



## PATIENT

Everett Stovgard

## SPECIES

Canine

## BREED

Treeing Walker  
Coonhound

## SEX

Male

## AGE

7 Years

## WEIGHT

49.8 pounds

## INTERPRETED BY

R. McKenzie Daniel,  
DVM, DABVP (Canine  
/ Feline Practice)

## IMAGING PERFORMED BY

Dr. Ackmann

## HOSPITAL NAME

Buffalo Veterinary  
Clinic

## REFERRING VET

Dr. Bessler

## INVOICE

14470

## DATE

03/20/26

## PRESENTING CLINICAL SIGNS

- 3/11/26: Symptoms started after dog bite to face in Nov. Pt has been off food, vomiting bile 3x/week, intermittent soft stool, acts like belly hurts after he eats (does down dog freq) and has just been lethargic. Will only eat 6 bites then will stretch neck and do down dog. Stomach is gurgly after eating. He has lost 8#. Started on Panacur SID x 3, vit b 12 SQ 800 mcg (0.8cc) weekly x 6 then monthly x 3, 10 mg famotidine BID x 7 then SID, low fat EN, proviable.
- 3/18/26: Pt has lost 2 more pounds, not eating well and predominantly diarrhea. Does down dog alot especially after eating. Good appetite.

Abnormal PE/Chem/CBC/UA Results: 3/11/26: MM pale pink, BCS 1.5/5, rectal exam: soft formed feces and prostate feels normal. Fecal float negative. CBC normal Chem low TP (4.9) and albumin (2.1), ALT 173 Rads show loss of serosal detail in central ventral abdomen, formed feces in colon, small mineral opacities that appear to be small fragments of bone. U/S scant ascites and fluid dilated, thickened SI. 3/18/26: Recheck radiographs: Rads still show loss of serosal detail and still has what appears to be bone chunk, possibly moved into colon.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder was normal in size and tone exhibiting regional mild to variably thickened nonhomogenous hyperechoic urinary bladder wall with an example of wall width measuring 1.1 cm. The trigone, cystourethral junction, and visible pelvic urethra 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 change were noted.

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 approximately 3.0 cm in diameter.

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 measured 7.7 cm in length. The right kidney measured 6.3 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 0.68 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 0.59 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. 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 variably echogenic, focally shadowing ingesta without signs of obstruction or foreign material.

The small intestine exhibited segmental intact nonthickened wall with maintained normal wall layer ratio. Concurrent segmental to variably thickened intestine exhibiting indistinct loss of mural detail and variable mural echogenicity with concurrent empty small intestinal segments and variable intestinal ileus. Within the fluid dilated intestinal segments, at least one yet suspected multiple mild irregular strongly shadowing echoes were present consistent with foreign material.

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

### **Pancreas**

The pancreas was indistinctly visualized owing to increased peripancreatic omental artifact.

### **Free Abdomen**

Suspect segmental indistinct intussusception in the mid abdomen likely involving the jejunum. Generalized nonhomogenous indistinctly nodular omentum and probable isoechoic nonhomogenous variable mesenteric lymphadenopathy. A mild/moderate volume of echogenic peritoneal effusion was present.

## ULTRASONOGRAPHIC FINDINGS

### **Primary Findings**

- Retained variably echogenic focally shadowing gastric ingesta.
- Variably thickened small intestine exhibiting segmental intact indistinct to loss of intestinal mural detail, small intestine foreign body to likely foreign bodies with segmental intestinal obstructive pattern.
- Suspect jejunal intussusception.
- Regional mildly thickened urinary bladder wall.
- Nonhomogenous mesentery with suspect indistinct nonhomogenous mesenteric lymphadenopathy and mild/moderate volume of peritoneal effusion.

### **Secondary Findings**

- Benign prostatic hyperplasia, potential for prostatitis.



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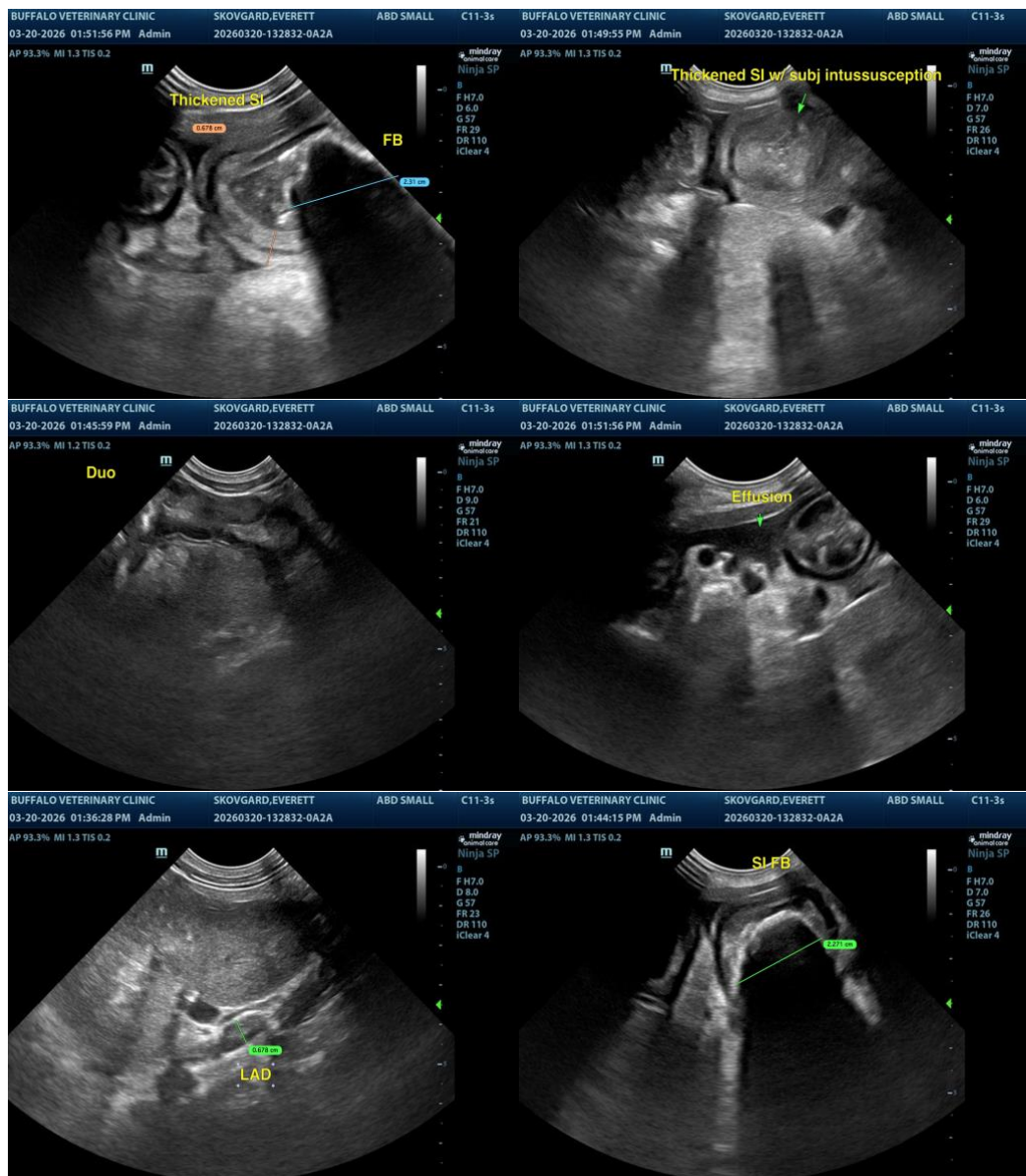
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## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The intestinal mural changes may indicate significant to chronic inflammatory or potential necrotic criteria owing to chronic gastrointestinal foreign bodies. However, high concern for multicentric intestinal, urinary bladder, potential lymphatic or omental neoplasia such as carcinomatosis, lymphomatosis or similar is warranted.

Correlation with effusion analysis cytology +/- culture and sensitivity if evidence of effusion, inflammatory components or peritonitis is recommended. Exploratory laparotomy given intestinal obstructive pattern, foreign bodies and suspect jejunal intussusception is warranted. However, expectations toward likely extensive intestinal to multicentric abdominal pathology is indicated.





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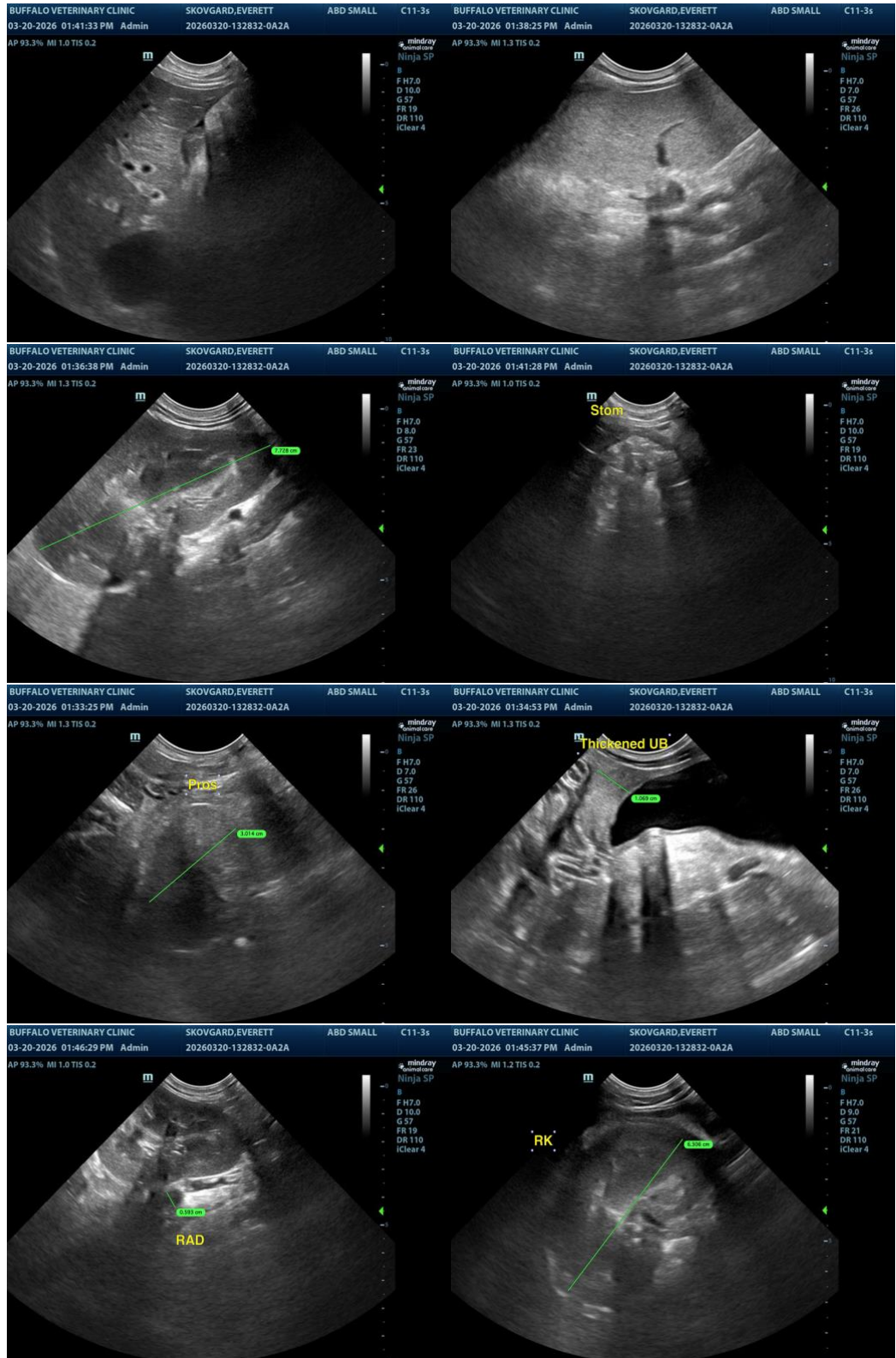
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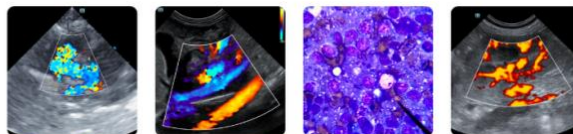
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

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