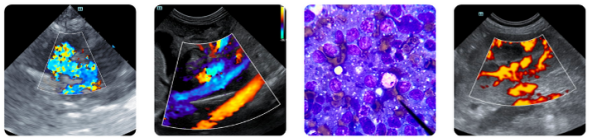




**PATIENT**

Bailey Sincavage

**SPECIES**

Canine

**BREED**

Labrador

**SEX**

Female Spayed

**AGE**

10 yrs

**WEIGHT**

38.6 kgs

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Renee Trionfetti, VMD

**HOSPITAL NAME**

Blue Pearl Wyomissing

**REFERRING VET**

Oley Valley AC

**INVOICE**

12906

**DATE**

12/10/25

## PRESENTING CLINICAL SIGNS

History: AUS to further evaluate chronic, recurrent vomiting / regurgitation. Weight loss of 4 lbs in 2 mos. Presented to pDVM on 12/9/25 for vomiting/regurgitation x few weeks. But for the past 2 days has been vomiting after every meal. Vomit described as solid, undigested very wet food. Has also been seen heaving outside. Is also possibly regurgitating and is described as "food floods out", some gagging but no heaving. Appetite is normal. O unsure if D+ (roams 1.5 acres). AXR concerning for FB partial vs full obstruction vs ileus.

Abnormal PE/Chem/CBC/UA Results: pDVM Diagnostics: - CBC: Hct 51.2%, Plts 244, remainder NSF - Chem: NSF - CXR/AXR (AI): No obvious megaesophagus. Heart subjectively slightly enlarged; AI reading indicated a slightly high vertebral heart score. (11.6). Lungs show slight fibrosis but no evidence of pneumonia or tumors. Stomach is empty. Two distinct populations of SI observed normal gas pattern and dilated, gas-filled loops. Possible plication of intestines noted. An unknown opacity is present centrally possibly, causing ventral displacement of the colon. Liver appears pointed, spleen unremarkable, bladder normal with no evidence of stones.

## 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 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.

The area of the aortic trifurcation was free of pathology.

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 5.8 cm in length. The right kidney measured 6.3 cm in length.

### *Adrenal Glands*

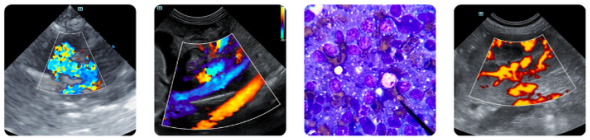
The left adrenal gland was subjective mildly subnormal to flattened in appearance. The left adrenal gland measured 0.48 cm width at the caudal pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.77 cm width at the caudal pole.

### *Spleen*

Solitary, mildly expansive, non-homogeneous, hypoechoic splenic nodule with mild associated symmetrical medial capsule distortion measuring 1.8 cm in diameter. The remainder of the spleen was sonographically normal with probable small benign perihilar hypoechoic myelolipoma.

### *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





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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 normal intact wall layering in the fundus and gastric body. Subjective mildly thickened pylorus exhibiting intact indistinct pyloric mural detail. Pylorus wall potentially measured 1.2 cm width. By comparison, normal appearing ventral gastric body wall measured 0.6 cm width. The lumen of the stomach was empty with mild lumen gas.

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 formed feces in lumen.

### *Pancreas*

The area of the pancreas was sonographically normal.

### *Free Abdomen*

Solitary, mildly prominent mid abdomen mesenteric node was present. The lymph node was essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). No evidence of peritoneal effusion was present.

### *Heart*

Rapid view of the heart revealed no evidence of pericardial masses or effusion in the visible window. Subjective normal left and right cardiac chamber dimension with adequate LV systolic function.

## ULTRASONOGRAPHIC FINDINGS

- Empty stomach with subjective mildly thickened non-obstructive pylorus wall
- Mildly expansive splenic nodule
- Age-related renal changes
- Mildly subnormal left adrenal gland

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Mild pyloric hypertrophy inflammation, infectious disease with pyloric neoplasia thought less likely, possible. No evidence of obstruction to pyloric outflow. Smaller more frequent feedings of a canned novel protein or hydrolyzed diet with avoidance of dry food and gastro protectant Omeprazole 1.0 mg/kg SID and +/- empirical helicobacter coverage with clinical monitoring of the next 10-14 days is suggested. A GI panel to include PLI/TLI/Cobalamin/Folate and screening cortisol level to assess for occult disease in conjunction with weight loss suggested. The mildly expansive splenic nodule may indicate lymphoid hyperplasia, hematopoiesis, inflammation, granuloma or emerging neoplasia. Assuming normal clotting status and using 25-gauge needle, splenic nodule FNA cytology for further clarification. Diagnostic and prophylactic splenectomy with gross inspection of the stomach and upper intestinal tract with potential for biopsies could be considered.

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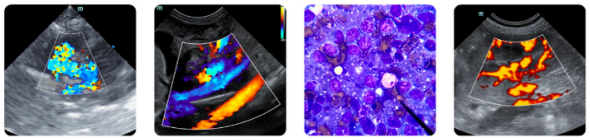

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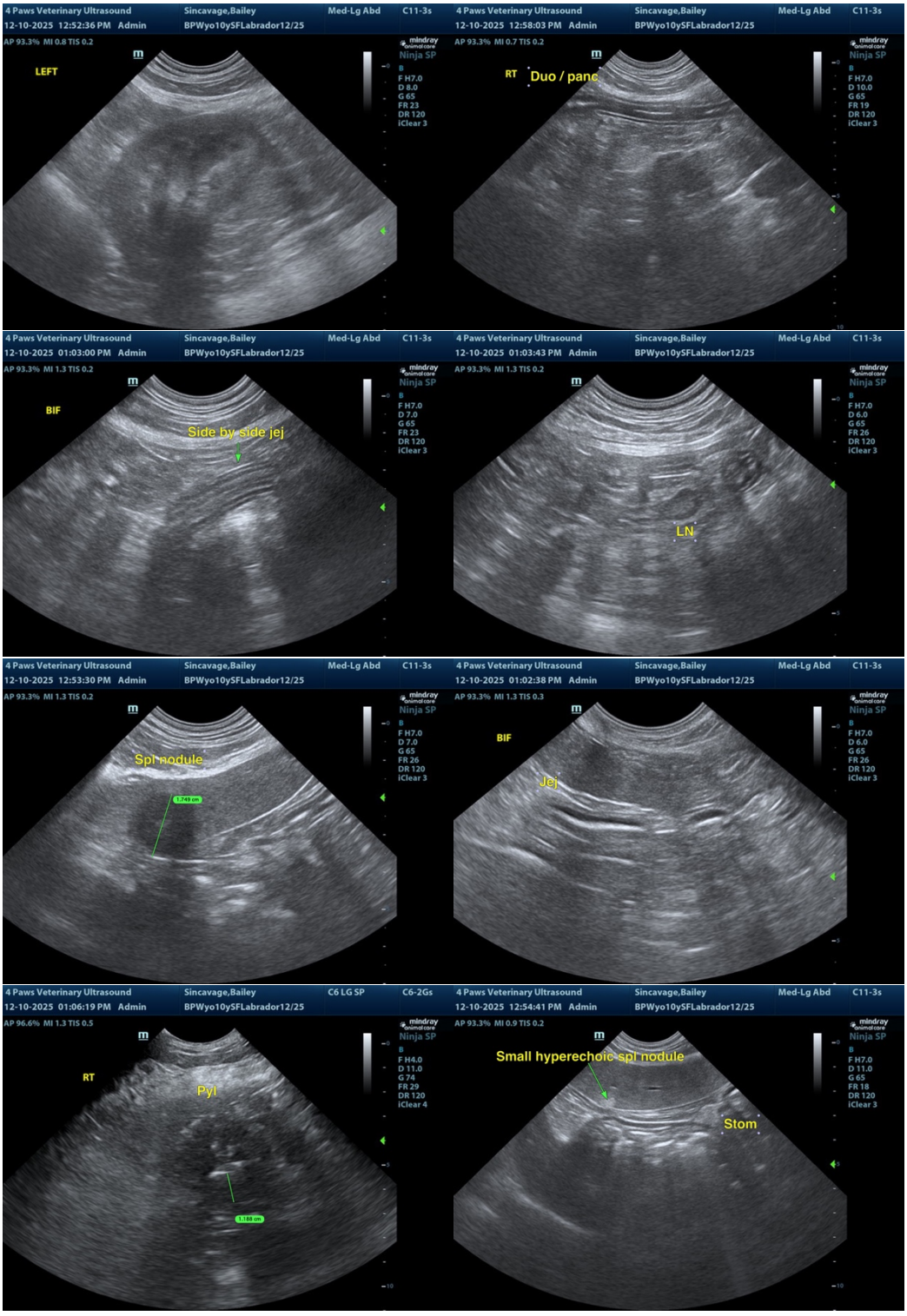

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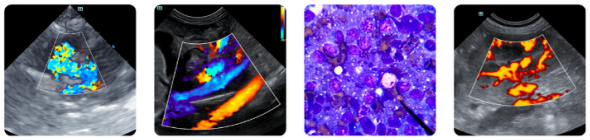

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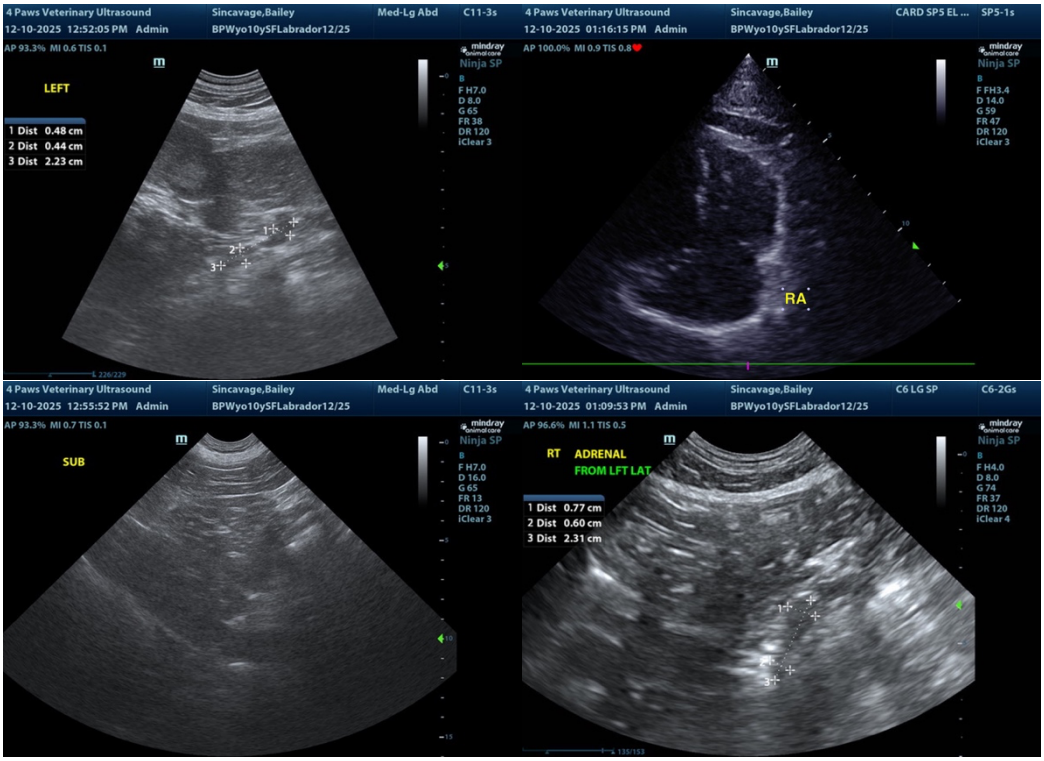


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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)**

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