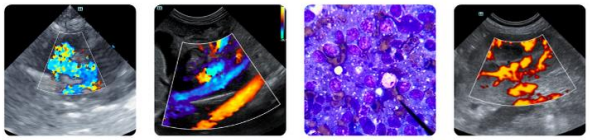


PATIENT

Luna Bui

SPECIES

Canine

BREED

Samoyed

SEX

FS

AGE

9

WEIGHT

55

INTERPRETED BY

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

IMAGING PERFORMED BY

Jenn

HOSPITAL NAME

Rockaway AH

REFERRING VET

Dr. Dubos

INVOICE

10354

DATE

11/14/25

PRESENTING CLINICAL SIGNS

chronic vomiting , unknown etiology 1-2 months Current meds Omeprazole
Abnormal PE/Chem/CBC/UA Results: CBC/Chem/CPL/4DX all neg/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 evidence of urine or lumen sediment, mineral, or calculi. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

No evidence of pathology in the area of the aortic trifurcation.

Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 6.0 cm in length. The right kidney measured 5.1 cm in length.

Adrenal Glands

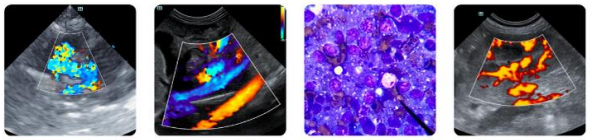
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.60 cm width at the caudal pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.47 cm width 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/ Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was mildly nonuniform and hypoechoic to the spleen with a moderate coarse echotexture and subjective mild parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size. Peripheral lumen, potentially adhered, hyperechoic to emerging mineralized gallbladder debris was present. The common bile duct was not definitively visualized.



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Gastrointestinal

The stomach presented intact mildly prominent gastric wall owing to mild to variably prominent gastric mucosa and mildly prominent rugal folds. The stomach contained a mild amount of anechoic fluid and minor hyperechoic nonshadowing ingesta extending into the pyloric outflow. Definitive evidence of obstruction to pyloric outflow was not obvious. The pylorus wall width measured 0.93 cm in width. The ventral gastric body wall measured 0.65 cm width.

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 foreign material. Mild nonobstructive duodenal ileus was present.

The colon exhibited intact visible wall. The colon exhibited generalized distention with non-formed to liquid fecal matter and segmental gas.

Pancreas

The area of the pancreas was sonographically normal.

Free Abdomen

No overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- Hypomotile gastritis with mild retained gastric fluid / ingesta
- Possible concurrent low-grade duodenitis
- Normal area of pancreas
- Mild distended colon with non-formed to liquid fecal matter

Secondary Findings

- Gallbladder peripheral lumen hyperechoic to mineralized debris

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is no obvious or definitive evidence of mechanical pyloric or upper intestinal obstruction. Continued empirical therapy for gastritis which may include current gastroprotectants and canned hydrolyzed diet +/- empirical therapy for helicobacter and avoidance of dry food over the next 2-3 weeks with clinical and as-needed sonographic monitoring, is suggested. Although considered less likely, screening cortisol level to rule out occult Addison's Disease and a spec cPL to assess for low-grade pancreatitis which may present as sonographically normal, may be considered. Upper gastrointestinal endoscopy would be ideal if continued clinical signs.

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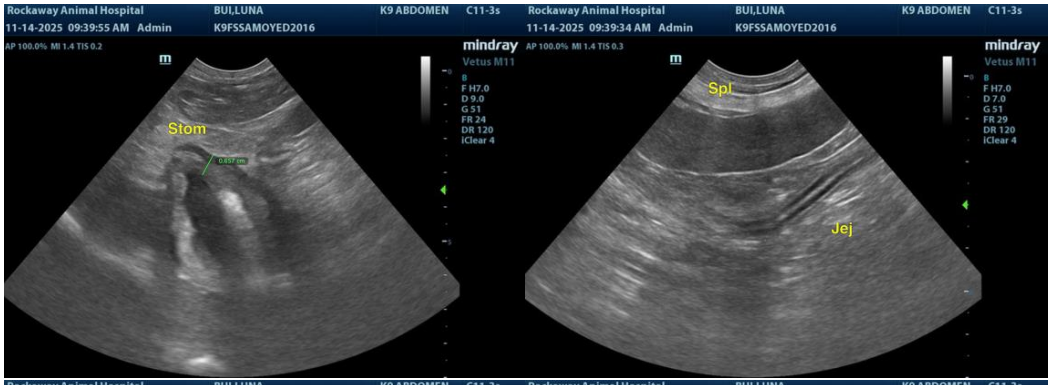

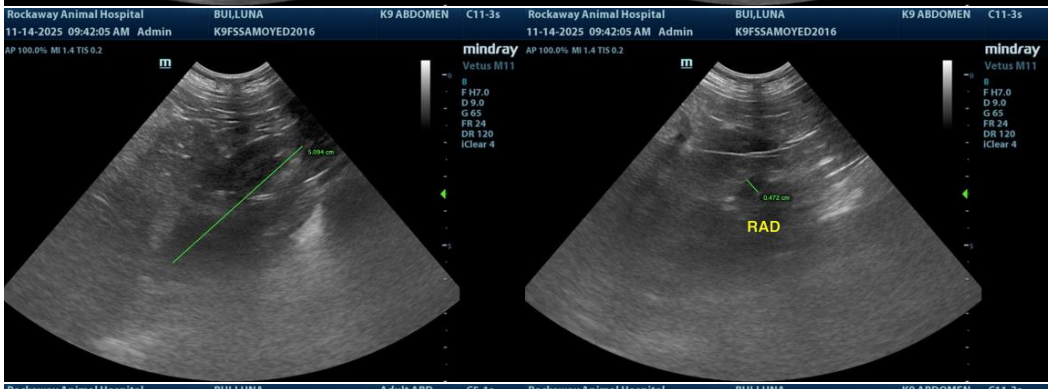

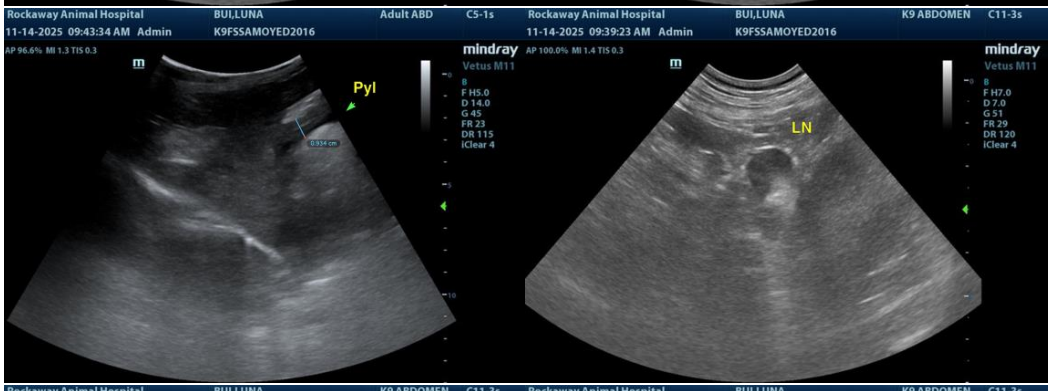

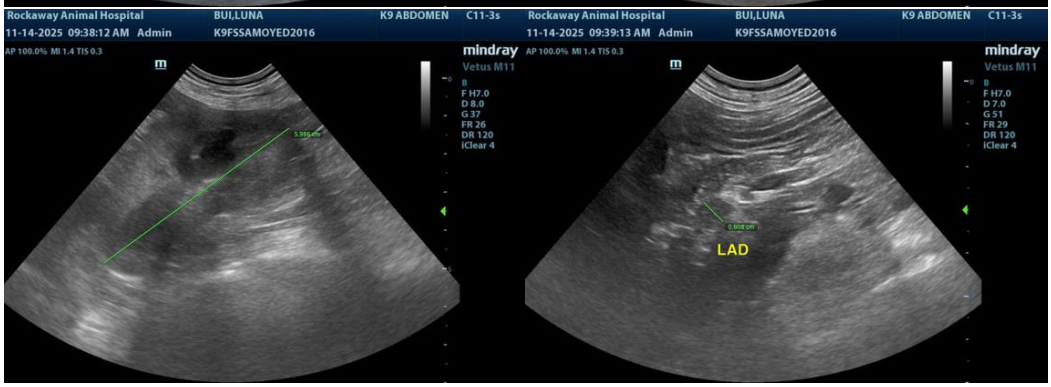

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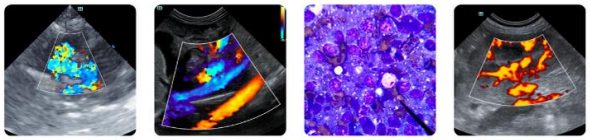

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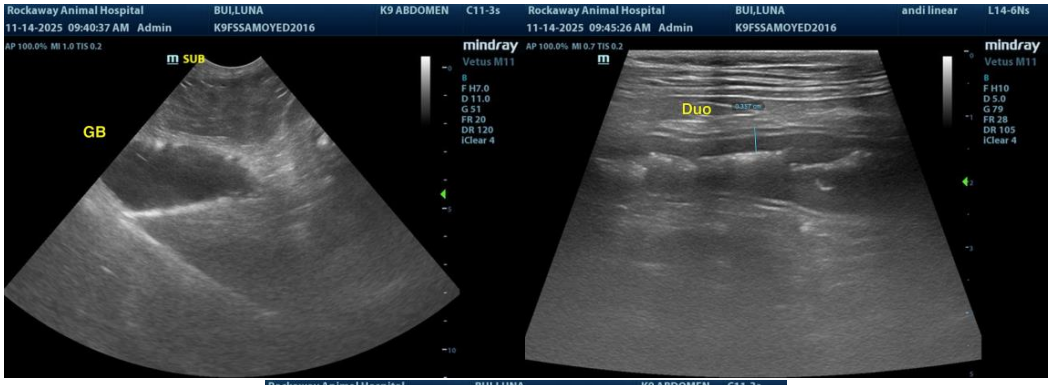

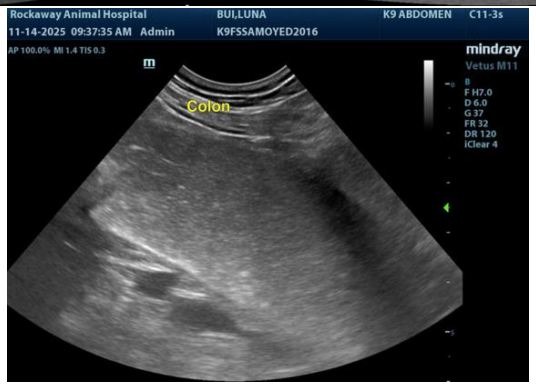

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@sonopath.com