

PATIENT	PRESENTING CLINICAL SIGNS
Indy Shipp	<p>PATIENT HAS HAD GI ISSUES BEGINNING 12/21...O NOTES THAT P ATE PART OF A PLASTIC "TAKEOUT" CONTAINER EARLY JANUARY. BLOOD WORK AND EXAM DONE AT ER AROUND THAT TIME ALSO. BW WAS WNL PER THEIR NOTES. THEY SUSPECTED A PIECE OF PLASTIC AT THE PYLORUS AND DID AN ENDOSCOPE ON 1/3/26 AND REMOVED THAT. DOG WAS A LITTLE "LOW" THE DAY FOLLOWING THE PROCEDURE BUT THEN DID FAIRLY WELL FOR THE NEXT 2 DAYS AFTER...STARTED TO DO DOWN HILL THIS MORNING...VERY LETHARGIC, WATERY/BLOODY DIARRHEA/VOMTING, WILL NOT EAT ANYTHING. RADS AND NEW BLOOD WORK DONE IN OUR CLINIC TODAY...THICK INTESTINAL LOOPS WITH GAS SEEN, FOOD OR FOREIGN MATERIAL IN STOMACH? (LAST MEAL WAS 1/5 PM AND DOG VOMITED UP THAT WHOLE MEAL, AS IN WHOLE FOOD THIS AM 1/6) AND THEN DOG VOMITED AGAIN ON CAR RIDE HERE. IS THERE STILL FOREIGN MATERIAL IN THIS P? NEED EXPLORATORY SX? VS GI TRACT IS JUST CONTINUING TO BE IRRITATED FROM EATING PLASTIC...NO FEVER. P DEPRESSED HERE.</p> <p>Abnormal PE/Chem/CBC/UA Results: BW (CHEM, CPL, CBC, LYTES) NORMAL EXCEPT ELEVATED TOTAL WBC COUNT (24, 000...WITH SEGS AND MONOS BEING ELEVATED)</p>
SPECIES	
Canine	
BREED	
Labrador Retriever	
SEX	
Neutered Male	
AGE	
3 Years	
WEIGHT	
80 pounds	
INTERPRETED BY	ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN
R. McKenzie Daniel, DVM, DABVP	Urinary System
	The urinary bladder was mildly distended in size with normal tone. The trigone, cystourethral junction, and visible pelvic urethra to a depth of 4.0 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 change were noted. No evidence of obstruction to urine outflow.
	No evidence of pathology in the area of the residual prostate.
	The area of the aortic trifurcation was free of pathology.
IMAGING PERFORMED BY	
Tiffany Boomer	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.
HOSPITAL NAME	Adrenal Glands
Moyock Animal Hospital	The left adrenal gland was indistinctly visualized yet overtly normal in size, position and shape. The left adrenal gland measured 0.63 cm width.
REFERRING VET	The right adrenal gland was not definitively visualized.
Dr. Tracy Eure	Spleen
INVOICE	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.
12990	
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Liver & Gallbladder

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.

Gastrointestinal

The stomach presented overtly normal intact wall. The stomach was overall nondistended containing a mild amount of retained fluid and progressively shadowing ingesta along with lumen gas. Pyloric gas pocket with potential for nonobstructive pyloric shadowing content measuring approximately 2.5 cm to 3.0 cm in diameter.

The visualized segments of small intestine exhibited intact wall layering and normal wall layer ratio with empty intestinal lumen.

The visualized colon exhibited normal intact wall layering containing semi formed to soft fecal matter and lumen gas.

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 was evident.

Free Abdomen

No significant omental lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Nondistended stomach with progressively shadowing ingesta, retained fluid and gas with possible nonobstructive pyloric shadowing content versus pyloric gas pocket.
- Generalized normal empty small intestine.
- Subjective semi formed to soft fecal matter in colon.
- Normal area of pancreas.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given reported inappetence, the presence of gastric ingesta with retained fluid and gas may indicate metabolic gastric stasis, potentially secondary to mild gastric inflammation or irritation given the patient's history. Potential for recurrent gastric foreign material is of concern although not definitive. No obvious evidence of small intestinal obstructive pattern or definitive foreign material.

Given this presentation, hospitalization with gastrointestinal support including IV fluids in an attempt to dissipate gastric or gastrointestinal gas pattern, documented 12-hour fast and sonographic reassessment of the gastrointestinal tract would be reasonable. If persistent shadowing gastric ingesta in concurrence with continued clinical signs, upper gastrointestinal endoscopy or exploratory laparotomy with gross inspection of the gastrointestinal tract would be indicated. If surgery is elected, gastrointestinal biopsies despite exploratory findings to assess for underlying disease which may



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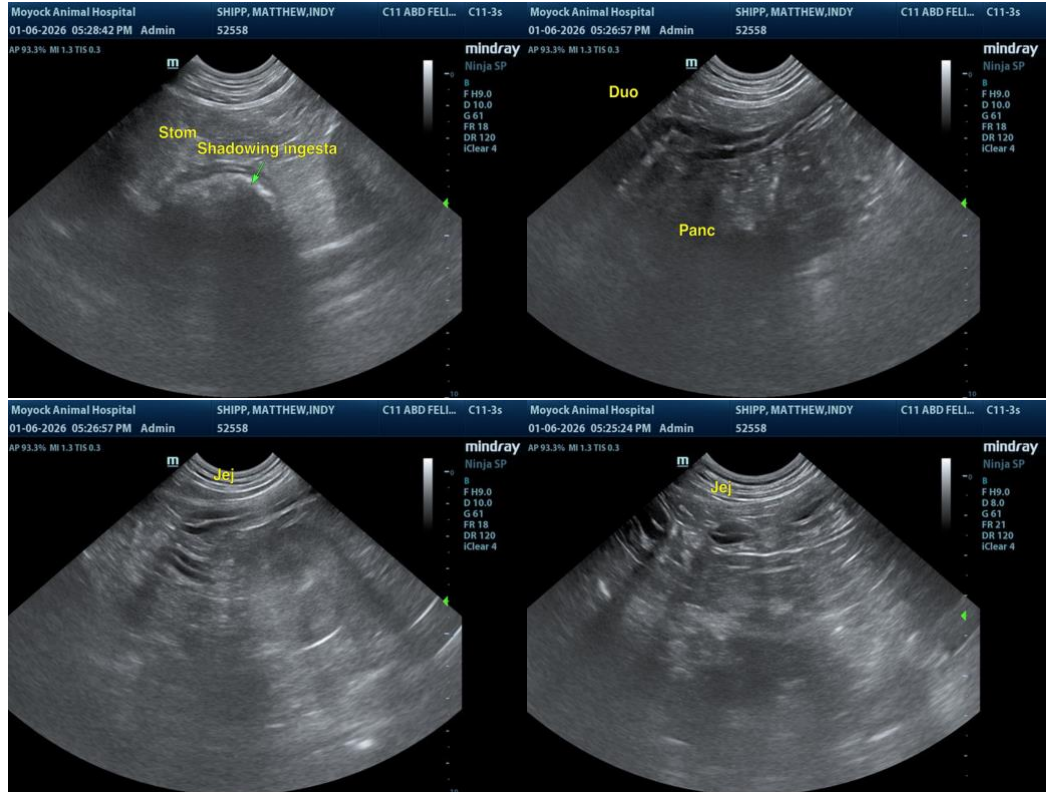
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predispose to pica is recommended. Occult Addison's disease is considered unlikely given the evidence of stress, leukogram and normal electrolyte ratio.





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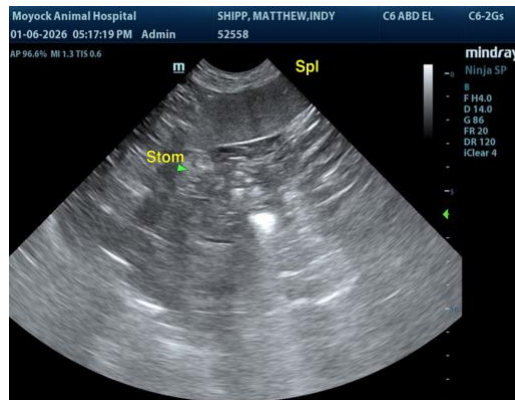
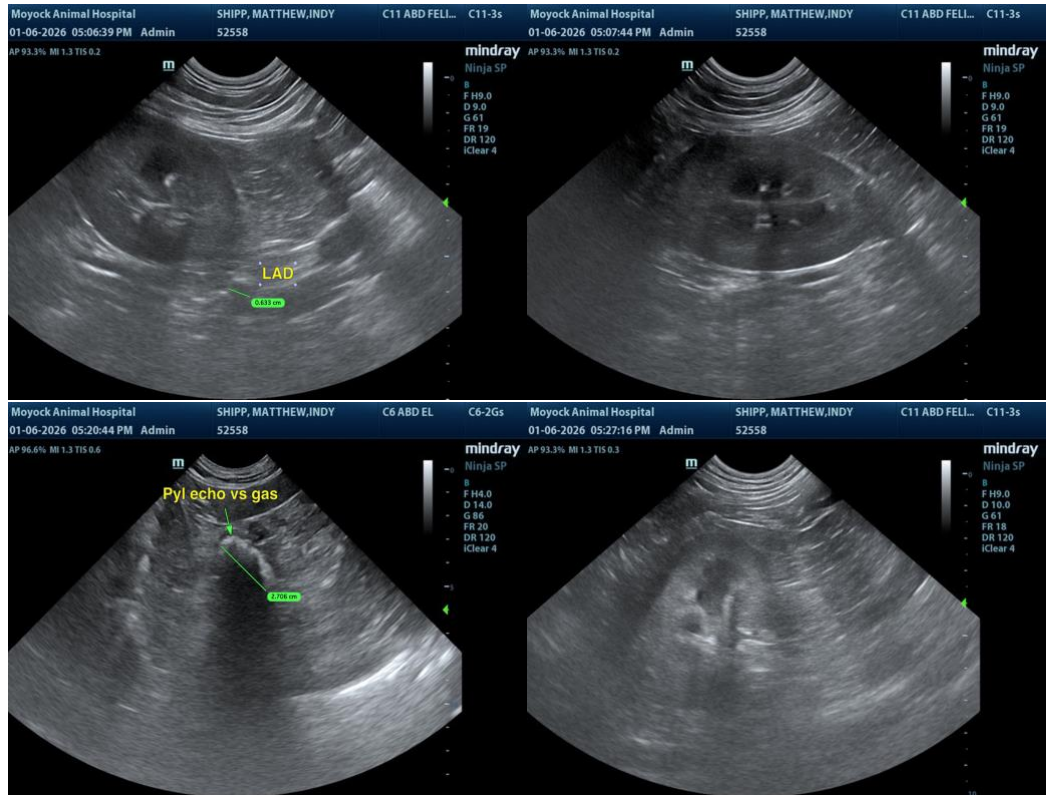
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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