



<b>PATIENT</b>	<b>PRESENTING CLINICAL SIGNS</b>
Maxwell Russo	Vomiting. Hx of gastrotomy, enterotomy and R&A on 12/29/2022. Hosp1/15-1/16 for vomiting. Weight loss. Current meds: IVF, Cerenia, Famotidine, Dexdomitor/Torbutrol for u/s.
<b>SPECIES</b>	
Canine	<b>ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN</b>
<b>BREED</b>	<b>Urinary System</b>
Hound Mix	The urinary bladder, trigone, and cystourethral junction 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 was noted.
<b>SEX</b>	
MN	No overt pathology was noted in the area of the residual prostate.
<b>AGE</b>	The area of the aortic trifurcation was free of pathology.
1 year	Normal size and margination were 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 5.8 cm in length. The right kidney measured 5.5 cm in length.
<b>WEIGHT</b>	
36.2 lbs	
<b>INTERPRETED BY</b>	<b>Adrenal Glands</b>
R. McKenzie Daniel, DVM, DABVP (Canine and Feline)	The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 2.6 cm length x 0.40 cm width at the caudal pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 2.7 cm length x 0.40 cm width at the caudal pole.
<b>IMAGING PERFORMED BY</b>	<b>Spleen</b>
Shari Reffi, CVT	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.
<b>HOSPITAL NAME</b>	<b>Liver/ Gallbladder</b>
Newton Vet	The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.
<b>REFERRING VET</b>	<b>Gastrointestinal</b>
Dr. Chun	The stomach presented mild to moderate wall thickening secondary to mild to moderate echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. Mild retained anechoic to echogenic fluid was present in the gastric lumen without evidence of gastric distention. Potential for a mild amount of nonspecific, hyperechoic ingesta in the stomach is possible. The gastric body wall width measured 0.6 cm.
<b>INVOICE</b>	
13118	
<b>DATE</b>	
1/20/22	



<b>PATIENT</b>	
Maxwell Russo	
<b>SPECIES</b>	
Canine	
<b>BREED</b>	
Hound Mix	
<b>SEX</b>	
MN	
<b>AGE</b>	
1 year	
<b>WEIGHT</b>	
36.2 lbs	
<b>INTERPRETED BY</b>	
R. McKenzie Daniel, DVM, DABVP (Canine and Feline)	
<b>IMAGING PERFORMED BY</b>	
Shari Reffi, CVT	
<b>HOSPITAL NAME</b>	
Newton Vet	
<b>REFERRING VET</b>	
Dr. Chun	
<b>INVOICE</b>	
13118	
<b>DATE</b>	
1/20/22	

The small intestine exhibited primarily intact yet prominent wall layering owing to propensity for mildly prominent duodenojejunal mucosa. Segmental duodenojejunal retained fluid exhibiting oral / aboral movement, along with retained chyme was present subjectively extending distally to a strongly shadowing intestinal luminal echo, measuring approximately 4.0-5.0 cm in diameter, subjectively within the mid to caudal abdominal segments. Concurrent empty small intestine without evidence of mechanical or metabolic ileus suspected to be distal to the strongly shadowing Intestinal luminal echo were also present. A focal area of prominent to indistinct wall layering suspected to represent previous area of resection anastomosis was present in a focal midabdominal intestinal segment. The duodenum wall width measured 0.43 cm.

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

**Pancreas**

The parenchyma of the left limb, body, and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease were evident.

**Free Abdomen**

intermittent jejunal to jejunocolic lymph nodes present. These lymph nodes were homogenous, mildly hypoechoic and smoothly marginated. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic inflammation was evident. Generalized, primarily peri intestinal reactive mesentery was present. No overt evidence of free fluid was noted.

**ULTRASONOGRAPHIC FINDINGS**

**Primary Findings**

- Strongly shadowing mid to caudal abdominal small intestinal echo, concurrent mild small intestinal obstructive pattern likely proximal to the strongly shadowing intestinal echo with empty small intestine likely distal
- Moderate gastroduodenitis to generalized gastroenteritis pattern
- Associated jejunal to jejunocolic lymphadenitis with generalized, primarily peri intestinal, reactive mesentery

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Abdominal study consistent with suspected recurrent intestinal foreign body with secondary likely proximal mild to moderate obstructive pattern with empty small intestine likely distal. Exploratory laparotomy with expectation toward enterotomy along with gross inspection of the remainder of the gastrointestinal tract including the stomach is recommended. No overt evidence of failure of previous resection anastomosis, yet gross inspection at the time of surgery is recommended. Gastrointestinal biopsies despite exploratory findings may be considered to assess for potential underlying gastrointestinal disease as a possible cause of recurrent pica.



**PATIENT**

Maxwell Russo

**SPECIES**

Canine

**BREED**

Hound Mix

**SEX**

MN

**AGE**

1 year

**WEIGHT**

36.2 lbs

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Shari Reffi, CVT

**HOSPITAL NAME**

Newton Vet

**REFERRING VET**

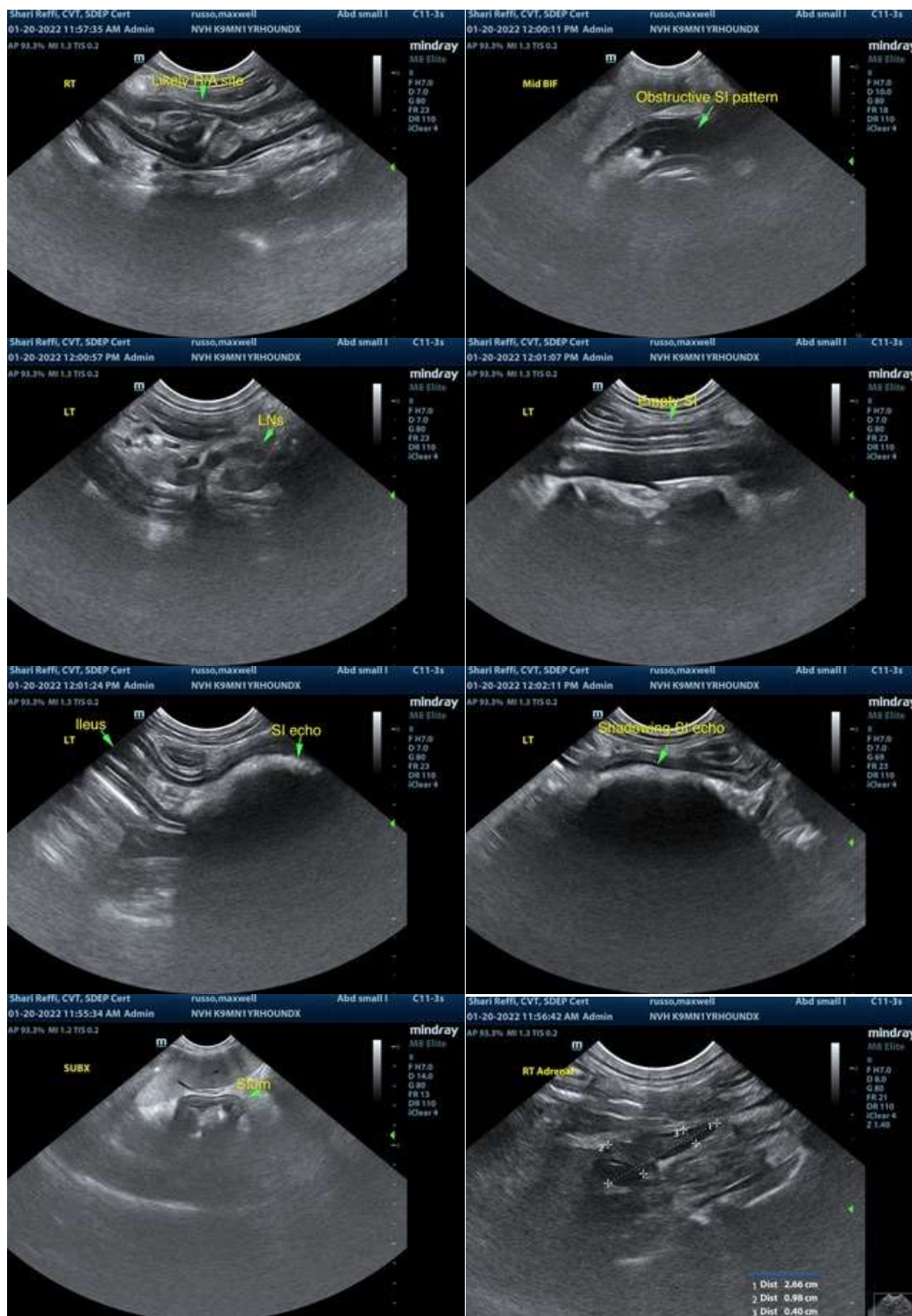
Dr. Chun

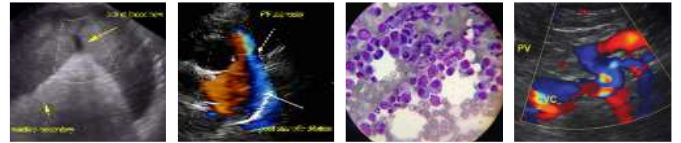
**INVOICE**

13118

**DATE**

1/20/22





**PATIENT**

Maxwell Russo

**SPECIES**

Canine

**BREED**

Hound Mix

**SEX**

MN

**AGE**

1 year

**WEIGHT**

36.2 lbs

**INTERPRETED BY**

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

**IMAGING  
PERFORMED BY**

Shari Reffi, CVT

**HOSPITAL NAME**

Newton Vet

**REFERRING VET**

Dr. Chun

**INVOICE**

13118

**DATE**

1/20/22



The information and recommendations provided are based on the images presented by the referring veterinarian. 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)**  
info@SonoPath.com