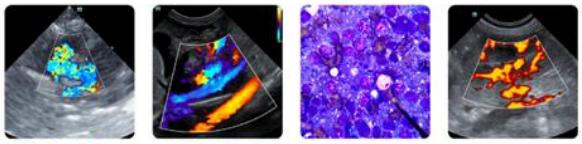


PATIENT

Jake Routh

SPECIES

Canine

BREED

Labrador Retriever

SEX

M

AGE

4

WEIGHT

56.1

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Jenny Russel

HOSPITAL NAME

Southwest Texas Veterinary Medical Center

REFERRING VET

Dr. Brianna Stofas

INVOICE
23334

DATE
12/24/2025

PRESENTING CLINICAL SIGNS

Presented on 12/16 for acting lethargic and vomiting a few times. Is able to hold down wet food, not dry. Was sent home on: fenbendazole, fortiflora, maropitant, sucralfate, and prednisone for back pain. Today, still only able to hold down wet food. Lost 7 lbs, despite eating and holding down wet food. Owners report shifting leg lameness and P seems sore.

Abnormal PE/Chem/CBC/UA Results: PE on 12/16: dry mm, prolonged skin tent, tense on abdominal palpation, stiff hind legs, painful on lumbar palpation. Fecal, Giardia, Snap4dx on 12/16: negative CBC/Chem on 12/16: Globulins 3.8, Neutrophils 10,000, otherwise WNL Abdominal Radiographs on 12/16: NSF Today: Tacky mm, muscle wasting and weight loss since last week. No signs of lameness today. Increased respiratory rate and effort. Thoracic Radiographs: bronchial to interstitial pattern; lung aspirates show blood contamination with neutrophils and monocytes Mesenteric LN aspirates: primarily reactive, few suspect cells unsure what they are

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 mild non-dependent particulate sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

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 7.5 cm in length. The right kidney measured 7.5 cm in length.

Asymmetrically enlarged non-homogenous hypoechoic medial iliac lymph node to nodes were present, an example of a medial iliac lymph node measured 5.1 cm x 2.3 cm.

The area of the residual prostate appeared normal and free of pathology

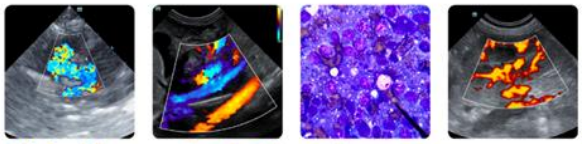
Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.88 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 0.74 cm width at the caudal pole.

Spleen

The spleen was subjective mildly enlarged in size with mild splenic folding and 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



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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. Normal vascular volume. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and minor non-organized debris. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented moderate to significant distention with retained primarily anechoic to echogenic fluid. A small subjective area of non-obstructive ingesta or pyloric echo at the level of the pyloric outflow was visualized measuring ~ 1.2 cm in diameter.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. Empty duodenum and segmental jejunum with mild segmental non-shadowing jejunal ingesta present to the level of the colon.

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

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 overt omental lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary

- Moderate to significant distended stomach with retained fluid and mild hyperechoic to focally shadowing gastropyloric ingesta.
- Normal small intestine exhibiting mild segmental non-shadowing ingesta- no evidence of small intestinal obstructive pattern
- Mildly enlarged folded spleen- patient variant, sedation, hyperplasia, hematopoiesis, inflammation, probable occult splenic neoplasia not excluded yet thought less likely
- Irregular enlarged non-homogenous to hypoechoic medial iliac lymphadenopathy- hyperplasia, inflammation, neoplasia possible.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The distended stomach with fluid and ingesta may indicate metabolic gastric stasis but potentially secondary to sonographically unremarkable gastropathy, gastroenteropathy or mild pancreatitis which may present sonographically normal. The ingesta may suggest retained food echogenicity or focally shadowing medication in conjunction with patient history. Intermixed gastric foreign material or non-visualized upper intestinal mechanical obstruction cannot be definitively excluded.

Initial gastric evacuation, documented 12-hour fast and sonographic reassessment of the upper gastrointestinal tract would be reasonable. Alternatively, if available, upper gastrointestinal endoscopy is likely ideal for further clarification of the gastric interior and pyloric outflow.

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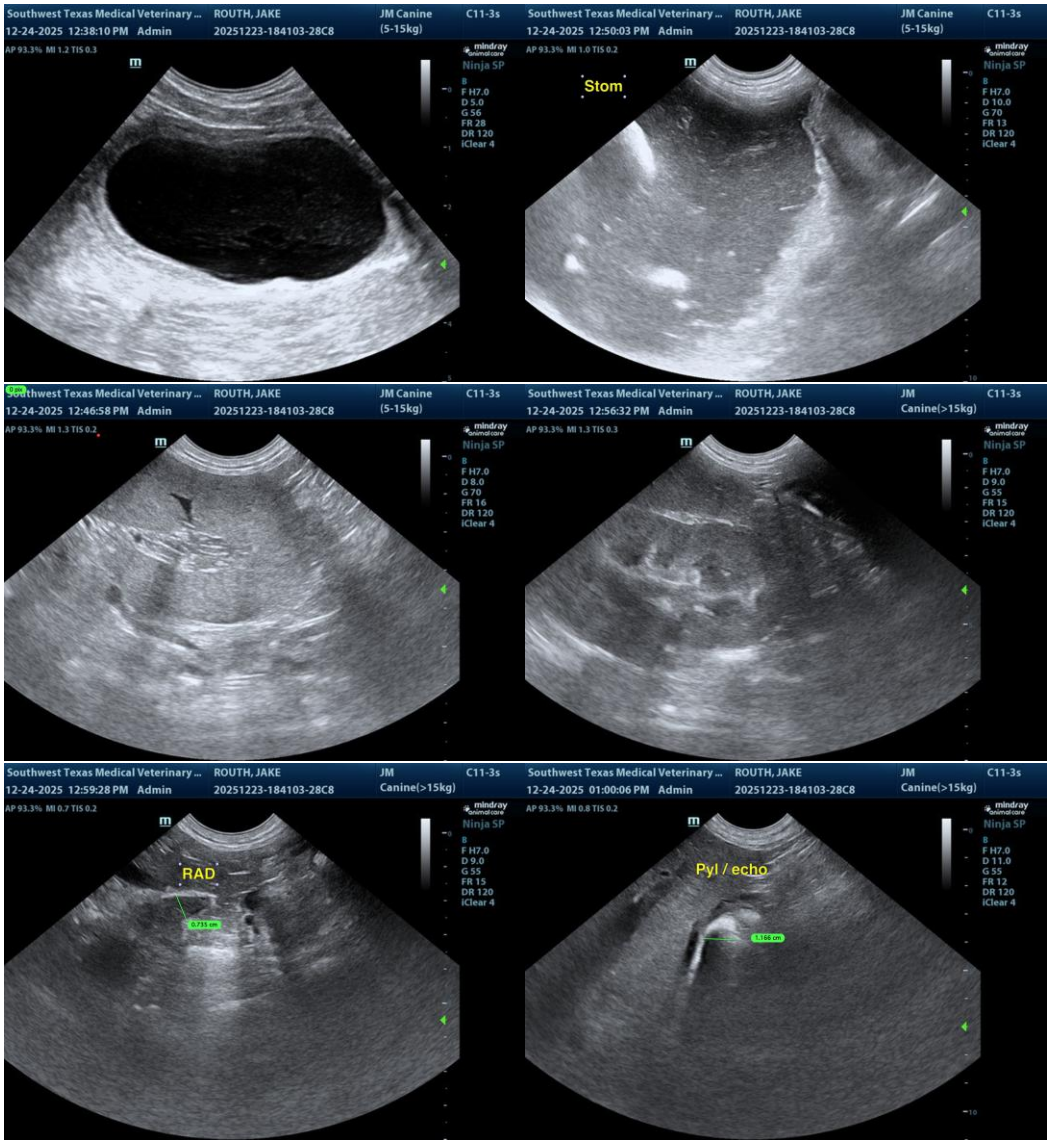
Assuming normal clotting status and using a 25 ga needle, a splenic and medial iliac lymph node cytology is recommended for further clarification.



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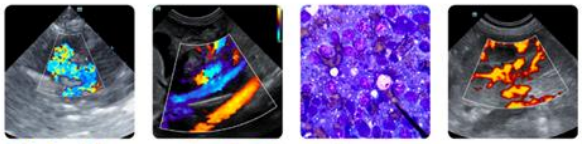

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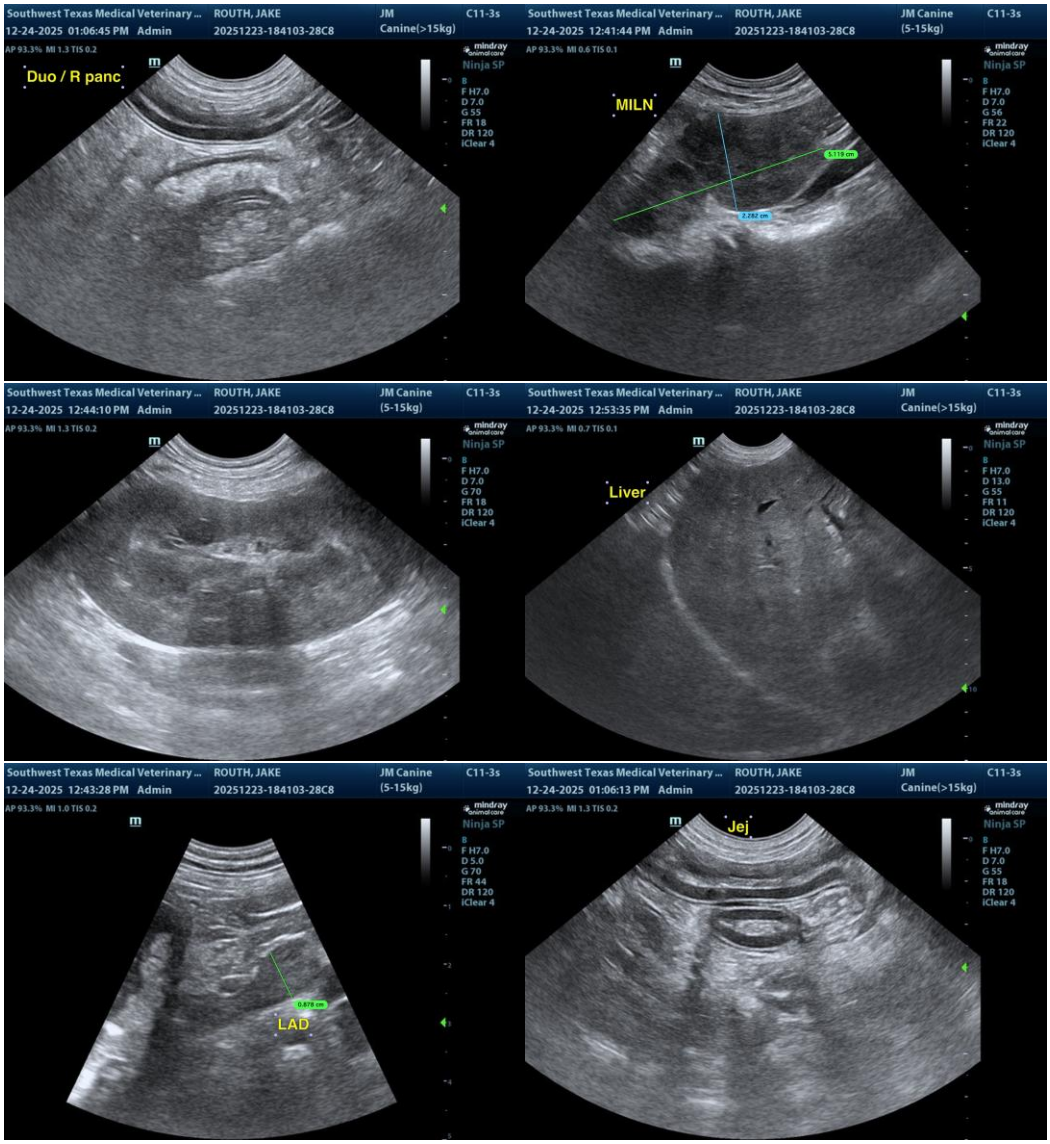

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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