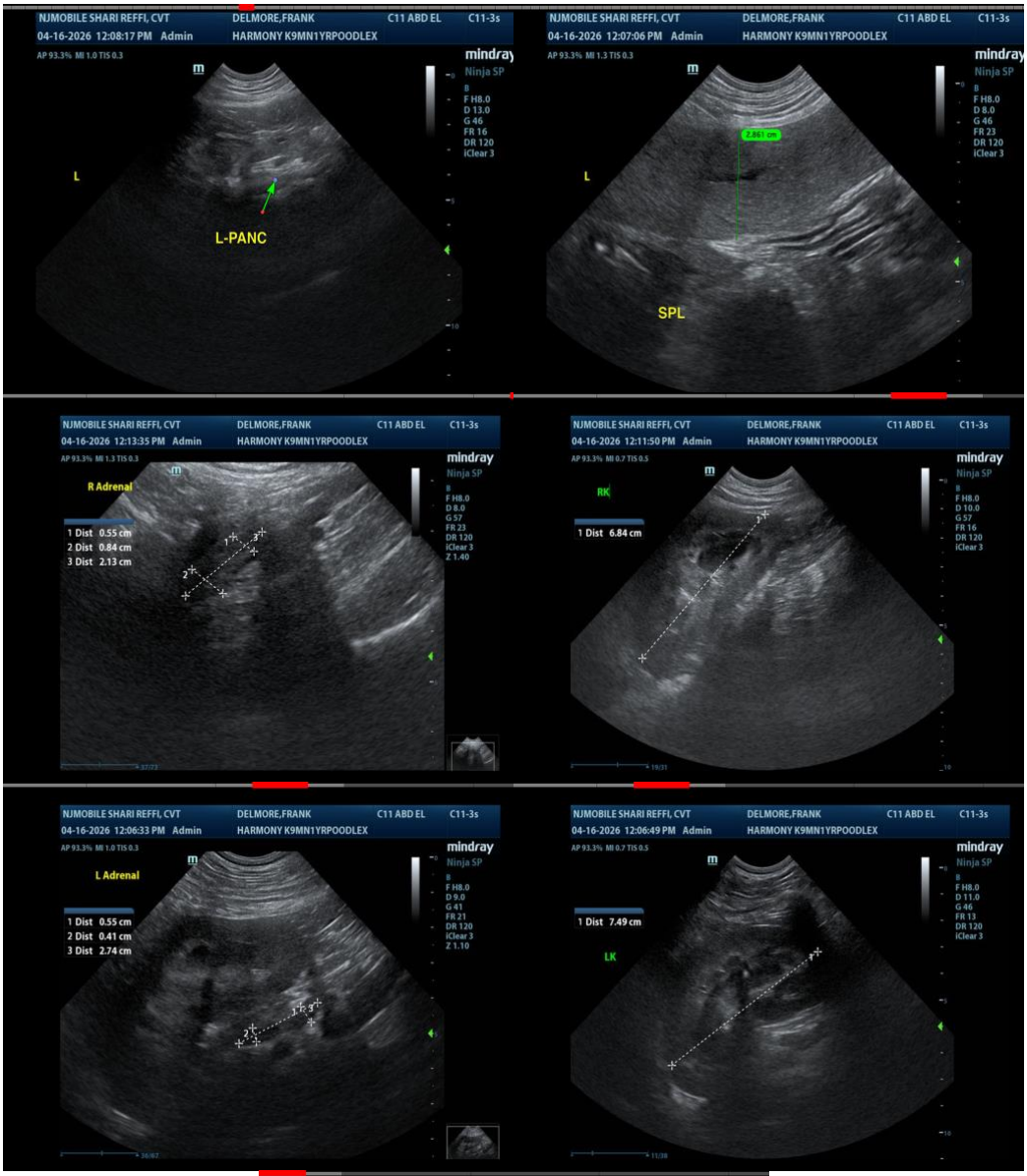

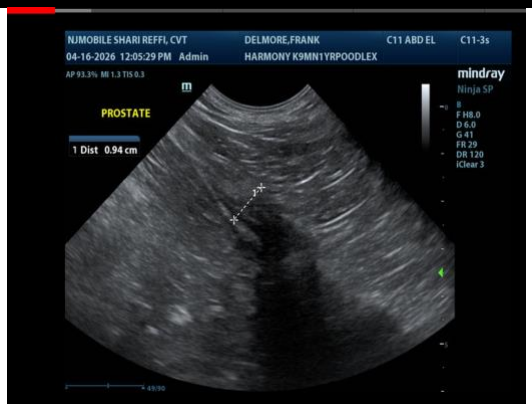

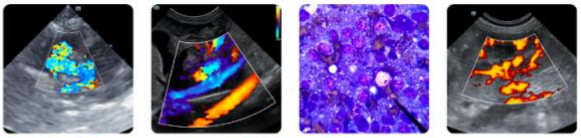

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

info@sonopath.com