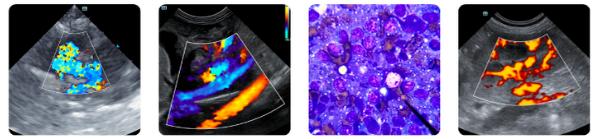


PATIENT

Dudu Zhang

SPECIES

Canine

BREED

Mini Schnauzer

SEX

Male

AGE

4 months

WEIGHT

12

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Sharkaway

HOSPITAL NAME

Union Vet AH

REFERRING VET

Dr. Sharkaway

INVOICE

12999

DATE

12/30/25

PRESENTING CLINICAL SIGNS

History: No more vomiting

Abnormal PE/Chem/CBC/UA Results: PE-wnl soft stool, Tar like Fecal analysis- pending

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 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 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 4.3 cm in length. The right kidney was not definitively visualized.

Adrenal Glands

The left and right adrenal glands were not definitively visualized.

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

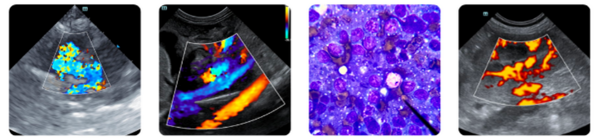
The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact persistent mildly thickened wall measuring 0.57 cm gastric body wall width. The stomach is empty without evidence of persistent retained gastric fluid or overt foreign material.

Persistent, mildly thickened upper duodenum with mild retained duodenal fluid. A focal area of duodenal to potential upper jejunal shadowing was present yet did not appear to be obstructive. Previously noted linear echo was not definitively visualized. The overall jejunum exhibited intact wall layering with normal wall layer ratio and empty lumen to the level of the ileum and colon.

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



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Pancreas

The area of the pancreas was sonographically normal.

Free Abdomen

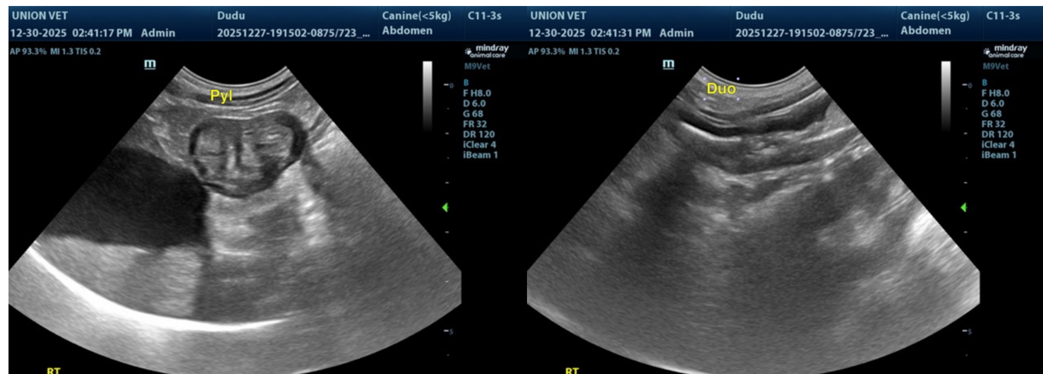
Intermittent, mildly prominent to enlarged jejunal nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). No evidence of peritoneal effusion was present.

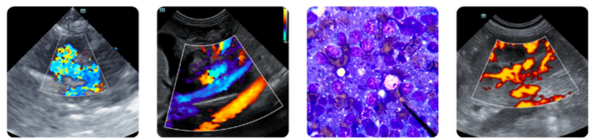
ULTRASONOGRAPHIC FINDINGS

- Suspect persistent mild to resolving gastroduodenitis with overall empty gastrointestinal tract
- Minor persistent duodenal fluid and possible focally shadowing non-obstructive duodenal or upper jejunal echo
- Intermittent mild benign mesenteric lymphadenopathy

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Resolved gastric and overall upper intestinal ileus without evidence of definitive obstructive pattern or previously noted possible linear echo. The potential for a small amount of persistent yet non-obstructive upper intestinal foreign material cannot be definitively excluded. Given reported improving to resolved gastrointestinal signs, continued gastrointestinal support and clinical monitoring would be reasonable. Sonographic reassessment indicated if recurrent or progressive gastrointestinal signs. Correlation with pending fecal analysis and continued monitoring of fecal output for evidence of potential foreign material.





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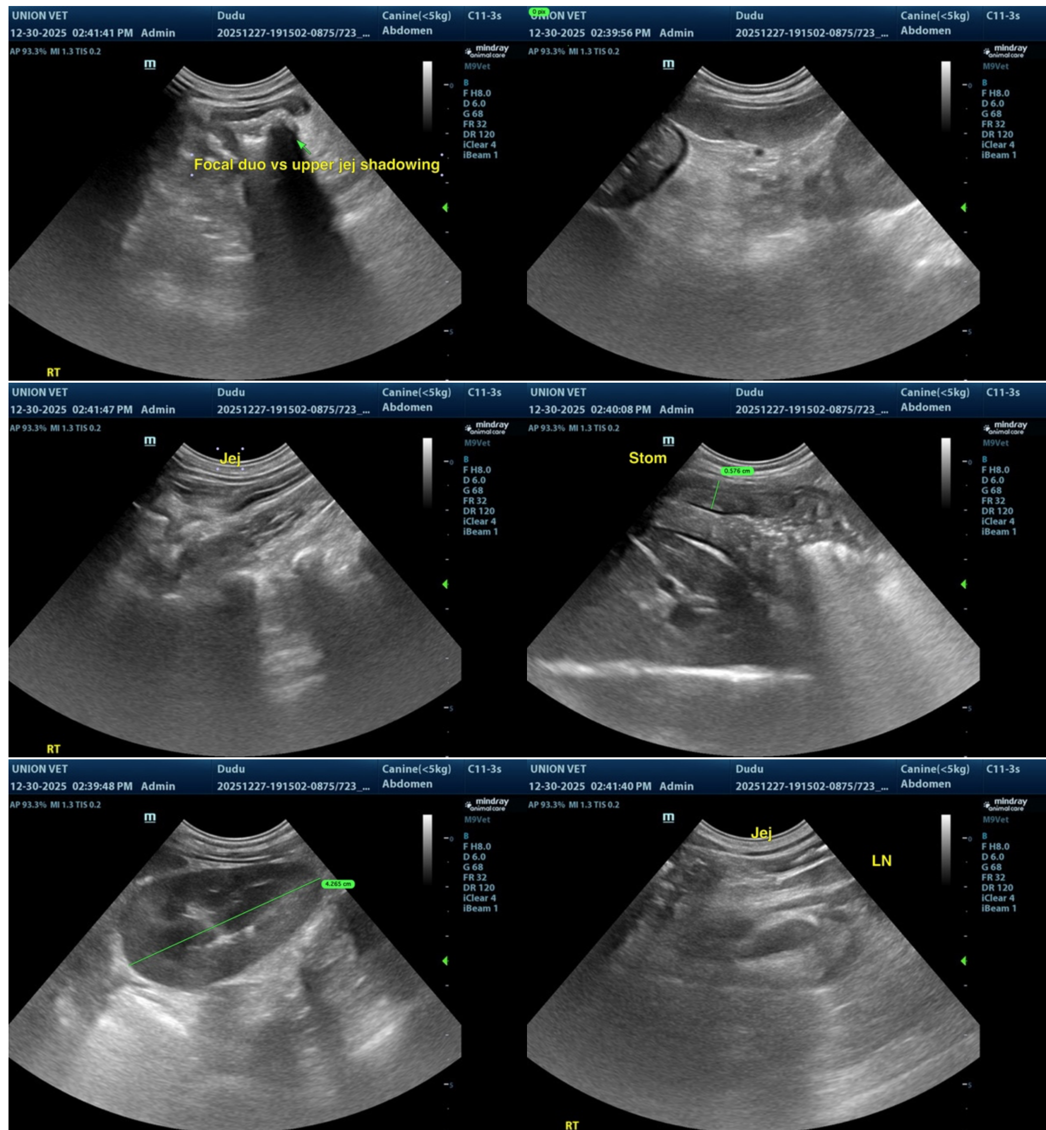

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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