



PATIENT

Jax McGraw

SPECIES

Canine

BREED

Dachshund

SEX

MN

AGE

6.5mo

WEIGHT

5kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Melissa Randolph

HOSPITAL NAME

Shores Veterinary
Emergency Center

REFERRING VET

Julia Kerr

INVOICE

23387

DATE

12/30/2025

PRESENTING CLINICAL SIGNS

*presented 12/30 3:30 am for no bm since 7am 12/29, vomiting. O suspects P ate his nylabone and is constipated. Patient has been straining to defecate tonight (12/29). Last stool was 21 hours ago. Patient has also been vomiting for 2 days (5-6 times). He also has hiccups, is sleeping more than normal, and is shaking. Patient is known to consume foreign material. On 12/17, he vomited cloth, hair, and other things. admitted for supportive care; iv fluids with KcL, buprenorphine, cerenia, pantoprazole. *concern for gastroenteritis, small bowel fb with obstruction, other

Abnormal PE/Chem/CBC/UA Results: PE: 2/4- Mild Pain, with lower abd palpation; splints during palpation; Reactive, do think I palpated some soft foreign material; abd: Other, rectal no stool palpable just gas EPOC: Na 139(L), K+ 3.2 (L), Chloride 105(L), pH 7.48(H) Liver: ALP 143, glucose 128 rads: some gas distended loops of SB concerning for foreign material; On VD- left side foreign material vs stool rads 12/30 12 pm: fluid & gas filled stomach w/ mild dilation. small amt of heterogenous content w/in the small bowel may be poorly digested food or foreign material. some seg of SB are fluid & gas dilated which may be functional ileus secondary to enteritis, partial mechanical obstruction or an early complete mechanical obstruction. soft feces present w/in colon. reduced peritoneal serosal detail caudal to stomach.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone and cystourethral junction 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 4.3 cm in length. The right kidney measured 4.5 cm in length.

The area of the aortic trifurcation was free of pathology.

The residual prostate appeared normal and free of pathology. Mildly dilated prostatic urethra with normal post-prostatic urethra structure, tone and depth to 3 cm.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.37 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 0.39 cm width.

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



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thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

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

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Gastrointestinal

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The stomach presented wall thickening secondary to echogenic mucosa hypertrophy. Intact wall layering was maintained and distinct. 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.

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The small intestine presented overall intact wall layering with maintained muscularis/mucosa ratio. Empty duodenum and segmental jejunum was present with concurrent mildly distended jejunal segments with mildly retained fluid, gas and potential intermittent jejunal and ileal non-obstructive shadowing content.

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The visualized colon exhibited intact mildly prominent descending colon wall. The proximal colon distal to the subjective ileocolic junction exhibited mild distension with non-formed fecal matter with shadowing fecal matter present in the descending colon. Concurrent segmental colon gas was present.

Pancreas

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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.

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Free Abdomen

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No omental masses, overt lymphadenopathy or peritoneal effusion was present.

Melissa Randolph

ULTRASONOGRAPHIC FINDINGS

HOSPITAL NAME

Primary

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Emergency Center

- Hypomotile gastritis pattern
- Enteritis exhibiting empty duodenum and segmental jejunum with concurrent mild dilated jejunal segments with fluid, gas and potential shadowing content to level of the ileocolic junction.
- Non-formed fecal matter in proximal colon with shadowing fecal matter in descending colon

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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The gastrointestinal presentation is highly concerning for non-obstructive potentially passing segmental intestinal foreign material extending to the level of the ileocolic junction. Potential passed foreign material within the segmental to likely descending colon is suspected. Overall, no evidence of gastric foreign material or definitive small intestinal obstructive pattern.

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Given this presentation, hospitalization with 24-hour IV fluid/ gastrointestinal support, documented 12-hour fast and sonographic reassessment of the gastrointestinal tract with concurrent monitoring of fecal output would be reasonable.

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However, in conjunction with patient clinical signs and history, exploratory laparotomy is warranted with gross inspection of the gastrointestinal tract potential for enterotomy and /or manual manipulation of the colon if evidence of foreign material.

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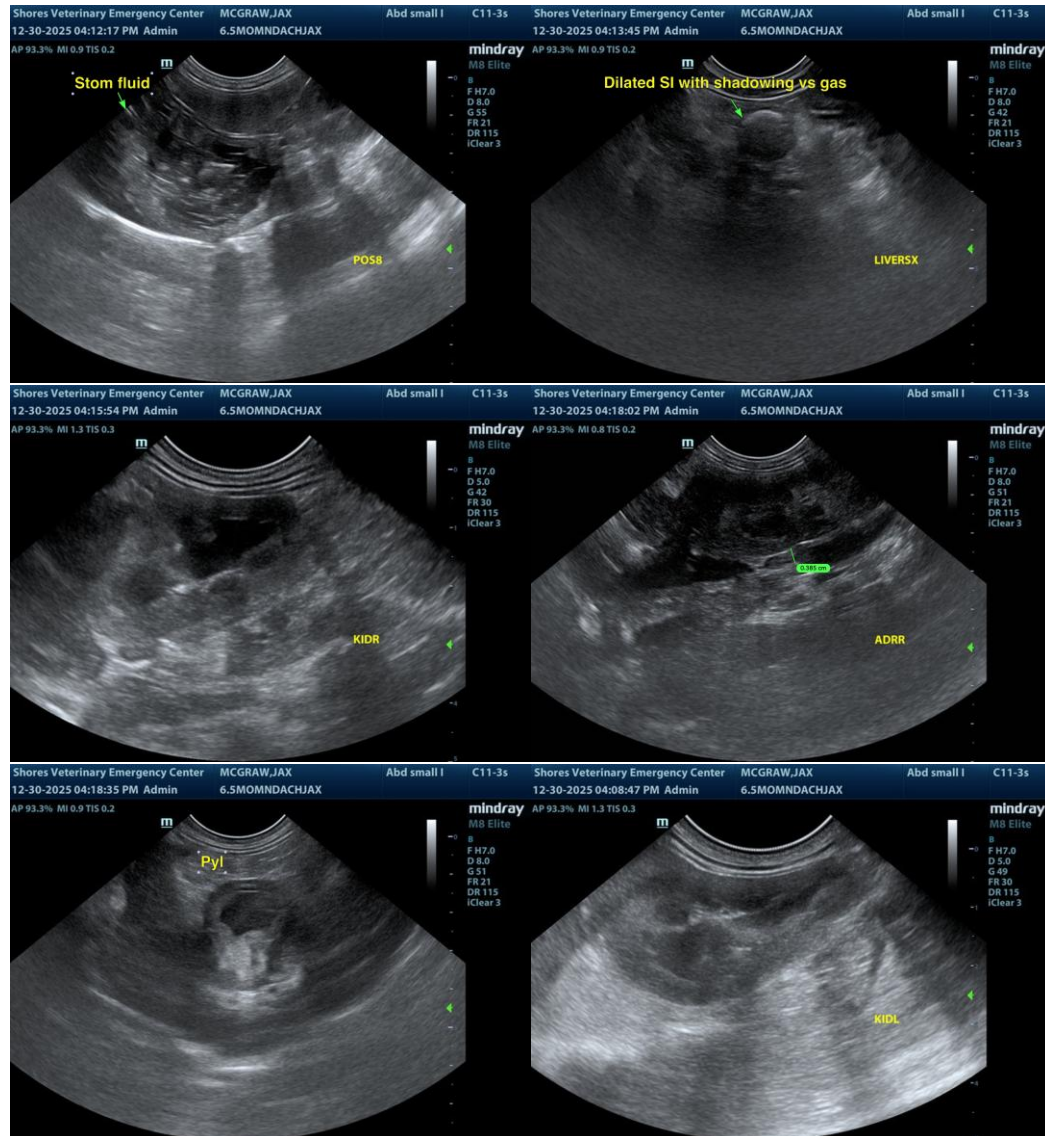
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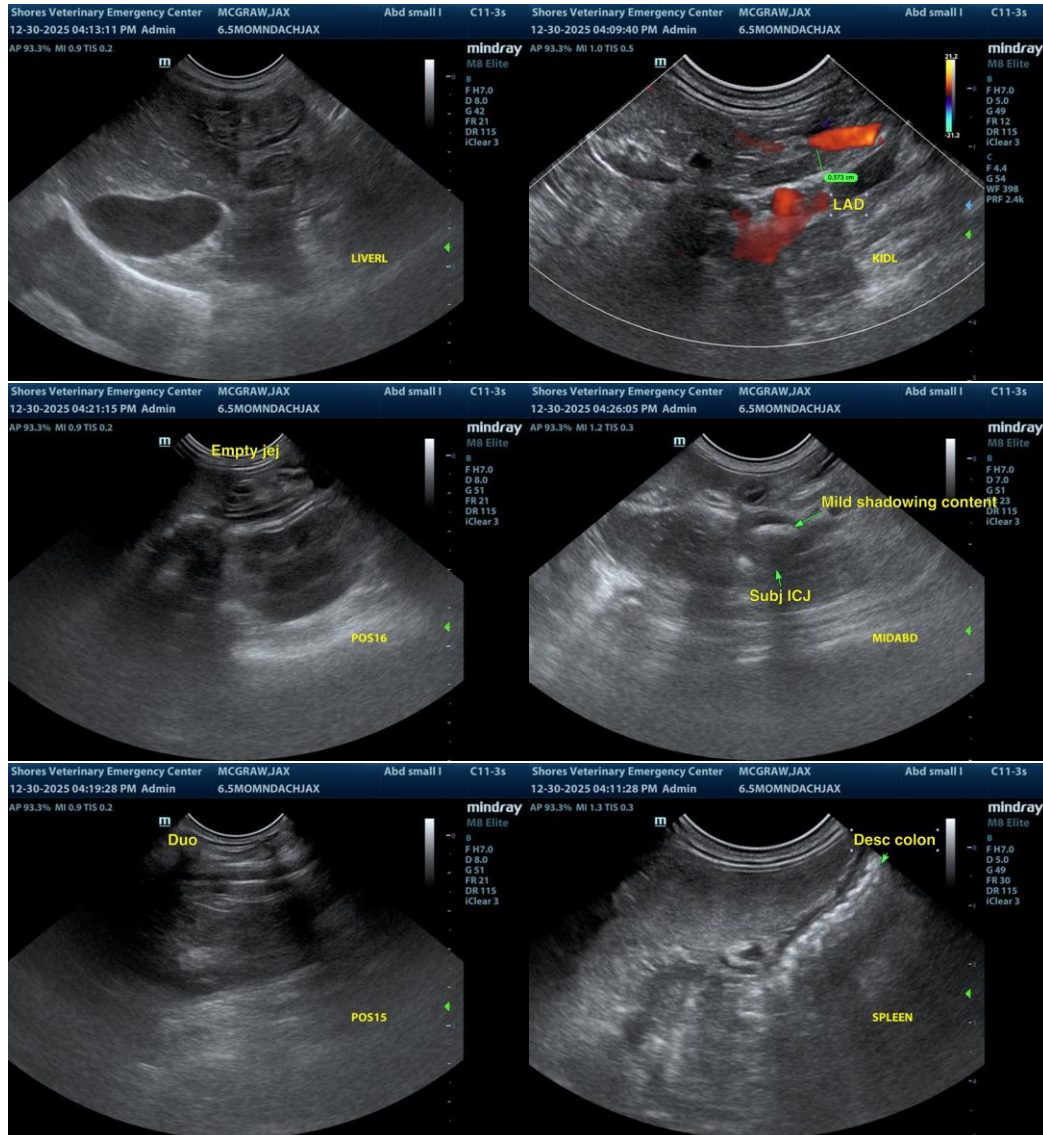
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)
info@sonopath.com