

PATIENT

Winston Heuser

SPECIES

Canine

BREED

Lab Mix

SEX

MN

AGE

3 years

WEIGHT

27 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques,
LVT

HOSPITAL NAME

Alpine AH

REFERRING VET

Dr. Molly Burbank

INVOICE

10697

DATE

3/18/26

PRESENTING CLINICAL SIGNS

History:

- Working diagnosis, rule out non-obstructive foreign body, food allergy, IBD, other
- intermittent soft stool, vomits every 2-3 days for the past 6 weeks. On initial presentation 2/5, BW and radiographs were done which did not show any foreign material or definitive obstruction. Pt was treated supportively but did not respond. O brought pt to emergency referral hospital (AEC) 2 days after initial presentation for melena, persistent vomiting and anorexia. Recheck BW at AEC showed persistent mild eosinophilia, mildly elevated BUN:creat ratio. Pt was treated supportively with IVF and gastroprotectants for suspected GI ulceration. Pt was discharged the following day with oral gastroprotectants and a 5 day course of Panacur. O brought pt back in about a month later and noted persistent chronic GI symptoms. Weight has remained stable. O declined Texas GI panel, hypoallergenic diet trial, recheck BW.

Abnormal PE/Chem/CBC/UA Results: 02/05/26: Chem: mild hypokalemia, mild hyperalbuminemia
CBC: HCT 60, mild neutrophilia, mild eosinophilia 02/05/26: cPL WNL 02/06/26: fecal= neg 02/07026:
Baseline cortisol 2.58

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 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.

The residual prostate was symmetrically normal in size with uniform parenchyma and slight coarse echotexture.

The area of the aortic trifurcation was free of pathology.

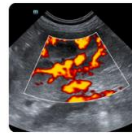
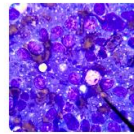
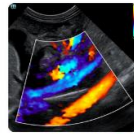
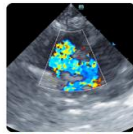
Normal size and margination were present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 6.5 cm in length. The right kidney measured 6.2 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 0.65 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 0.73 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



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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/ 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. 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 was empty with mild lumen gas. There were no signs of ileus, obstruction, or foreign material.

The small intestine presented primarily intact wall layering with maintained wall layer ratio and overall empty small intestinal lumen. A segment of mid-abdomen jejunum exhibited thickened, irregular wall with evidence of corrugation. Indistinct, potential loss of associated segmental jejunal wall layer detail was noted with segmentally thickened jejunum potentially measuring 5.0-6.0 cm in length, with wall width measuring 0.58 cm. By comparison, normal-appearing jejunum measured 0.37 cm width. Regional peri intestinal mild hyperechoic omentum and minor effusion were present around the thickened segmental jejunum.

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

Pancreas

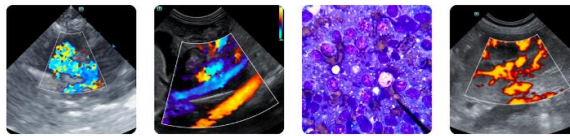
The parenchyma of the left limb, body, and right limb of the pancreas presented isoechoic to the adjacent omental fat. A normal curvilinear capsule contour of the pancreas was present. The visible pancreatic duct was normal. No signs of active inflammation or neoplastic disease were evident.

Free Abdomen

Intermittent, subtle, isoechoic to mild nonhomogeneous mesenteric lymphadenopathy was noted. Regional peri intestinal mild hyperechoic omentum and minor effusion were present around the thickened segmental jejunum.

ULTRASONOGRAPHIC FINDINGS

- Segmentally thickened corrugated jejunum exhibiting indistinct wall layer detail - nonobstructive
- Associated regional peri intestinal mild hyperechoic omentum and minor effusion
- Intermittent mild to discreet mesenteric lymphadenopathy
- Normal empty stomach with mild lumen gas
- Normal adrenal glands



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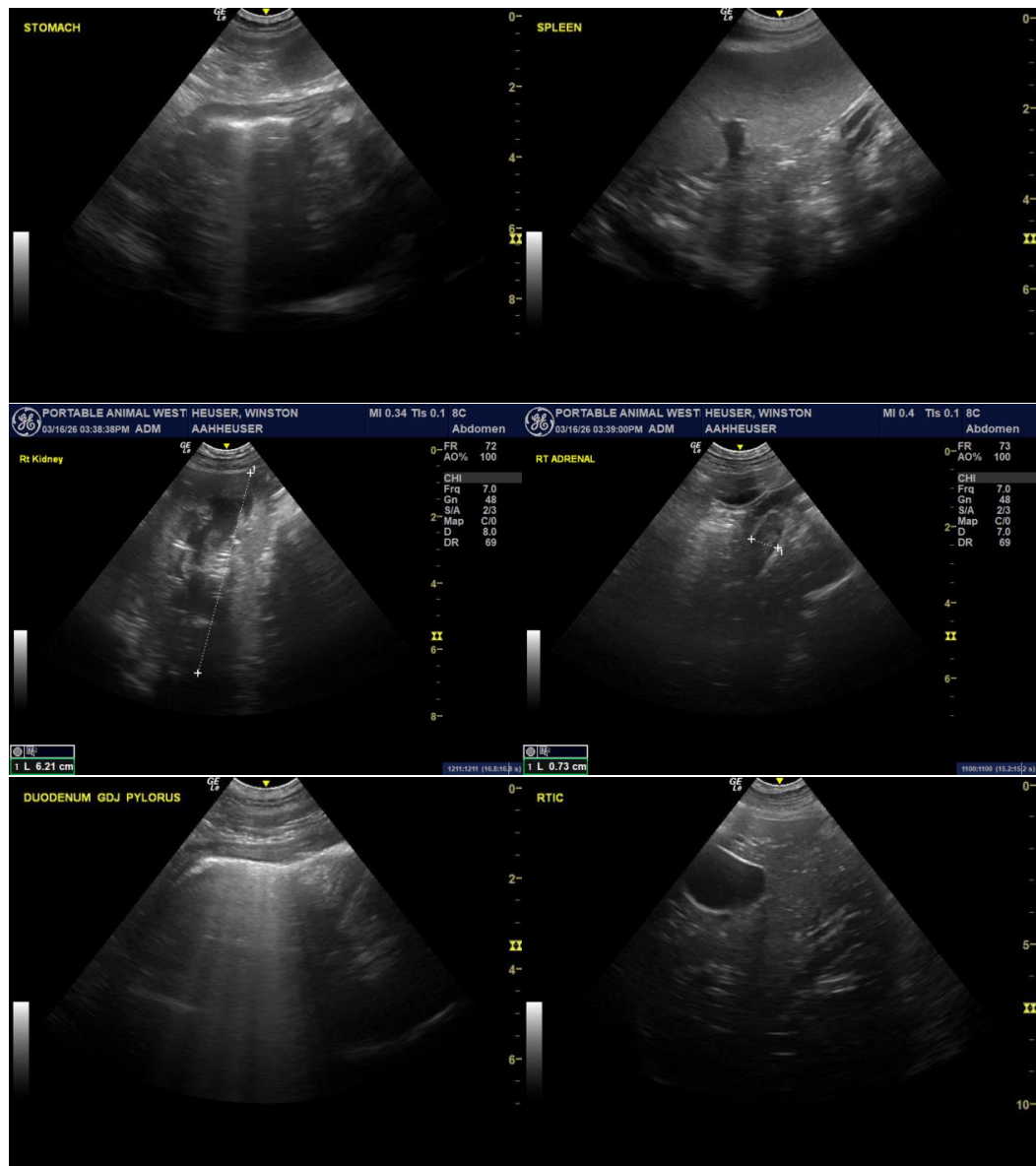
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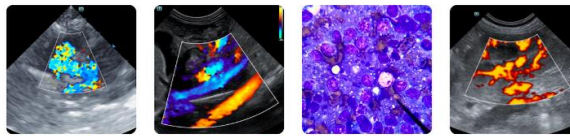
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Considerations for the segmental pathological jejunum may include inflammatory, infectious, or emerging neoplastic disease with potential for associated ulceration, bowel infarction, or necrosis. No overt evidence of foreign body or additional sonographic evidence of gastrointestinal mural pathology. Given recurrent gastrointestinal signs, laparotomy with gross inspection of the gastrointestinal tract and resection / anastomosis of pathological jejunum with concurrent histopathology is recommended. Three-view chest radiographs are suggested prior to surgical considerations.





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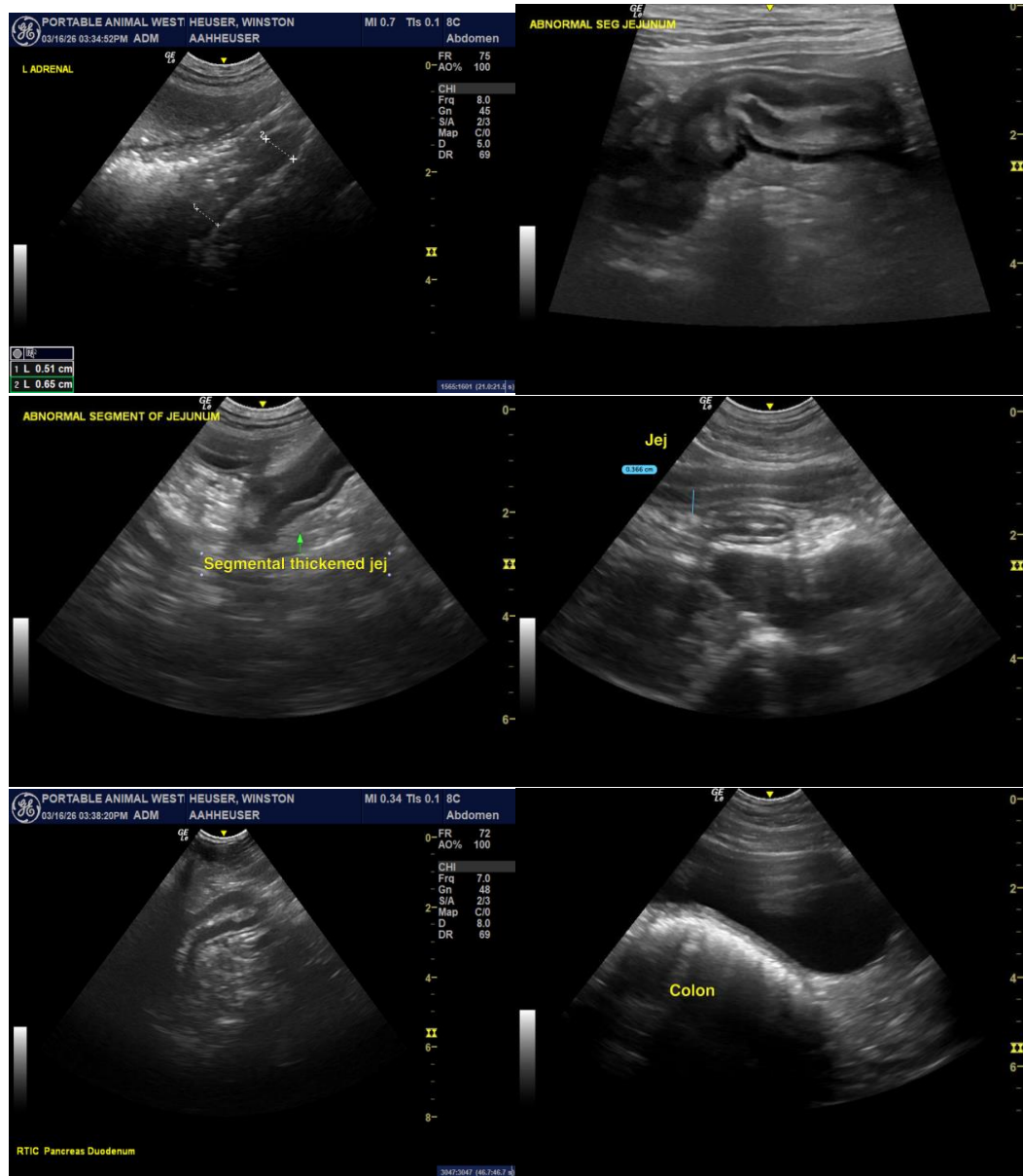
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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