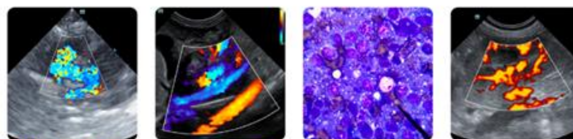


PATIENT
Brandi Tennant

SPECIES
Canine

BREED
Labrador Retriever

SEX
FS

AGE
8yr

WEIGHT
73lb

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

IMAGING PERFORMED BY
Aaron Lucas DVM, PhD

HOSPITAL NAME
Taylorsville Veterinary Clinic

REFERRING VET
Ashleigh Bisset

INVOICE
24097

DATE
03/02/2026

PRESENTING CLINICAL SIGNS

Brandi is an 8-year, 5-month-old, female spayed, Labrador retriever presenting for persistent vomiting. The patient was seen on February 10, 2026, for suspected bilious vomiting - patient was sent home with famotidine and asked to split up dinner to a later meal. On Feb 26th, owner reports that despite administering Famotidine and changing the feeding schedule to smaller, more frequent meals of a bland diet, there has been no significant improvement. The vomiting continues to occur primarily at night, but has also been noted in the morning. The character of the vomitus has changed from primarily bile to now containing undigested food. At this time, bowel movements and energy was normal. Sent Patient home with Cerenia and owner declined radiographs at this visit. BW on 2/29 was WNL overall. No more vomiting episodes were seen throughout the weekend but patient became lethargic, stools became soft and dark brown in color and patient is refusing to eat. When hospitalized this morning, Patient vomited up a large amount of brown viscous material.

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 right kidney. 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 adequate size, asymmetrical margination and mild indistinct corticomedullary architecture and corticomedullary border demarcation. No evidence of left retroperitoneal inflammation. The left kidney measured 6.4 cm in length. The right kidney measured 7.4 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

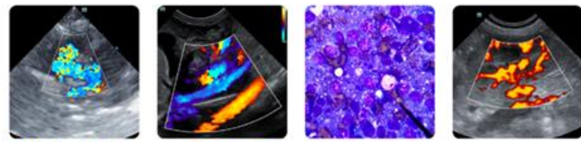
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.59 cm width at the caudal pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.66 cm width 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 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



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non-distended in size with thin walls and mild non-organized debris. The cystic and common bile ducts were normal.

Gastrointestinal

Regional variable to significantly thickened stomach wall exhibiting mural hypoechogenicity and loss of gastric mural detail. Concurrent intact non-thickened stomach wall also visualized. Thickened stomach wall measured ~ 1.3 to 1.6 cm wall width. By comparison, intact non-thickened stomach wall measured 0.38 cm in width. The stomach contained a mild amount of anechoic fluid and a small amount of non-shadowing ingesta.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of mechanical/metabolic ileus, obstruction or foreign material.

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 visualized peritoneal effusion was present.

Regional perigastric hyperechoic omentum.

Intermittent mid to caudal abdomen mesenteric and mild perigastric lymphadenopathy. An example of a lymph node measured 1.9 cm in diameter.

ULTRASONOGRAPHIC FINDINGS

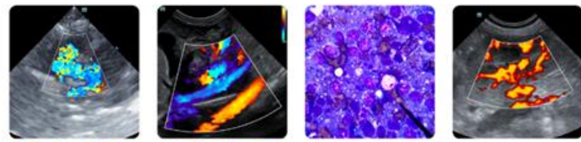
Primary

- Variably thickened hypomotile stomach exhibiting loss of regional gastric wall layer detail.
- Regional perigastric hyperechoic omentum and mildly swollen non-homogeneous perigastric lymph nodes.
- Normal empty small intestine.
- Normal liver /gallbladder.
- Mild gallbladder debris.
- Non-specific mild indistinct left kidney corticomedullary architecture and border demarcation.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Although sampling or biopsy is required for further clarification, the stomach meets neoplastic criteria with considerations including favored round cell neoplasia i.e. lymphoma, carcinoma or other. Highly suspect regional perigastric lymphatic metastasis. No obvious evidence of small intestinal mural changes or mechanical / metabolic ileus. Potential for significant gastritis, gastric edema, infectious gastropathy or other thought less likely.

The indistinct left kidney architecture and corticomedullary border demarcation are non-specific with potential age-related changes although monitoring is recommended.



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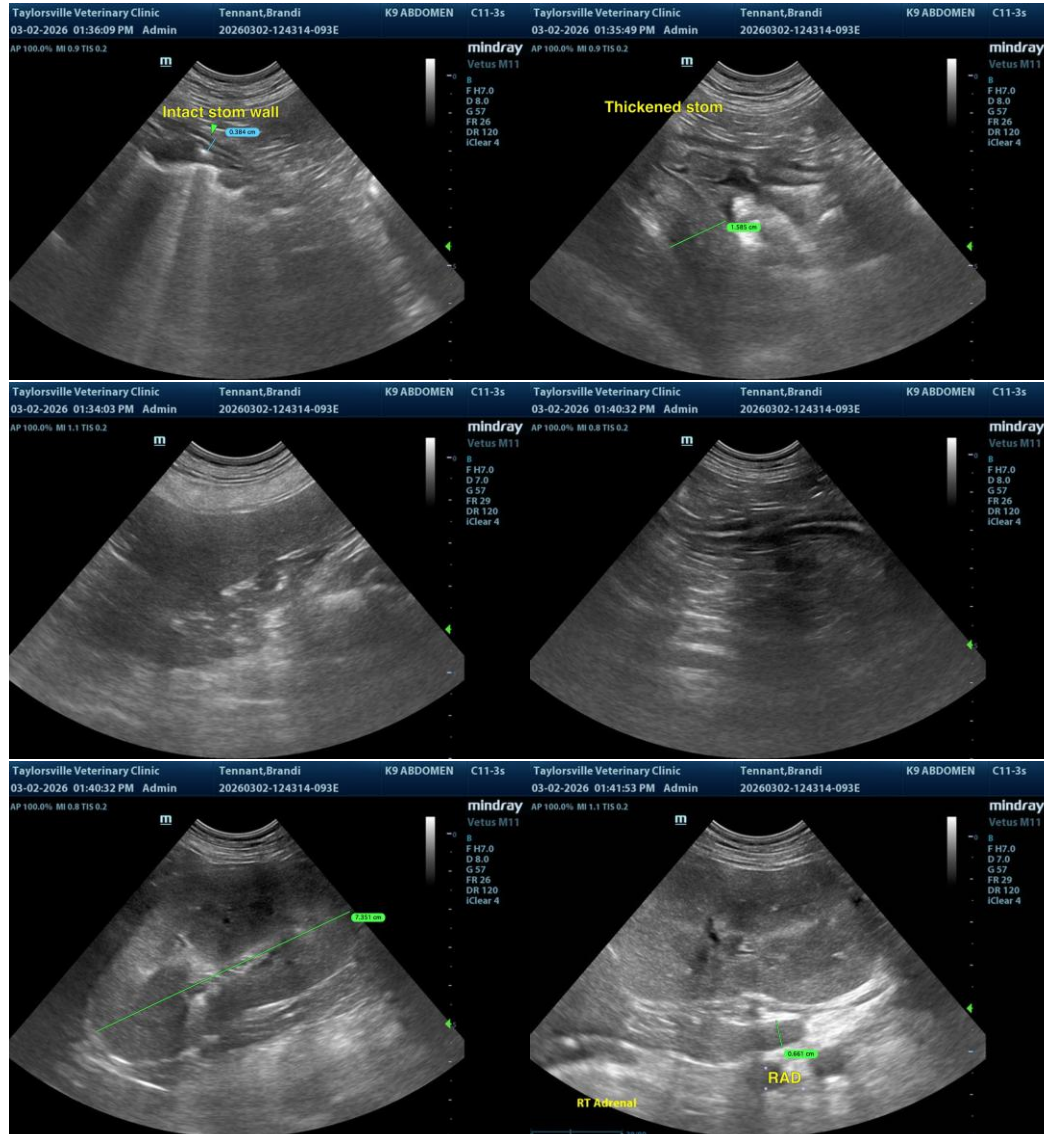
Surgical or endoscopic gastric biopsy is recommended with potential oncology consult. Continued broad spectrum gastroprotectants are recommended.



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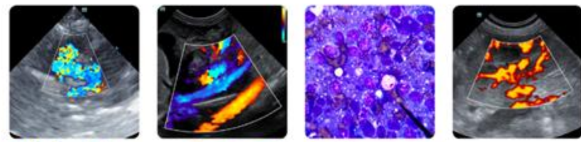

Clinical Sonography & Telecytology
Educational Teleconsultation Services™

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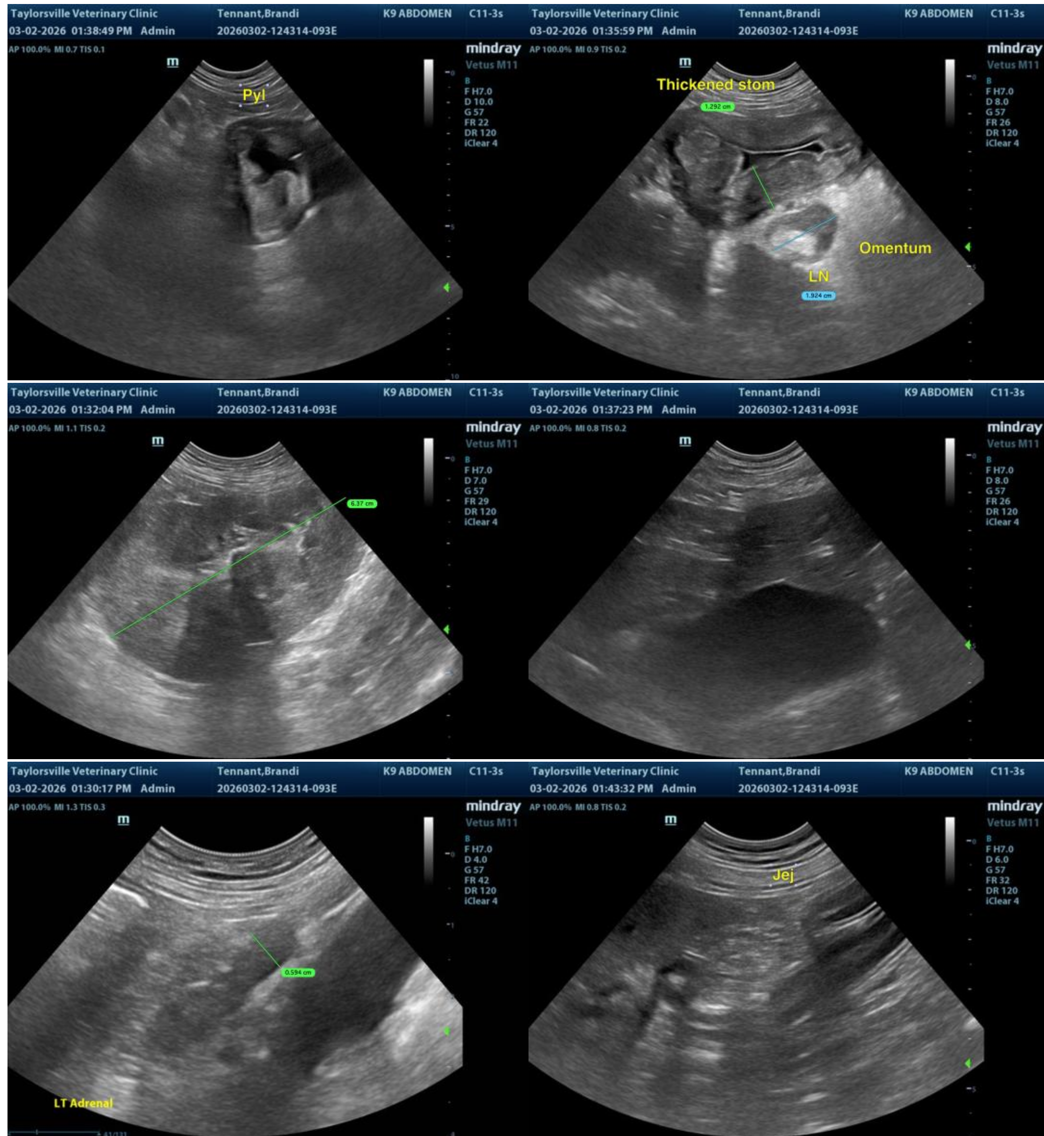

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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