



PATIENT

Lewey Flynn

SPECIES

Canine

BREED

Mixed Breed

SEX

MN

AGE

6yr

WEIGHT

31.8kg

PRESENTING CLINICAL SIGNS

- AUS to further evaluate persistent lethargy, anorexia to hyporexia, and weight loss for ~2 weeks. History of intermittent diarrhea, and chronically on Tylosin due to chronic diarrhea. Also had been on Pepcid BID, Tylan powder BID, Foritflora SID, Carprofen 50 mg BID up until 2/4.
- Patient transferred 2/7 from urgent care to ER for supportive care, Not eating or drinking since 2/4. P seen at pDVM for anorexia, cough, d+. Was at doggy daycare prior so O was worried he had kennel cough. Was seen again 2/6 at pDVM because the O was hearing raspy sounds with pt breathing. Remained anorexic and hypersalivating.
- Now ~40 hrs into hospitalization - patient was originally hypoglycemic and hypotensive - both have responded to fluid support and dextrose supplementation. Patient has been normoglycemic off of dextrose for 24 hrs. Still anorexic and lethargic.
- Low baseline cortisol. ACTH stim pending.
- Hosp Tx: IV Fluids, Dexamethasone SP 0.16mg/kg IV q24h, Entyce, Unasyn

Abnormal PE/Chem/CBC/UA Results: 2/7 rDVM: HCT - 60, WBC - 12.25×10^3 - normal Chem - Glu - 68, Creat - 2.3, ALT - 141, Lipase - 2063, BUN - 24 (normal) Radiographs - of chest - no overt esophageal FB nor aspiration pneumonia FAST - steatitis, no noted discomfort 2/7 5pm: EPOC: Creat 2.36, BUN 25, Glu 64, K 5.1, Na 149 PCV/TS: 63/6.8 - resting cortisol <0.5, post stim in house: <0.5 - ACTH stim to lab 2/8 6am: PCV/TS: 53/5.4 EPOC: Creat 1.67, BUN 15, K 4, Na 144, Glu 154 5pm: EPOC: iCal 1.09, Creat 1.49, BUN 11, K 4.3, Na 141, Glu 72 PCV/TS: 59/7 send out UA/UCS in order to start abx

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

INTERPRETED BY

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

IMAGING PERFORMED BY

enee Trionfetti, VMD

HOSPITAL NAME

Blue Pearl Wyomissing

REFERRING VET

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02/09/2026

Urinary System

The urinary bladder was normal following saline infusion. A catheter was present at the level of the cystourethral junction. The 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 6.4 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

Both adrenal glands were indistinctly visualized, exhibiting subjective subnormal size given patient body weight. The left adrenal gland subjectively measured 0.46 cm in width. The right adrenal gland subjectively measured 0.42 cm width.

Spleen



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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. The spleen was mildly subnormal in size, suggestive of volume contraction.

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 intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild non-shadowing ingesta and chyme sonographically suggestive of food echogenicity with no signs of obstruction or foreign material.

The intestinal walls demonstrated intact wall layering and maintained 1:3 muscularis / mucosa ratio. A mild segmental ileus pattern was present without obstruction or foreign material.

Normal visible colon wall layers were present. The colon appeared to be mildly gas distended.

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, overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary

- Structurally unremarkable gastrointestinal tract with mild non-shadowing gastric ingesta and mild segmental non-obstructive intestinal ileus
- Mild gas mild gas distended colon.
- Indistinctly visualized bilateral adrenal glands
- Volume contracted spleen
- Normal bilateral kidneys and post saline infused urinary bladder
- Sonographically unremarkable normal volume liver consistent with low grade benign hepatopathy given mild elevated ALT

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Correlation with pending full ACTH stimulation test and urinary workup is recommended. No evidence of mechanical gastrointestinal obstruction, i.e. foreign body, stricture, mass, etc. suggestive of mild functional or metabolic gastrointestinal ileus in conjunction with occult Addison's



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disease, infectious gastrointestinal disease, dysbiosis, enterotoxin, non-structural inflammatory bowel, mild pancreatitis, occult parasitism, less likely occult neoplasia, all potentials. Concurrent GI panel +/- fresh fecal analysis is suggested.

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Pending additional diagnostics, gastrointestinal support with as needed clinical and sonographic monitoring is recommended.

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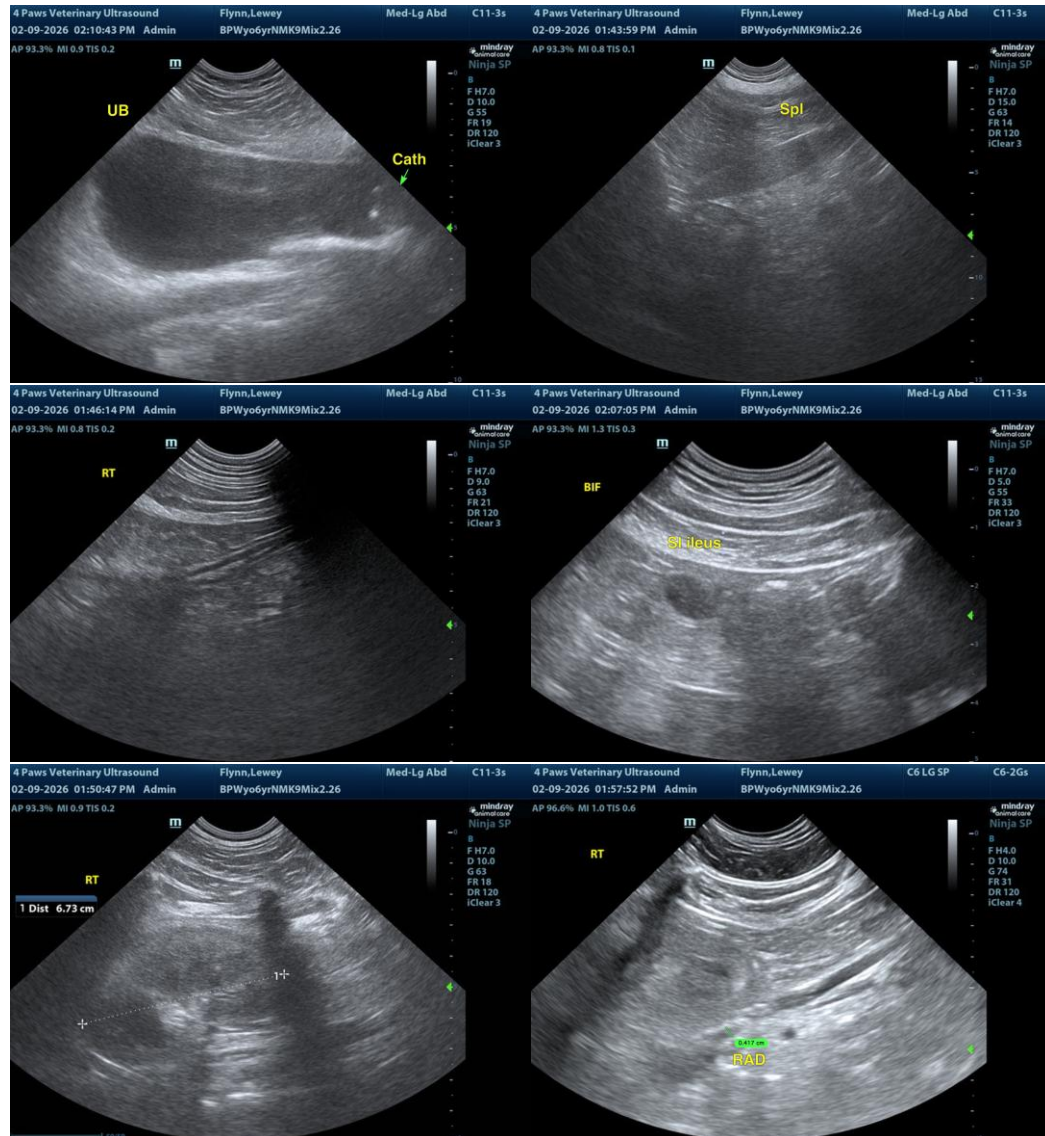
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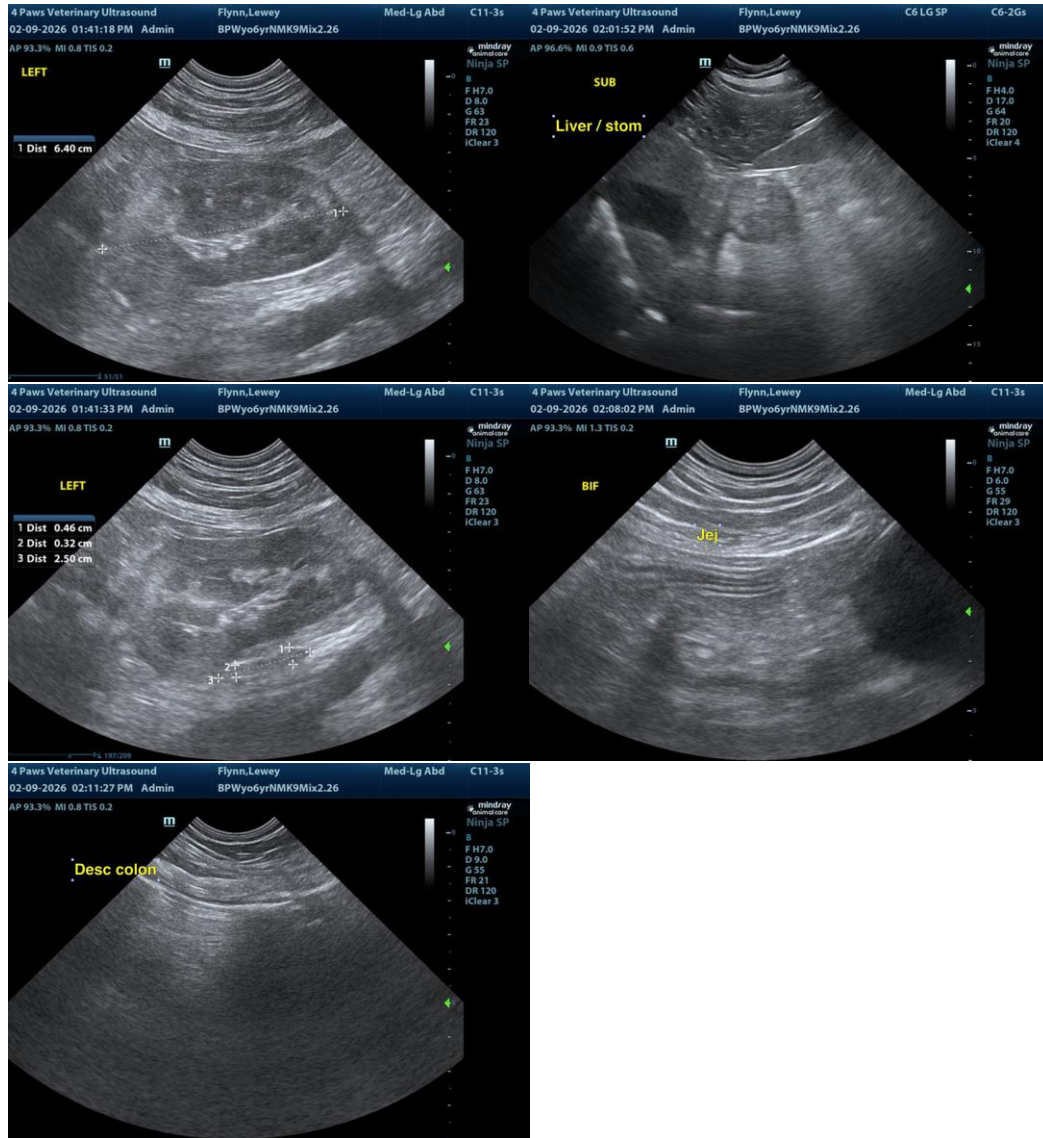
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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