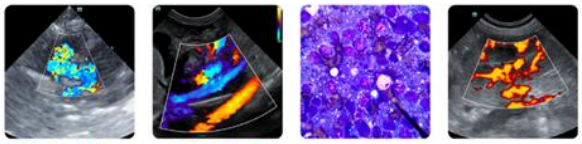


PATIENT

Remi Treszl

SPECIES

Canine

BREED

Goldne Retriever

SEX

MN

AGE

5yr

WEIGHT

38.4kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Michelle DeMelo, RVT

HOSPITAL NAME

Woodstock Veterinary Hospital

REFERRING VET

Dr. Esther Duschinsky

INVOICE
23191

DATE
12/9/2025

PRESENTING CLINICAL SIGNS

Remi presented on Dec 8, 2025 with a progressive 3 day history of reduced appetite and vomiting which progressed to complete anorexia and large amounts of vomit. - Abdominal radiographs were overall unremarkable - small amount of food in stomach, normal liver and spleen silhouette, no gas pattern, gas moving through GIT with some gas in colon, and some stool in colon. Treatment with maropitant has stopped the vomiting and he has received IV fluids, but he continues to be anorexic. Has also been treated with sucralfate and KCl added to the IV fluids. Foreign body is still on the Ddx list. We hope for some answers or direction from this ultrasound!

Abnormal PE/Chem/CBC/UA Results: - CBC - possible degenerative left shift - large numbers of band neutrophils seen on in clinic smear and with the idexx Procyte, but no leukocytosis. - 17 chemistries and spec CPL were all well within normal limits - Low normal sodium and potassium - Urinalysis showed very concentrated urine, possible low grade UTI, but no bacteria seen on dry mount of urine in clinic.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra 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 7.3 cm in length. The right kidney measured 7.3 cm in length.

The area of the iliac trifurcation was free of pathology including no evidence of medial iliac or sublumbar lymphadenopathy or masses.

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

Adrenal Glands

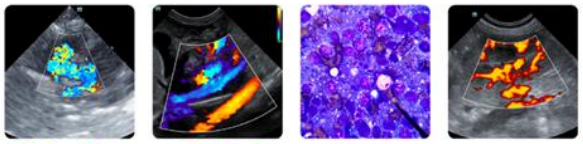
The left adrenal gland was indistinctly visualized. The left adrenal gland measured 0.55 cm width at the caudal pole.

Spleen

The spleen exhibited subjective mild enlargement in size with 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.

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



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non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach was indistinctly visualized. The stomach overall was non-distended and contained subjective mild retained ingesta and lumen gas.

The intestinal walls demonstrated intact wall layering and maintained 1:3 muscularis / mucosa ratio. The mucosa exhibited mild decreased echogenicity with occasional mucosal speckling. A segmental to diffuse ileus pattern consisting of mild fluid accumulation in the intestinal lumen was present without obstruction or foreign material. Segments of intestine exhibited potential for mild corrugation.

Intact, mild prominent proximal colon and cecum wall. Non-formed to soft fecal matter was present in the visualized transverse and descending colon.

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 peritoneal effusion was present.

Focally enlarged mesenteric lymph nodes were present. These lymph nodes were homogenous, mildly hypoechoic and smoothly marginated. A normal width: length ratio was maintained (<0.5). Evidence of perilymphatic inflammation was present. An example of lymph node size was 3.6 cm x 1.9 cm.

ULTRASONOGRAPHIC FINDINGS

Primary

- Indistinctly visualized, overtly non-distended stomach containing mild retained ingesta.
- Nonspecific enteritis pattern exhibiting segmental to primarily generalized intestinal ileus and mild segmental corrugation.
- Subjective distended proximal colon and possible cecum with non-formed liquid fecal matter, soft to non-formed fecal matter in visualized transverse to descending colon.
- Mesenteric lymphadenopathy- reactive hyperplasia, lymphadenitis owing to inflammatory bowel, occult neoplastic or metastatic lymphadenopathy thought less likely

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Definitive evidence of gastroenterocolic foreign material was not obvious yet given indistinctly visualized stomach with retained gastric ingesta which may suggest metabolic gastric stasis with retained food echogenicity, a non-obvious to non-obstructive or passing area of foreign material is not definitively excluded. Proximal colon and cecal inflammation / typhlitis is a potential. If accessible, a mesenteric lymph node FNA cytology could be considered for further clarification.

Without definitive obstructive gastrointestinal criteria, continued gastrointestinal support, empirical therapy for a nonspecific gastroenterocolopathy/ typhlitis with close clinical monitoring would be reasonable. If non-responsive or progressive gastrointestinal signs, exploratory laparotomy with gross

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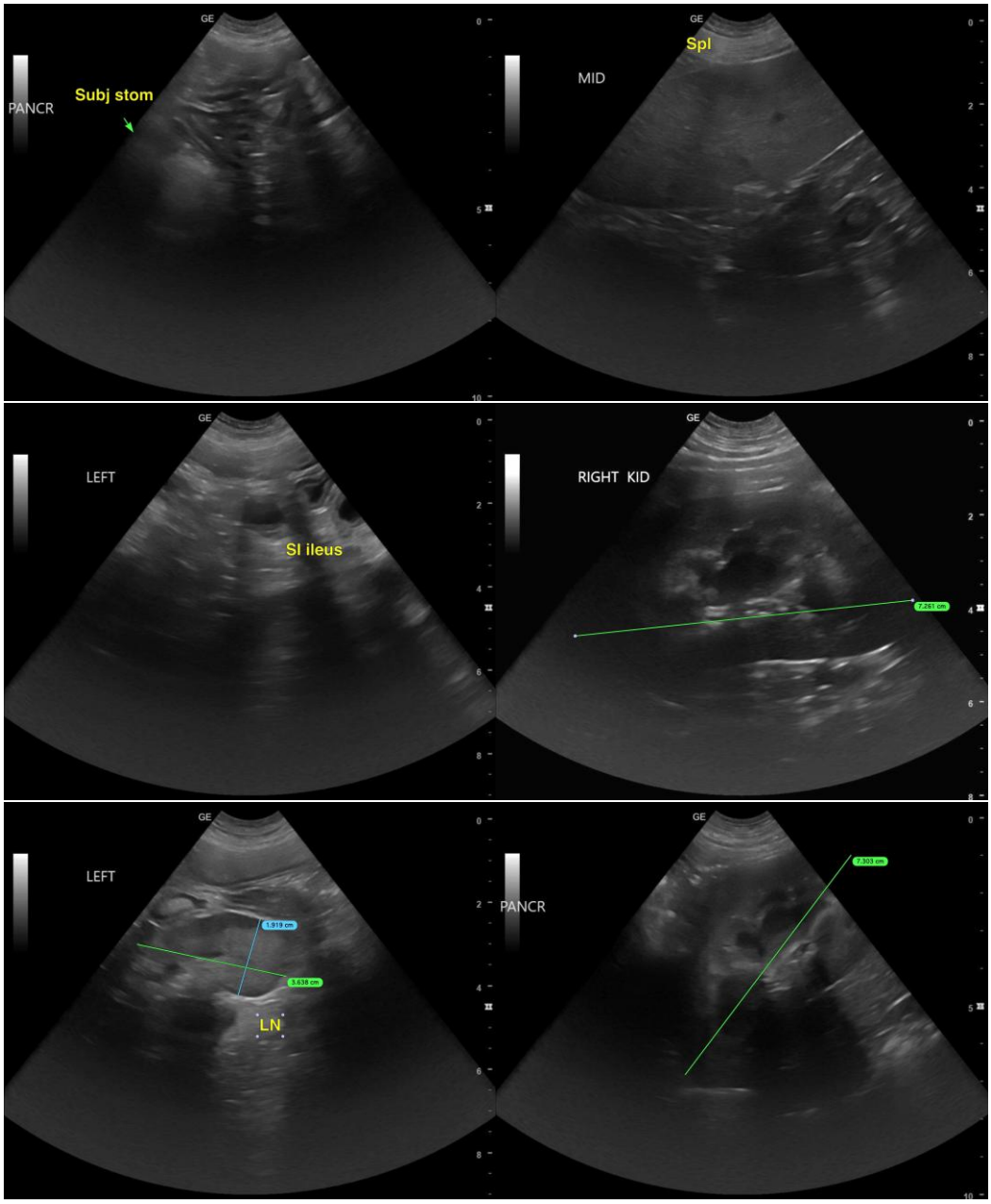
inspection of the gastrointestinal tract and with biopsies considered essential should be considered.



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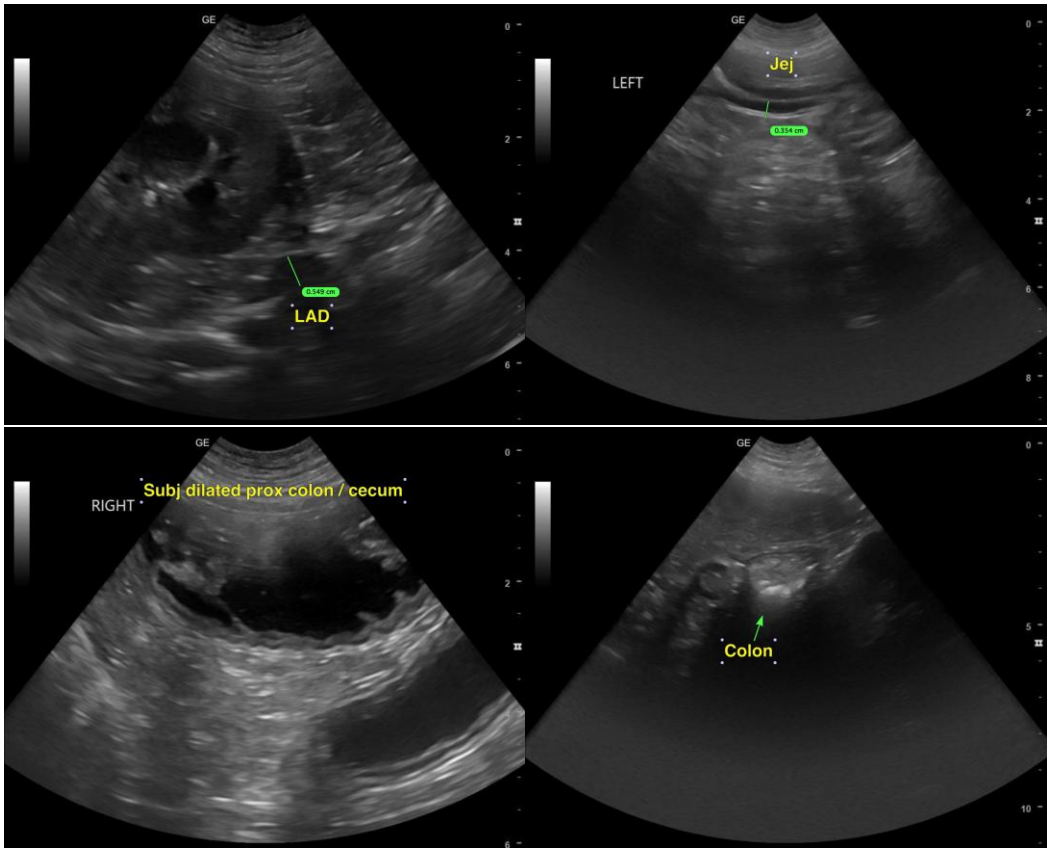

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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