



## PATIENT

Moon Wright

## SPECIES

Canine

## BREED

Huskey

## SEX

Male Neutered

## AGE

7 y

## WEIGHT

27 kgs

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Dr. Axenoff

## HOSPITAL NAME

Wilvet South

## REFERRING VET

Dr. Axenoff

## INVOICE

13140

## DATE

1/29/26

## PRESENTING CLINICAL SIGNS

### History:

- Patient presented for a 2-day history of vomiting which has progressed from clear/yellow bile to hematemesis. Patient had a small volume of yellow-green formed feces yesterday and has been straining to defecate since. P is still eating and drinking normally; energy levels are normal. Physical exam is unremarkable. A new box of dental treats has been started, but P has had these exact treats before with no adverse reaction.
- In 2024, P presented for similar concerns (hematemesis) - blood work and radiographs were unremarkable, and P responded well to outpatient supportive care of sucralfate and omeprazole.

Abnormal PE/Chem/CBC/UA Results: Pancreatic Lipase: 822 (H) CBC: WNL CHEM10: NSF

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra 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.

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 6.0 cm in length. The right kidney measured 6.0 cm in length.

### Adrenal Glands

The left and right adrenal gland were not definitively visualized.

### 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 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 mild, echogenic, nonmineralized biliary sludge. The cystic duct and common bile ducts were normal without evidence of dilation.



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## Gastrointestinal

The stomach presented mild thickened wall. Intact wall layering was maintained and distinct. The stomach contained a mild amount of anechoic fluid. No evidence of pyloric outflow obstruction.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material.

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

## Pancreas

The area of the pancreas presented sonographically normal.

## Free Abdomen

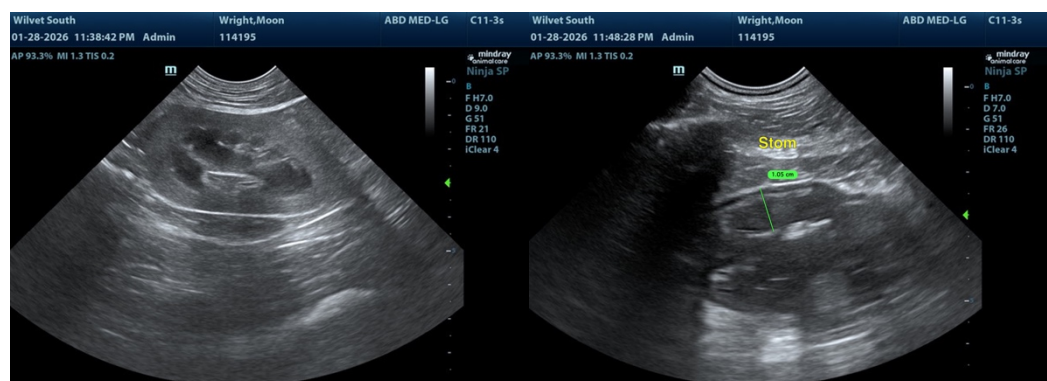
No overt lymphadenopathy or peritoneal effusion was present.

## ULTRASONOGRAPHIC FINDINGS

- Mild hypomotile gastritis
- Empty small intestine
- Normal area of pancreas

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of mechanical gastric or gastrointestinal obstruction or sonographic evidence of active pancreatitis. Mild pancreatitis at times may present sonographically normal and may be suspected if cranial abdomen/subxiphoid discomfort on palpation. Empirical therapy for gastritis and possible mild pancreatitis is recommended with clinical monitoring and sonographic reassessment if non-responsive or progressive gastrointestinal signs. Screening cortisol level to rule out occult Addison's disease.





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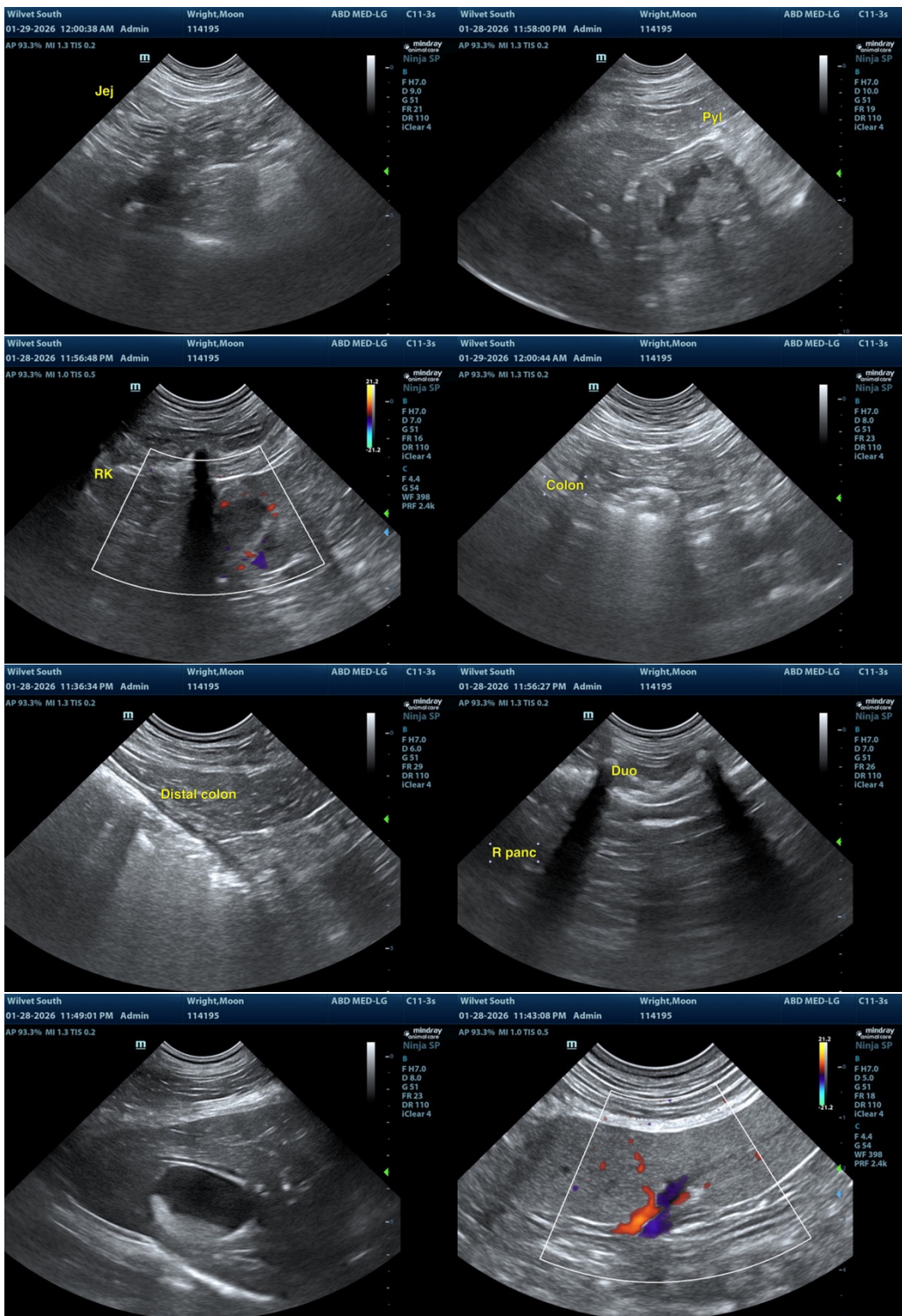
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

[info@sonopath.com](mailto:info@sonopath.com)