



**PATIENT**

Odie Krehlik

**SPECIES**

Canine

**BREED**

Labrador Retriever

**SEX**

MN

**AGE**

3y 9m

**WEIGHT**

86.4 lbs.

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Dr. Raul Casas-Dolz

**HOSPITAL NAME**

State Avenue VC

**REFERRING VET**

Dr. Raul Casas-Dolz

**INVOICE**

12082ag

**DATE**

11/2/22

**PRESENTING CLINICAL SIGNS**

Initially presented 10/29 for V+ on/off for about 24hrs. not been able to keep food down; today he V 2-3 times; O is not sure if he has been able to keep water down; was a bit drooly; was licking his lips and whining; tonight he was stretching some; O does not about feces; tonight he was sl less active; has been known to eat rocks but will V them up; does not normally eat stuff or destroy things; no food changes; O opened a new bag of the same food about 5 days ago; other dog in home is fine Exam at that time: BAR; energetic; pink (sl bright) mm; tacky mm; CRT 2s; no mur/arrh; no abn lung sounds; no abd dist; got tense during abd palp; grunted sl once; no abns on abd palp; eyes, ears, LNs WNL; skin turg WNL; ambulating normally; T-102.1F BW WNL Presented for recheck today. More lethargic at home. V+ last night. Eating well but ADR

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3 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 was noted.

The residual prostate was symmetrically normal in size with uniform parenchyma and slight coarse echotexture.

The area of the aortic trifurcation was free of pathology.

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 7.0 cm in length. The right kidney measured 7.3 cm in length.

**Adrenal Glands**

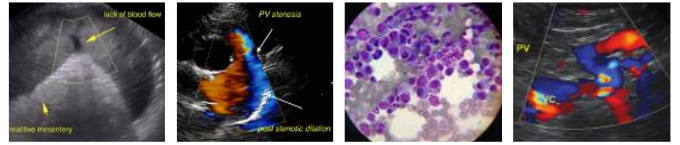
The left and right adrenal gland were not definitively visualized.

**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/ 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 with non-dependent non-organized echogenic debris. No



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evidence of gallbladder or peripheral gallbladder inflammation was present. The cystic and common bile ducts were normal.

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**Gastrointestinal**

The stomach presented intact variably prominent wall layering owing to an echogenic prominent to thickened mucosa layer. Mild associated asymmetric luminal surface contour was present. The lumen of the stomach contained mild hyperechoic progressively shadowing ingesta with no signs of ileus, obstruction, or foreign material. The pylorus wall measured 1.1 cm in width.

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The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine contained segmental to generalized non-shadowing ingesta/chyme with no signs of ileus, obstruction, or foreign material.

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

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**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.

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**Free Abdomen**

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No peritoneal effusion was present.

An enlarged gastric lymph node was present adjacent to the pylorus. This lymph node was homogenous, mildly hypoechoic and smoothly marginated. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic and perigastric inflammation was evident. An example of lymph node size was 2.0 cm in diameter.

**IMAGING PERFORMED BY**

Dr. Raul Casas-Dolz

**ULTRASONOGRAPHIC FINDINGS**

**Primary Findings**

- Variably thickened stomach containing mild on-specific ingesta
- Sonographically unremarkable small bowel with mild non-shadowing ingesta/chyme
- Focal gastric lymphadenopathy

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The presence of mild shadowing gastric ingesta is nonspecific and may indicate post-prandial presentation. The possibility of a small amount of gastric foreign material cannot be excluded given patient history. Monitoring for evidence of gastric emptying vs persistent retained gastric ingesta is suggested.

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The appearance of the stomach may suggest gastritis although other gastropathy i.e. infectious disease, less likely potential for early infiltrative neoplasia could be possible. Given continued reported appetite in this patient some or all of the following protocol or similar could be considered with assessment of clinical response and sonographic monitoring.



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A resting cortisol level to rule out occult Addison's disease is warranted. Ultimately upper GI endoscopy may be indicated if persistent/progressive vomiting despite conservative therapy. Three view chest radiographs are recommended if not done to assess for occult thoracic or esophageal pathology.

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Some or all of the follow protocol or similar may be considered with assessment of clinical response. A clinical trial of **Zithromax (Dogs: 5-10 mg/kg PO q24h. May increase dosing interval to q48h after 3-5 days of treatment), Metronidazole (10-20 mg/kg PO BID), Pepcid (0.5-1 mg/kg PO SID.) and Sucralfate (0.5-2 g/dog PO) or Omeprazole (1 mg/kg PO SID.)** over the next 3 weeks along with a **novel-protein or hydrolyzed diet** with slurry feeding BID/TID. over the next 2-4 days and then increase to canned diet bid. Dry food should be avoided over the next 4 weeks. A recheck sonogram to assess GI improvement or progression would be ideal in 4 weeks.

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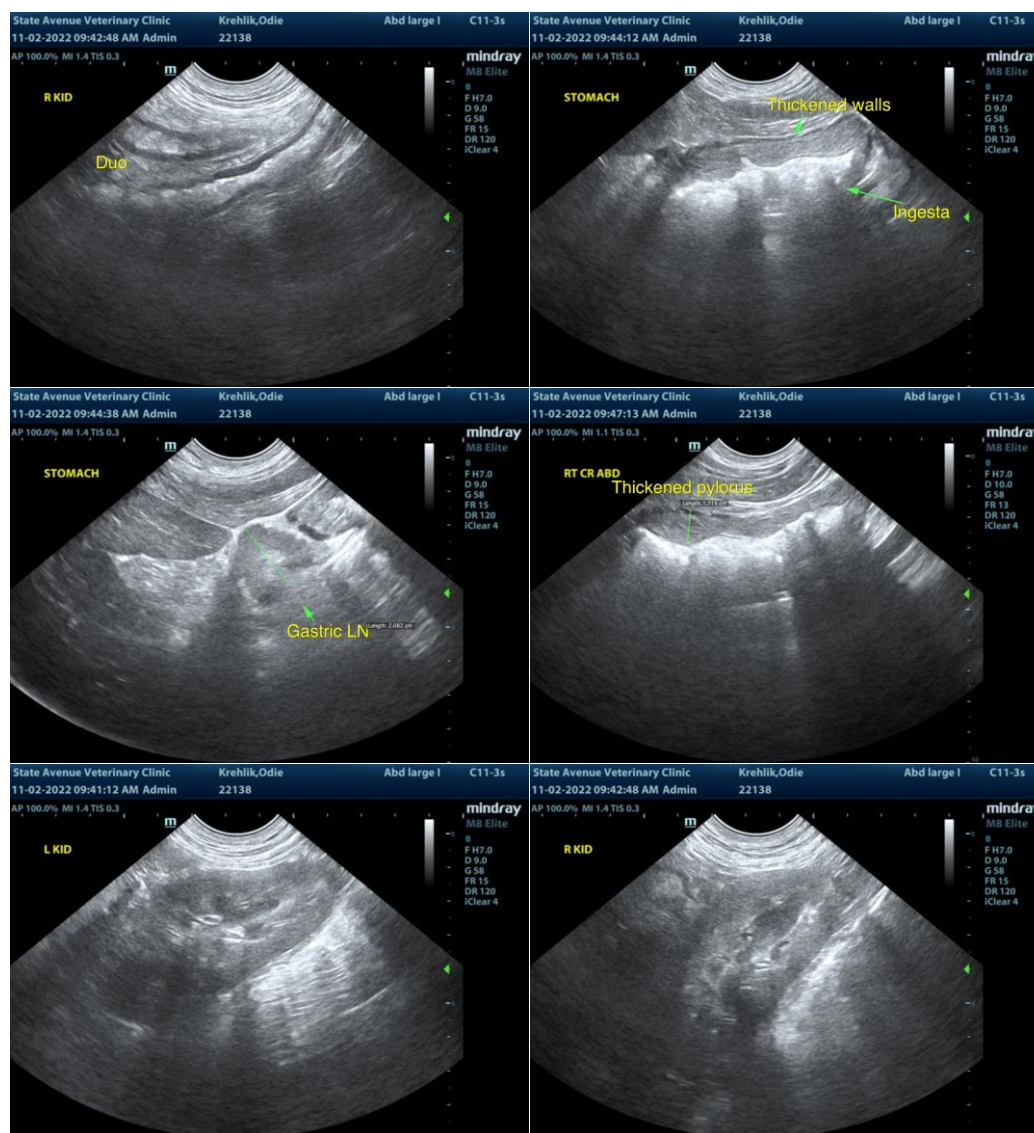
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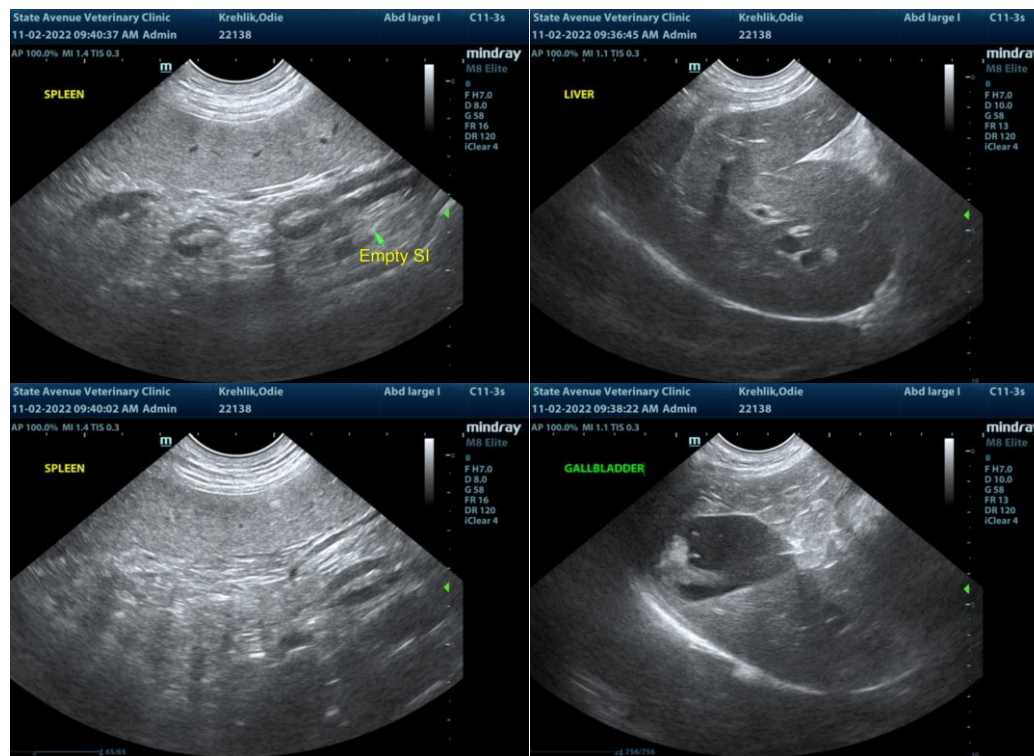
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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