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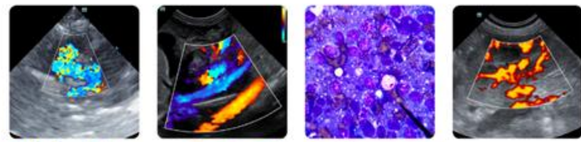
FOSTERING THE ART OF VETERINARY MEDICINE™



Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath.com info@sonopath.com 1.800.838.4268

PATIENT
Falkor Mindt

SPECIES
Canine

BREED
Lab Mix

SEX
MN

AGE
4yr

WEIGHT
53.8lb

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

IMAGING PERFORMED BY
Dr. Jessie Evoniuk

HOSPITAL NAME
State Avenue Vet Clinic

REFERRING VET
Dr. Jessie Evoniuk

INVOICE
23359

DATE
12/19/2025

PRESENTING CLINICAL SIGNS

- Anorexia >1 week; minimal intake (wet dog food, chicken strips, dental bone, beef broth via syringe) - Last ate: half chicken strip and half dental bone last night - Water intake: drank last night; urinating normally, multiple times this morning - Vomiting: single episode of bile during kennel stay (4 days before Christmas) - Defecation: hard, small stool during kennel stay; no bowel movement today; gassy on palpation - Intermittent cough: started 2 days post-Bordetella vaccine, resolved after 7 days doxycycline (100 mg BID) - Pruritus: butt scooting noted post-exam - Weight loss: ~10 lbs over short period - No travel outside ND except to Sidney, MT in past year - Bordetella vaccine administered ~2 days prior to onset of clinical signs

Abnormal PE/Chem/CBC/UA Results: - CBC and chemistry: performed; findings include hematocrit 55.95, lymphocytosis 5.7 (RI: 1–4.8), BUN 52 (RI: 7–25), creatinine 2.6 (RI: 0.3–1.4), calcium 13.1 (RI: 8.6–11.8), phosphorus 8.1 (RI: 2.9–6.6), albumin 2.7 (RI: 2.5–4.4), sodium 134 lo, NA:K ratio 24.8 - SDMA: 16 (RI: ≤14) - T4: 1.9 - Urinalysis: cloudy, opaque; SG 1.022–1.020; pH 6; bilirubin 3; urobilinogen 4; WBC/RBC <1/hpf; cocci bacteria; no crystals; casts detected - Quiet, subdued demeanor - Slightly pale, slightly tacky mucous membranes - Mild gas on abdominal palpation - Pruritus: butt scooting observed post-exam

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 evidence of urine/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.

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 7.1 cm in length. The right kidney measured 6.7 cm in length.

The area of the aortic trifurcation was free of pathology.

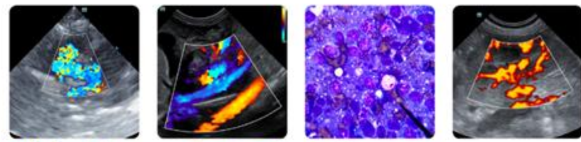
The area of the residual prostate appeared normal and free of pathology

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.64 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 0.48 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.



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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. 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 primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. The gastric body wall measured 0.77 cm width. Mild gastric distension with primarily anechoic fluid and chyme was present. No evidence of shadowing gastric echo, overt foreign material or mechanical pyloric outflow obstruction.

The small intestine presented intact wall layering with maintained muscularis/mucosa ratio. Segmental, primarily jejunal ileus with concurrent empty jejunal segments and segmental intestinal gas was present.

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 omental masses or peritoneal effusion was present.

Intermittent mildly prominent to enlarged mesenteric lymph nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5).

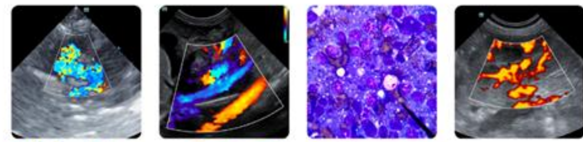
ULTRASONOGRAPHIC FINDINGS

Primary

- Hypomotile gastritis pattern
- Empty small intestine with concurrent mild intestinal ileus exhibiting retained fluid and segmental intestinal gas
- Semi-formed fecal matter in colon.
- Normal area of pancreas
- Sonographically normal liver/ spleen
- Intermittent mild mesenteric lymphadenopathy-not overtly consistent with neoplastic or inflammatory criteria

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Metabolic gastric and segmental intestinal ileus potentially secondary to dietary indiscretion, infectious disease, enterotoxin, inflammatory bowel, mild pancreatitis, occult Addison's disease, or possible occult to emerging neoplasia is possible. Although a definitive area of mechanical intestinal obstruction



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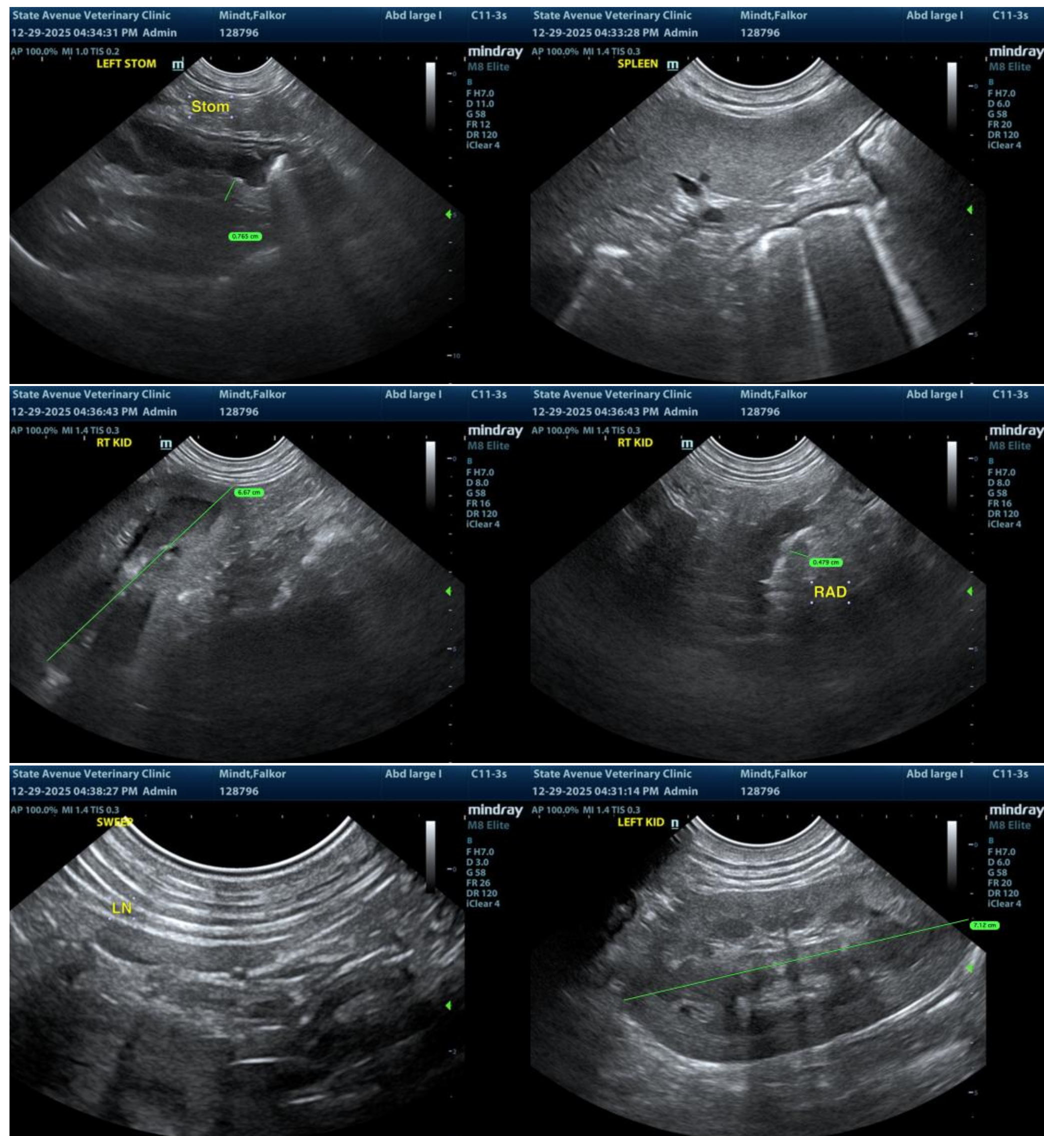
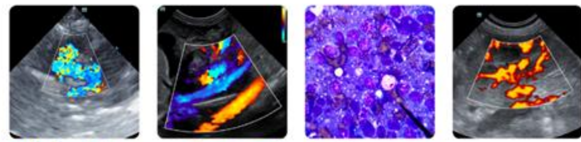
was not obvious, partial small intestinal obstructive pattern with potential foreign body obscured by intestinal gas is not excluded.

Three view chest radiographs, screening cortisol level, and GI panel to rule out occult disease is warranted. Given evidence of potential dehydration, hospitalization with IV fluid / gastrointestinal support, documented 12-hour fast, and sonographic reassessment of the gastrointestinal tract with clinical monitoring would be reasonable.

Exploratory laparotomy with gastrointestinal biopsy considered essential despite exploratory findings and in conjunction with weight loss recommended if non-responsive or progressive gastrointestinal signs or gastrointestinal ileus.





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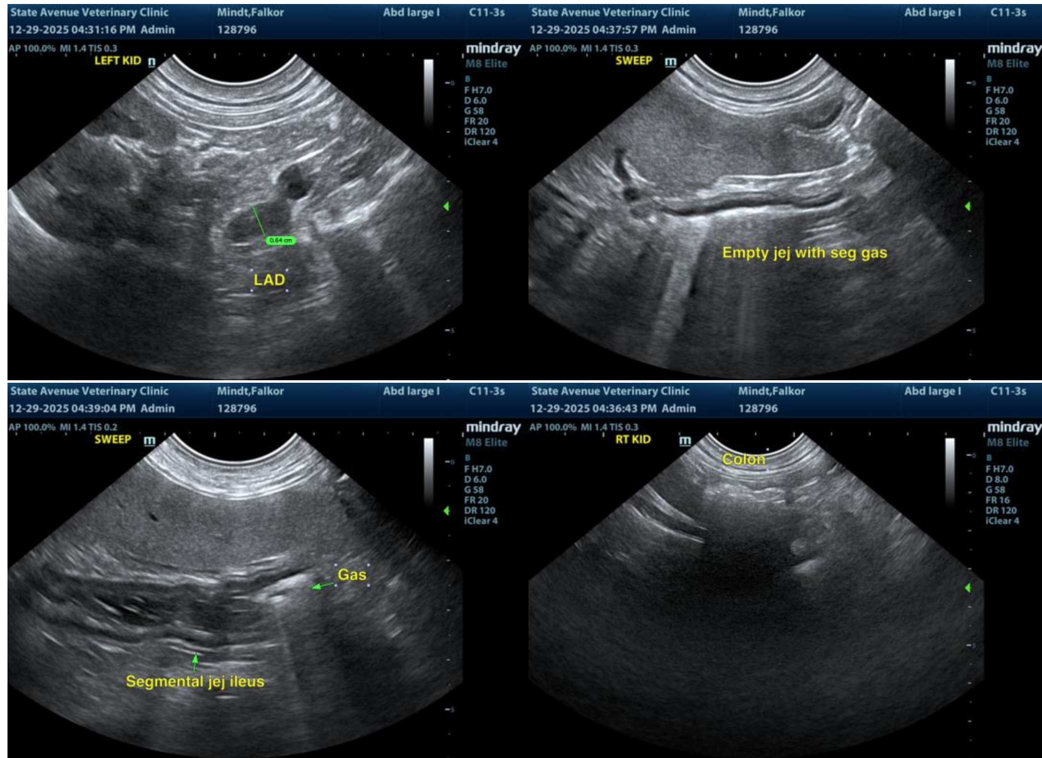

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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