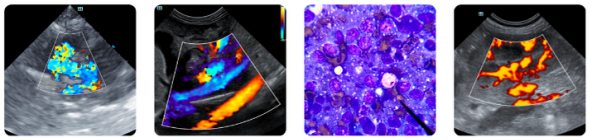


PATIENT

Roofus Mayer-Radke

SPECIES

Canine

BREED

French Bulldog

SEX

Male

AGE

1

WEIGHT

9.94 kgs

INTERPRETED BY

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

IMAGING PERFORMED BY

Wayland

HOSPITAL NAME

Wilvet South

REFERRING VET

Wayland

INVOICE

12985

DATE

12/27/25

PRESENTING CLINICAL SIGNS

History: Roofus presented 12/24 after an episode of vomiting and collapse in the yard followed by progressively worsening lethargy and difficult breathing. He was diagnosed with aspiration pneumonia and severe Gastric outflow obstruction. Contrast radiographs using an iohexol contrast media (due to the fear of aspiration) showed delayed transit from the stomach but no obstruction. Pt has a NG tube in place and continues to reflux. O has described pet as always having a sensitive stomach, occasionally vomiting food he ingested over 6 hours prior. Current reasoning for an abdominal ultrasound is to try and find a cause for the delayed gastric emptying. Pyloric sphincter hypertrophy has been suggested as a possible cause. ExLap was considered but pt has not be stable enough given the severe aspiration pneumonia. Pet is oxygen dependent, with a patent airway dependent upon positioning and so lateral positioning produces serious dyspnea. Pt was partially tilted into sternal positioning for the majority of the image capture and then turned to left lateral positioning (images should be labeled left lateral) to provide a different angle to the pylorus and duodenum. Right kidney images were not captured as pet became hypoxic and procedure had to be terminated.

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 prostate gland is mildly prominent in size with mild non-homogeneous parenchyma exhibiting prostatic presentation for a young, intact male canine without evidence of pathology measuring 2.3 cm in diameter.

The area of the aortic trifurcation was free of pathology.

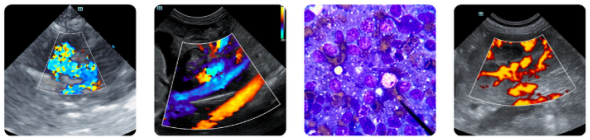
Normal size and margination was present in the left kidney. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 5.0 cm in length. The right kidney was not definitively visualized.

Adrenal Glands

The left and right were overtly normal in size, position and shape. The left adrenal gland measured 0.46 cm. The right adrenal gland measured 0.50 cm.

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.



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Liver

The liver was subjectively normal in size, structure, and contour with normal vascular volume. 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 mild, non-organized, echogenic, nonmineralized biliary sludge. The cystic duct and common bile ducts were normal without evidence of dilation.

Transdiaphragmatic view revealed mild comet tail lung pattern, which is echogenic sound wave interface with microconsolidations within the caudal lung field. The lung field should not be visualized by sonogram unless pathology is present. Chest radiographs are recommended to rule out alveolar/lung disease such as neoplasia, thromboembolic disease, chronic inflammatory disease with microconsolidation.

Gastrointestinal

The stomach presented normal intact visible wall layering with a normal wall layer ratio. The lumen of the stomach contained a moderate amount of variably echogenic, non-shadowing ingesta. No obvious evidence of obstruction to pyloric outflow or obstructive pyloric mural pathology. Pylorus wall measured 0.43 cm width. Ventral gastric body wall measured 0.43 cm width.

The small intestine presented overall intact wall layering with 1:3 muscularis/mucosa ratio and normal wall width. The small intestine exhibited generalized empty lumen to the level of the colon without evidence of mechanical/metabolic ileus. Mild mid descending duodenum corrugation which did not appear to be obstructive to the upper gastrointetsinal outflow. Duodenum wall measured 0.47 cm and jejunum wall measured 0.38 cm.

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 lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

- Normal non-thickened stomach wall with moderate to variably echogenic non-shadowing gastric ingesta – consistent with food echogenicity
- Overall normal empty small intestine with mild mid duodenal corrugation
- Sonographically normal area of pancreas
- Normal bilateral adrenal glands
- Transdiaphragmatic comet tail artifact – likely consistent with clinical history/pneumonia

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No obvious evidence of gastrointestinal, specifically gastro-pyloric or duodenal mural pathology as a definitive cause of the delayed gastric emptying. No evidence of obstructive foreign body. The segmental mild duodenal corrugation, although nonspecific and overtly non-obstructive may suggest

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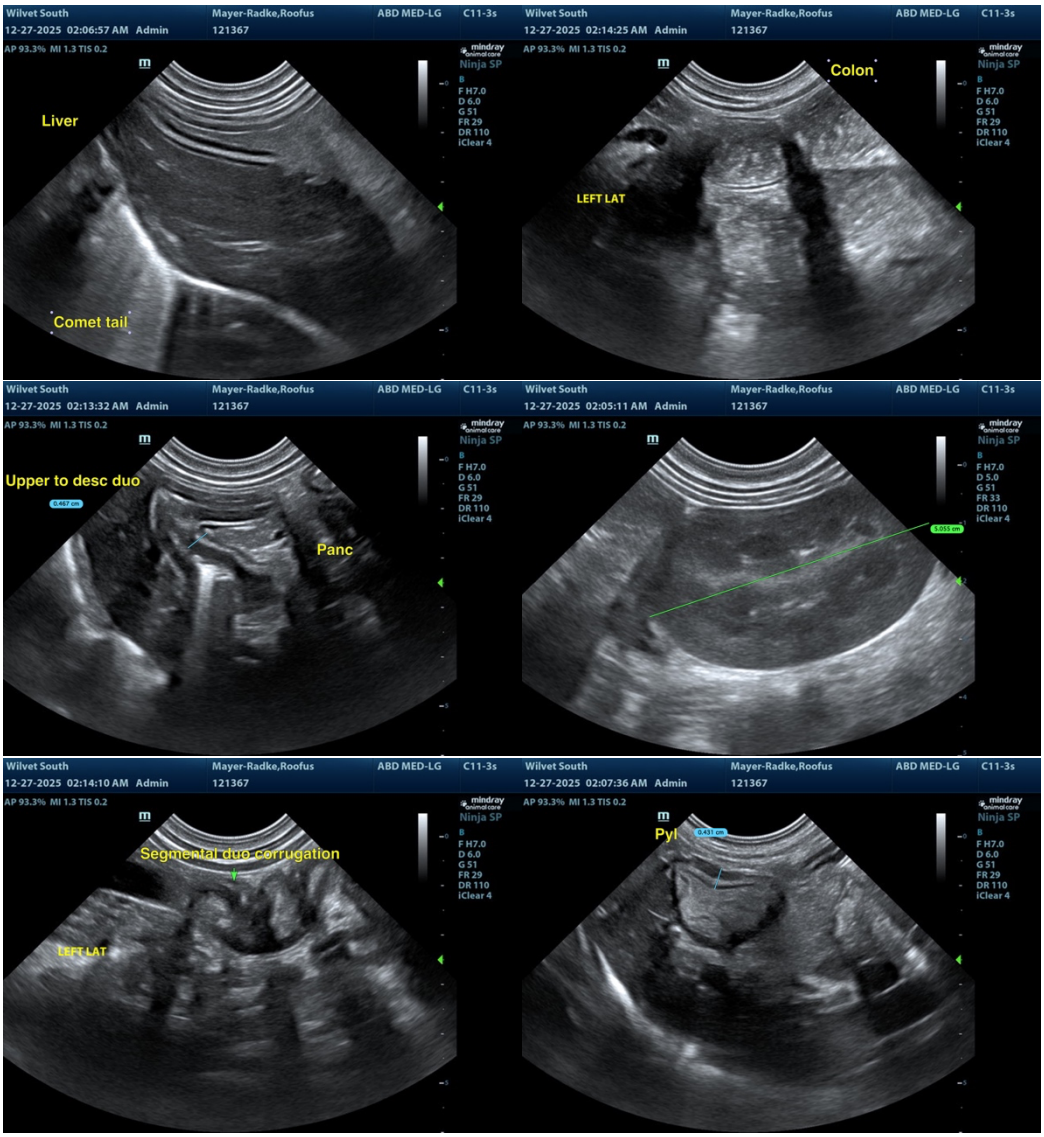
some degree of duodenitis. Pending further therapy for aspiration, pneumonia and clinical monitoring, upper gastrointetsinal endoscopy would be ideal for further assessment of the upper gastrointestinal tract and potential biopsies. Supportive care for gastro duodenitis and +/- empirical coverage for helicobacter would be reasonable. Screening cortisol level to assess for occult Addison's disease is recommended.



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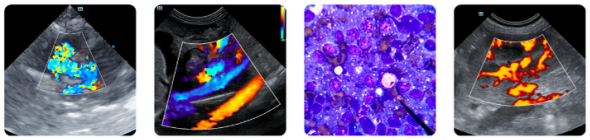

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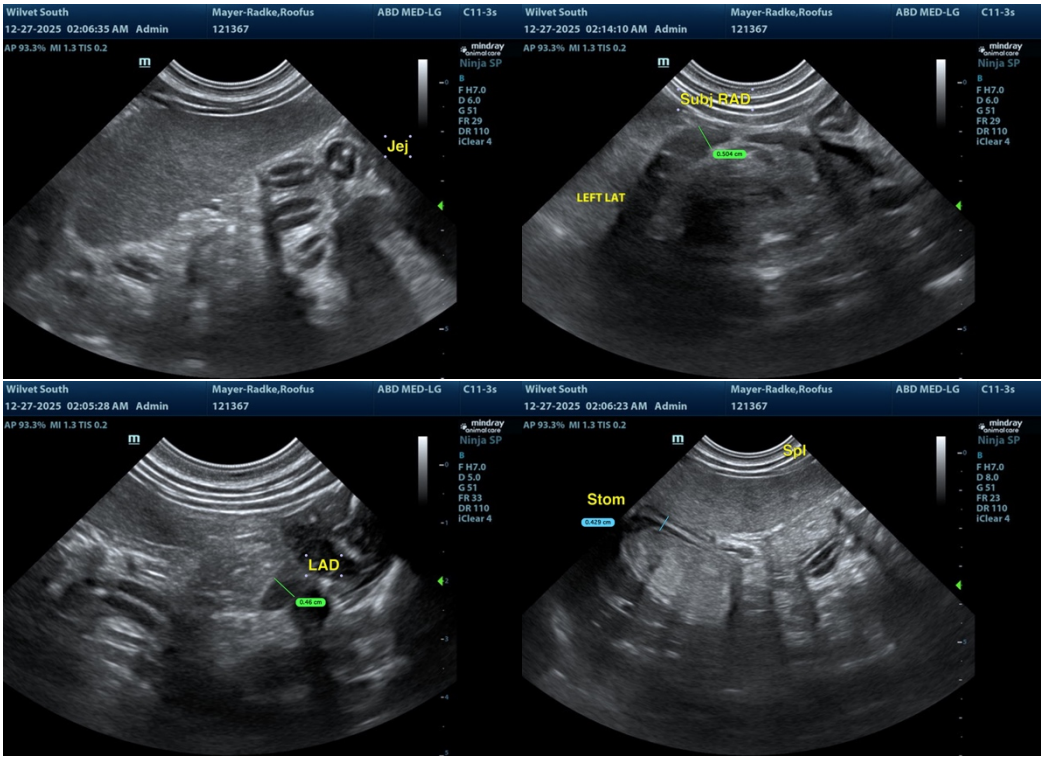

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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