



PATIENT

Bbodie Fortuna

SPECIES

Canine

BREED

Shepard X

SEX

Male Neutered

AGE

9y 11m

WEIGHT

26 kgs

INTERPRETED BY

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

IMAGING PERFORMED BY

Patti Mayfield, DVM

HOSPITAL NAME

Sunriver VC

REFERRING VET

Emily Kent, DVM

INVOICE

13205

DATE

2/12/26

PRESENTING CLINICAL SIGNS

History:

- First presented in NOV 2025, for intermittent borborygmi along with flatulence, patient was empirically dewormed and given probiotics and started on an rx diet trial for potential food allergies.
- Jan 26th: O notes that P appeared to be initially responsive to the diet trial, but then, after a month, symptoms reappeared. He began having hematochezia x 24 hrs and inappetence for 4 days.
- Performed lab work- elevated CPL,
- Meds: gave cerenia and sent home with HP diet and course of metronidazole and Pepcid course.
- Feb 5: O reports borborygmi and anorexia.
- Feb 11: Seen for continued borborygmi and anorexia. Intermittent soft stool. The metronidazole course did appear to improve symptoms, but maropitant and Pepcid did not appear to help.

Abnormal PE/Chem/CBC/UA Results: PE: Audible borborygmi, weight loss of 4.4 lbs seen since November when signs first began. - Jan 26 lab work: Fecal: Negative CBC: WNL Chem: AMY 1576, Lipase 371, remainder WNL (GLU 96, CRE 0.7, BUN 9, K 4.6, Na 150, TP 6.3, ALB 3.1, GLOB 3.2, ALT 35, AST 54, ALP 40, GGT 5, TBIL 0.1) Spec Cpl: 430 T4: 1.1 HWT: Neg

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

Normal size and margination was 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 exhibited a cranial thinly walled cyst containing anechoic fluid measuring 4.6 cm in diameter. The left kidney measured 7.9 cm in length. The right kidney measured 7.0 cm in length.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.69 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 0.56 cm width at the caudal pole.



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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 wall layering with a normal wall layer ratio. The lumen of the stomach contained mild, echogenic, non-shadowing ingesta without signs of obstruction or foreign material.

The duodenum and jejunum exhibited intact wall layering with maintained wall layer ratio to the level of the ileum. Mildly thickened ileum exhibited mild altered ileal wall layer ratio owing to prominent ileum muscularis layer. Jejunum wall measured 0.35 cm width, ileum wall measured 0.58 cm width, and duodenum wall measured 0.46 cm width.

The colon walls presented intact yet mild thickened wall layering. Generalized soft / non-formed fecal matter was present in the colon lumen. Descending colon wall measured 0.40 cm.

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

Intermittent, mildly prominent to enlarged jejunocolic 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).

PRIMARY FINDINGS

- Ileocolitis pattern
- Intermittent, mild jejunocolic lymphadenopathy – suggestive of benign criteria, i.e. mild hyperplasia or reactive lymphadenitis
- Sonographically normal pancreas
- Gastric ingesta – consistent with food echogenicity

SECONDARY FINDINGS

- Left kidney cyst



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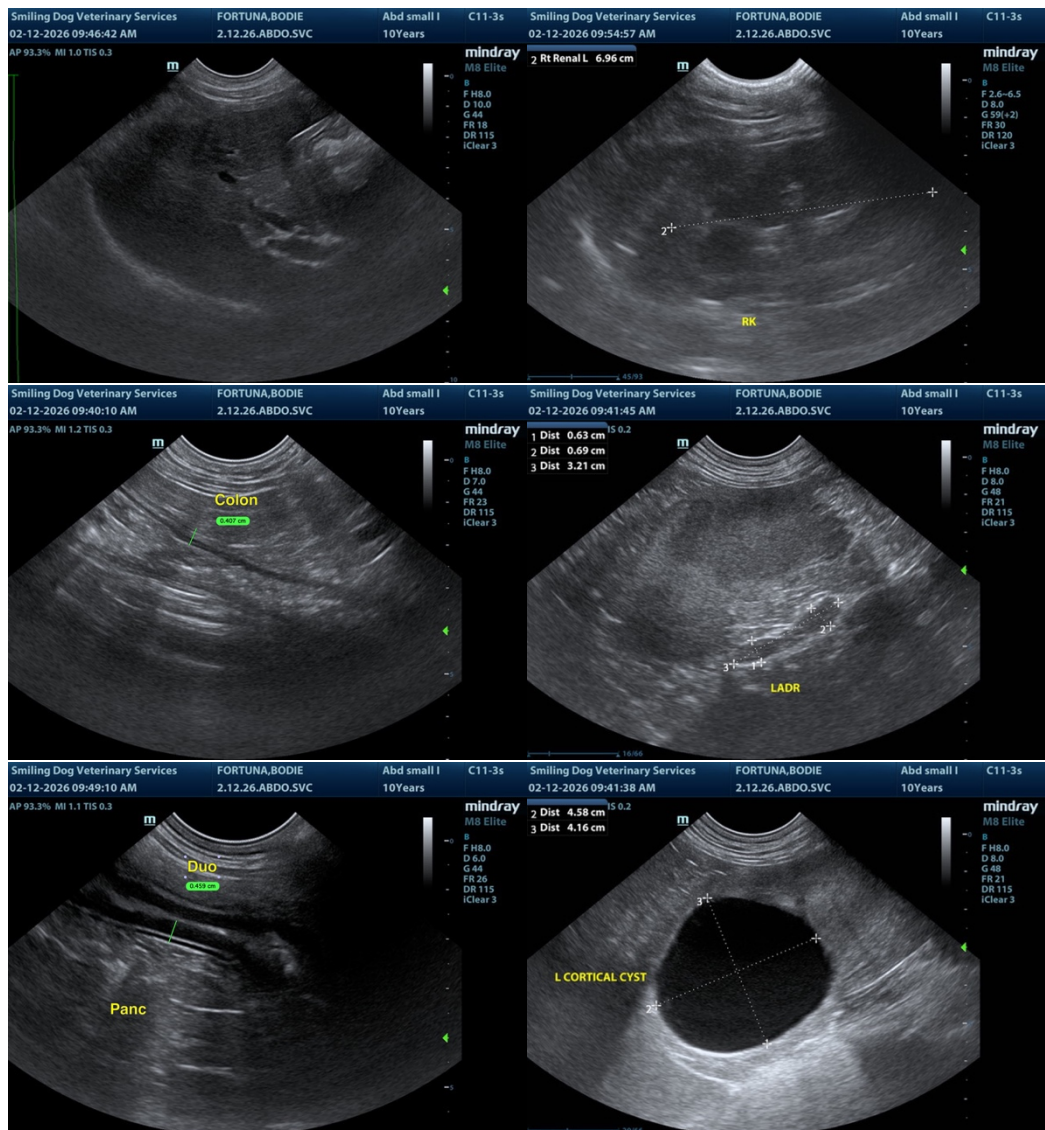
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A GI panel to include PLI/TLI/Cobalamin/Folate is recommended to correlate with suspect distal small intestinal disease as well as assessment for additional non-structural disease, i.e. dysbiosis, EPI, etc. Mild to chronic pancreatitis at times may present sonographically normal. Empirically, a limited antigen or hydrolyzed diet trial with potential long term dietary therapy, prophylactic deworming (Panacur 50 mg/kg SID x 5 consecutive days with repeat protocol in 3 weeks even if fecal testing is negative), high colony count probiotic (Proviale or Visbiome), and as needed gastro protectants is suggested with clinical monitoring. Note that recent research has shown that indiscriminate use of antibiotics may actually cause harm. Sonographic reassessment or monitoring indicated if non-responsive or persistent gastrointestinal signs or weight loss.





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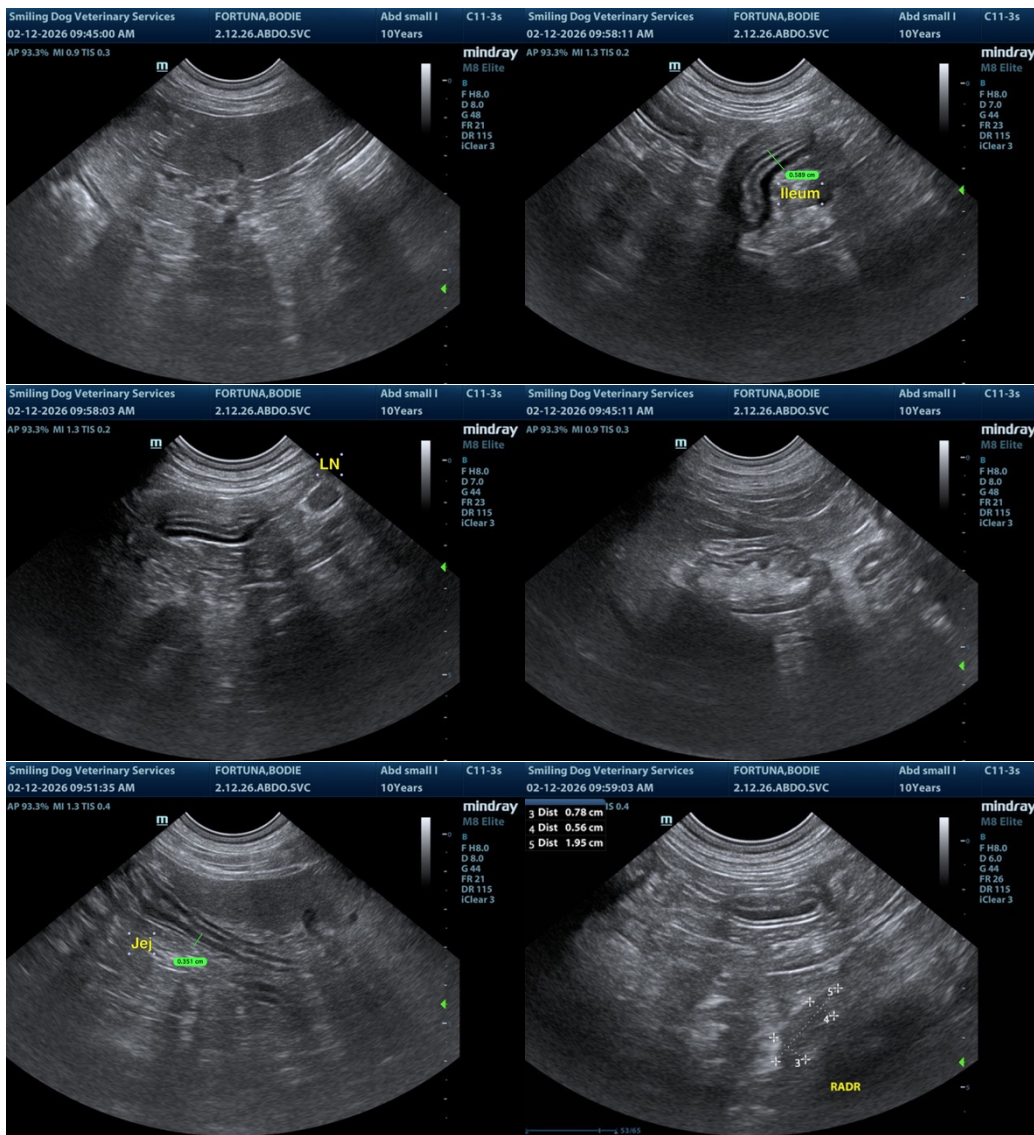
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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