



## PATIENT

Beau Hammett

## SPECIES

Canine

## BREED

Bichon Frise

## SEX

Male Neutered

## AGE

8y

## WEIGHT

8.3 kgs

## INTERPRETED BY

R. McKenzie Daniel,  
DVM, DABVP  
(Canine and Feline)

## IMAGING PERFORMED BY

Bennett

## HOSPITAL NAME

Wilvet South

## REFERRING VET

Bennett

## INVOICE

13093

## DATE

1/16/26

## PRESENTING CLINICAL SIGNS

History: Presented 1/15 PM for acute onset of vomiting/abdominal discomfort over past 12-24 hours. No known FB ingestion or toxin exposure but did have FB surgery due to rock ingestion as a young dog. No issues since then. Had blood work (unremarkable) & A-FAST (small amount of gastric fluid, GB sludge/early mucocele?), then went home with SQF & Cerenia. Returned overnight due to vomiting through Cerenia. Rads suspicious for two populations of bowel, possible obstructive pattern. P has been NPO on IVF for about 4 hours by time of US. \*\* After first round of US clips, placed NGT to empty stomach due to severe gastric distention. Removed 277 mL brown fetid fluid via NGT.

Abnormal PE/Chem/CBC/UA Results: Exam: QAR, halitosis. Slightly tacky MM. Normal H/L auscultation. No reaction to abdominal palpation. Regurgated a small amount of brown fluid when on the way to radiology for NGT placement. Blood work: Glucose 151 (H), ALT 210 (H), ALP 260 (H). CBC, lytes, cPL, & Cortisol all WNL.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

No obvious pathology in the area of the residual prostate.

The area of the aortic trifurcation was free of pathology.

Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 4.6 cm in length. The right kidney measured 4.8 cm in length.

### Adrenal Glands

The left and right adrenal glands were overtly normal in size, position and shape. The left adrenal gland measured 0.56 cm width at the caudal pole. The right adrenal gland measured 0.44 cm width at the caudal pole.

### Spleen

The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

### Liver

The liver presented subjective mildly enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen



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in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was distended in size with echogenic thickening of the gallbladder wall. There was biliary sludge that appeared to be non-mobile and organized. A stellate pattern to the organized biliary sludge was present. Evidence of pericholecystic omental inflammation and effusion was present. The common bile duct was not visualized.

**Gastrointestinal**

The stomach was markedly distended with anechoic to mildly echogenic fluid. No evidence of shadowing gastric content or visualized obstruction to pyloric outflow.

The small intestine presented overall intact visible wall exhibiting subjective segmental decreased mural echogenicity. The duodenum and segmental jejunum exhibited moderate to variable fluid distention with oral/aboral fluid movement. Possible shadowing mid to distal descending lumen echo vs gas pocket. Concurrent shadowing focal to possible segmental jejunal content consistent with foreign material with empty jejunum distal to the level of the ileum and colon.

Normal visible colon wall layers were present with apparent formed feces in lumen.

**Pancreas**

The area of the pancreas was sonographically normal.

**Free Abdomen**

Peri intestinal to regional mid abdomen hyperechoic inflamed omentum. No obvious visualized significant peritoneal effusion or omental lymphadenopathy present.

**ULTRASONOGRAPHIC FINDINGS**

- Jejunal to possible duodenal foreign body or potential multiple foreign bodies with obstructive gastointestinal pattern proximal, empty small intestine distal with enteritis mural criteria
- Peri intestinal to mid abdomen hyperechoic inflamed omentum
- Hepatopathy – subjective benign
- Immature gallbladder mucocele

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

If patient is stable for anesthesia, exploratory laparotomy with gross inspection of the gastrointestinal tract and expectation toward enterotomy to potential multiple enterotomies is recommended. The possibility of resection anastomosis pending gross inspection of the small intestine not definitively excluded if potential chronic obstruction or foreign bodies. Intestinal biopsies at time of surgery could be considered to assess for underlying intestinal disease. Assuming normal clotting status, gross inspection of the liver and gallbladder, +/- hepatic biopsies or cholecystectomy pending gallbladder gross appearance is recommended. Peri operative empirical therapy for potential emerging peritonitis warranted.



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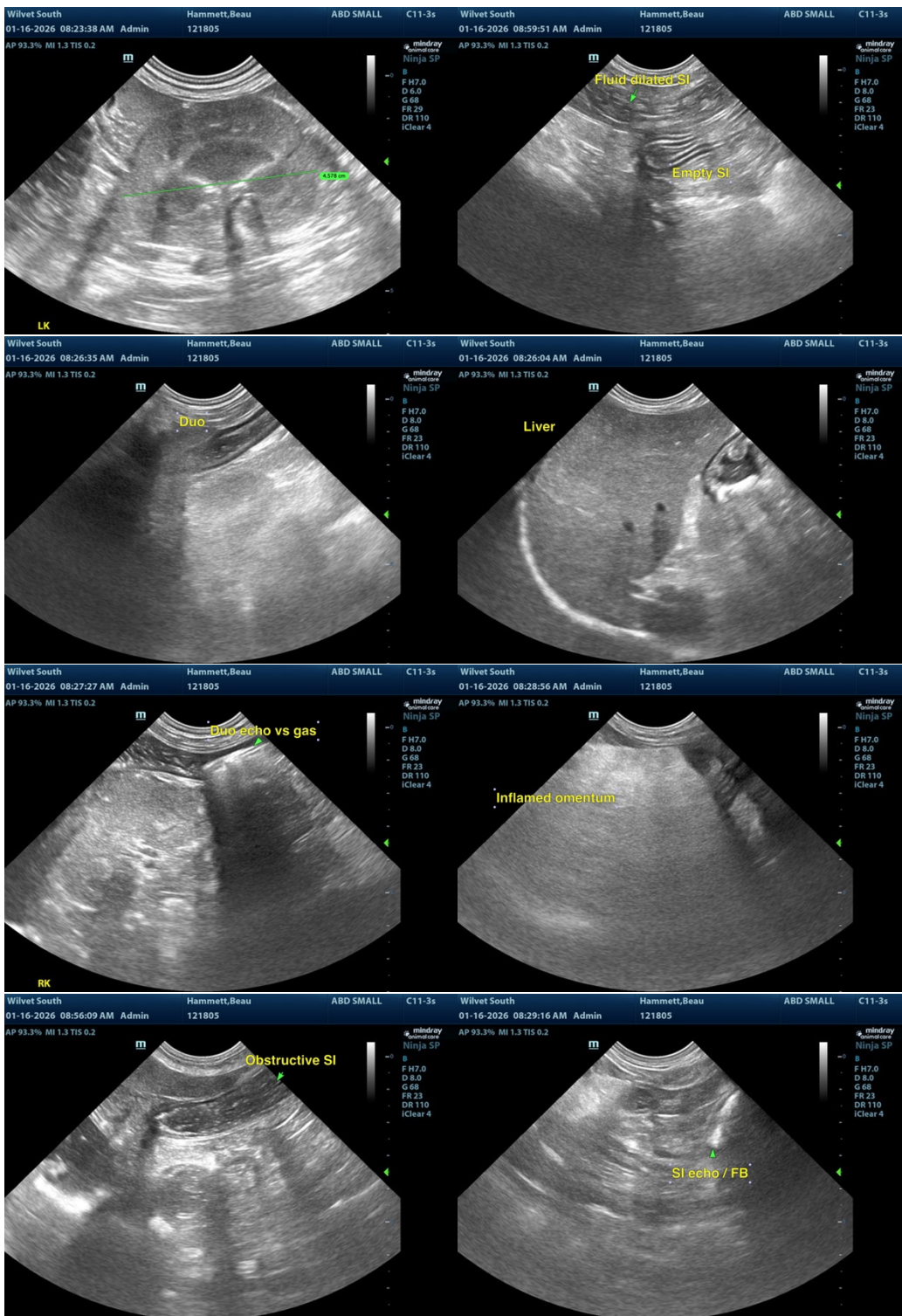
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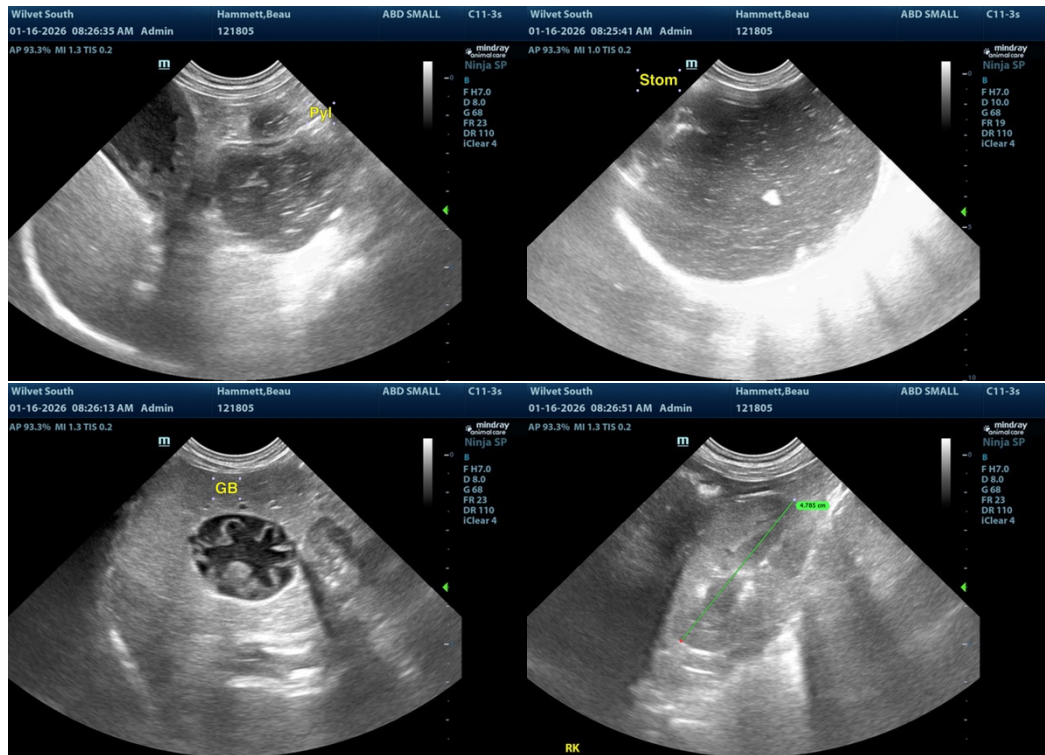
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

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