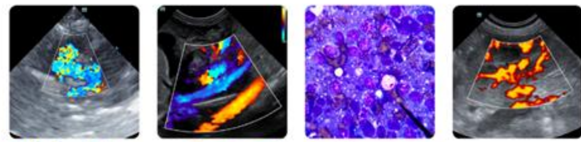
SonoPath
FOSTERING THE ART OF VETERINARY MEDICINE™



Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath.com info@sonopath.com 1.800.838.4268

PATIENT
Flynn Borris

SPECIES
Canine

BREED
Irish Terrier

SEX
MI

AGE
11mo

WEIGHT
15kg

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

IMAGING PERFORMED BY
Dr. Meghan Myers

HOSPITAL NAME
Hershey Animal Emergency Center

REFERRING VET
Dr. Cara Sinopoli

INVOICE
24199

DATE
03/14/2026

PRESENTING CLINICAL SIGNS

- Presented 3/13 as transfer from rDVM for acute V+ and hematemesis -
- was fed at ER overnight as a trial and regurgitated post feeding.
- NPO since 4am
- Abd: Nauseated on palpation; gas distended/palpable in cranial abdomen
- Dehydration: 5-6%
- crt 4s
- Abnormal PE/Chem/CBC/UA Results: 1. Mottled soft tissue and gas opacity structure noted in the mid abdomen, within an intestinal loop (likely the large intestines however this is difficult to confirm). This may be due to presence of a small amount of feces however a small and nonobstructive foreign body is not excluded 2. Moderate accumulation of fluid and gas in the stomach; there is no definitive evidence of a gastric outflow or duodenal obstruction. The findings are currently equivocal and may be secondary to gastroduodenitis however a partial obstruction of the intestines is not excluded EPOC at 12am: Potassium Low (3.2) Chloride Low (100) Sodium low end of normal (142) Intake diagnostics: PCV of 69% Lactate H (3.22) Pancreatic lipase wnl repeat epoc this morning- normal electrolytes

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 6.2 cm in length. The right kidney measured 6.8 cm in length.

The area of the aortic trifurcation was free of pathology.

The prostate was enlarged in size with intact, symmetrical capsule contour. The margins of the gland were intact and able to be differentiated from the surrounding tissue. The prostatic parenchyma was mildly echogenic to heteroechoic without parenchymal mineralization. The prostate measured 3.0 cm in diameter.

Adrenal Glands

Subjective bilateral borderline subnormal adrenal size with symmetrical contour and homogeneous parenchyma. The left adrenal gland measured 0.39 cm width at the caudal pole. The right adrenal gland measured 0.44 cm width at the caudal pole

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.

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 diffusely mild to variably thickened wall with hypoechoic mural echogenicity and loss of mural detail. The stomach contained a moderate amount of non-shadowing to progressively shadowing hyperechoic ingesta. The ventral gastric body wall measured 0.75 cm in width. The pylorus wall measured 1.1 cm in width.

The small intestine presented primarily empty intestinal segments with segmental similar appearing mildly hyperechoic to progressively shadowing ingesta without overt intestinal obstructive pattern to the level of the colon.

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

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

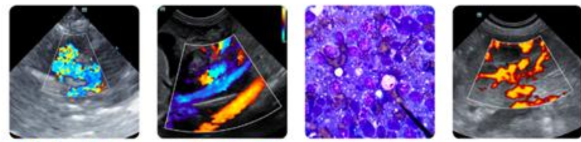
- Diffusely thickened stomach with hypoechoic wall exhibiting loss of mural detail, moderate retained variably shadowing gastric ingesta
- Intact normal small intestine wall with segmental nonshadowing to progressive shadowing intestinal ingesta
- Borderline subnormal adrenal glands

Secondary

- Mild prostatic hyperplasia

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Acute gastritis with gastric wall edema, infectious disease, occult gastric neoplasia all potentials. The gastrointestinal ingesta in nonspecific with metabolic gastric vs gastrointestinal ileus and variably retained food echogenicity, foreign material or combination possible. Laparotomy with gastrointestinal biopsies considered essential is warranted. Gastric evacuation (if possible) with upper gastrointestinal endoscopic biopsies could be considered. Additional 12-18 hour fast with gastroprotectants +/-



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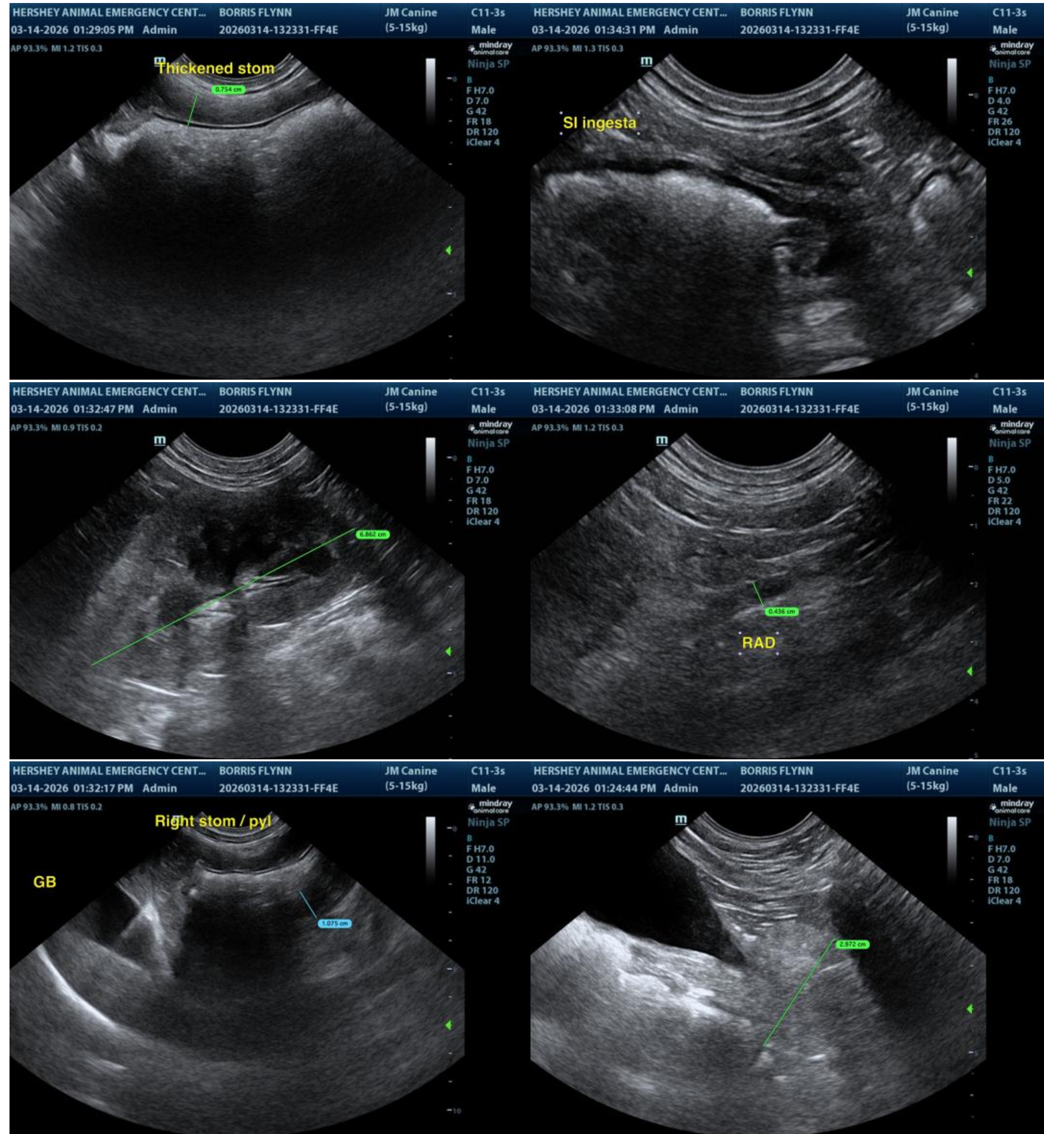
empirical Helicobacter coverage and sonographic monitoring with laparotomy indicated if persistent retained GI ingesta would be more conservative yet not contraindicated. A screening cortisol level is recommended.



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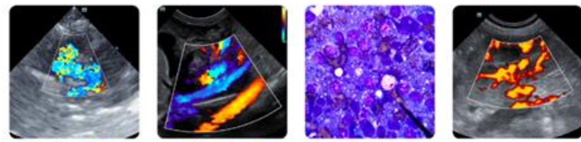

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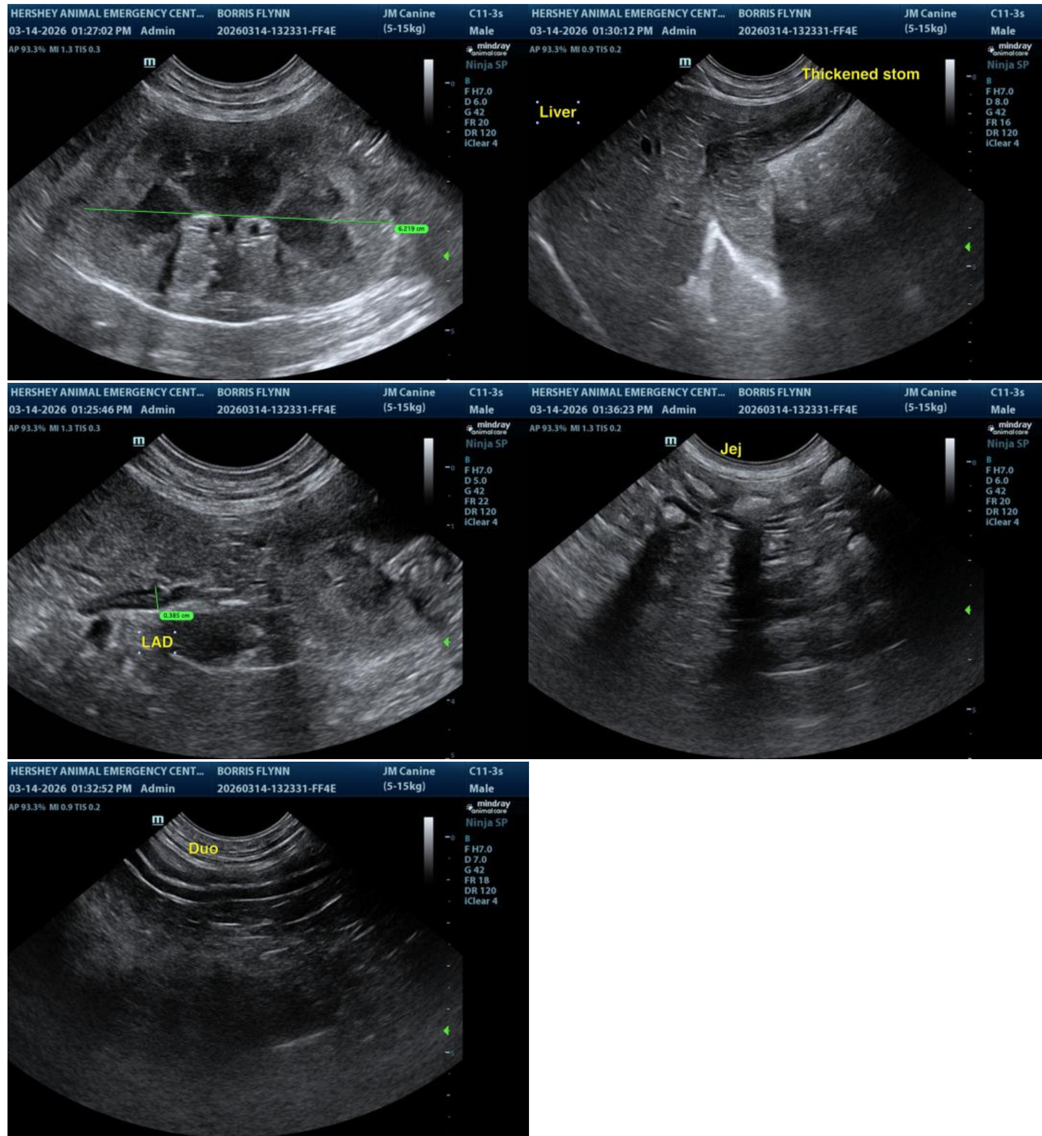

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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