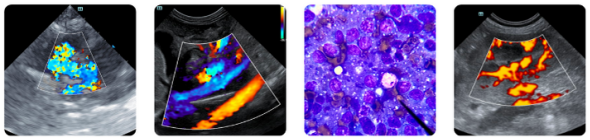


PATIENT

Stella Hentschel

SPECIES

Canine

BREED

Poodle

SEX

Female Spayed

AGE

1y 9m

WEIGHT

18.7 kgs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Jill Rankin

HOSPITAL NAME

Douglas Square Pet Clinic

REFERRING VET

Dr. Nikunj Patel

INVOICE

13307

DATE

3/20/26

PRESENTING CLINICAL SIGNS

History:

- Stella presented for acute vomiting with a previous history of ingesting foreign materials, raising clinical suspicion for a possible gastrointestinal obstruction.
- The p presented for vomiting five times. Initially, the vomiting was minor, but progressed to vomiting her food yesterday morning, with the vomitus described as dark brownish. The last vomit occurred around 12:00 PM yesterday. Since that time, she has not vomited and has kept down crushed ice and water.
- Clinically, the owner reported that Stella was bright with normal energy levels yesterday. However, during the examination today, she was observed to be quieter and tense on her cranial abdomen. The physical exam was otherwise unremarkable, with no fever or diarrhea noted. The patient was given Omeprazole.
- Diagnostic workup included bloodwork and radiographs. Blood analysis showed a mildly elevated ALT in the 200s, while the CBC was largely unremarkable with only a very mild increase in hemoglobin and reticulocytes. Radiographs taken yesterday and follow-up radiographs taken today showed the stomach remains distended with gas, and the small intestines are also gas-filled. No radiopaque foreign object was visible.
- The patient has a known history of ingesting soft items such as toys, cloth, and fabric in the past.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 cm 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 changes were noted.

The area of the aortic trifurcation was free of pathology.

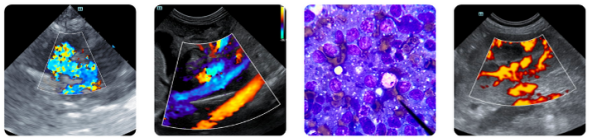
Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio and normal corticomedullary definition were maintained. The echogenicity of the cortex was similar to or slightly less than normal liver parenchyma while the medulla echogenicity was hypoechoic to the cortex with no evidence of pelvic dilation. The left kidney measured 6.3 cm in length. The right kidney measured 6.2 cm in length.

Adrenal Glands

The left adrenal gland was subjective mildly subnormal in size with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.39 cm. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.60 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.



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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

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 normal wall layering with a normal wall layer ratio. The was non-distended in size with lumen gas and no evidence of obstruction to pyloric outflow.

The small intestine presented intact wall layering with maintained 1:3 muscularis/mucosa ratio. Subjective mildly prominent hyperechoic jejunal submucosa layer. No evidence of pathology in the area of the ileocolic junction. The lumen of the small intestine was empty with no signs of 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

Intermittent, mildly prominent to enlarged mesenteric node was present. The lymph node was essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). The lymph node measured 1.3 cm x 0.67 cm. No evidence of peritoneal effusion present.

ULTRASONOGRAPHIC FINDINGS

- Empty stomach with lumen gas
- Empty small intestine exhibiting intact wall layering and propensity for prominent to hyperechoic jejunal submucosa
- Intermittent mild benign mesenteric lymphadenopathy – consistent with mild reactive hyperplasia or possible mild lymphadenitis
- Normal area of pancreas
- Subjective mild subnormal left adrenal gland - nonspecific

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No evidence of gastrointestinal mechanical obstruction or foreign material. Gastric gas prevented full evaluation of the gastric lumen yet no evidence of retained ingesta, fluid or gastric foreign material. The mildly prominent jejunal submucosa layer may be patient variant yet at times may suggest inflammatory enteropathy criteria such as IBD. Gastrointetsinal support indicated. A GI panel to include PLI/TLI/Cobalamin/Folate and screening cortisol level to assess for occult Addison's disease may be considered. Sonographic reassessment or monitoring is recommended if persistent or

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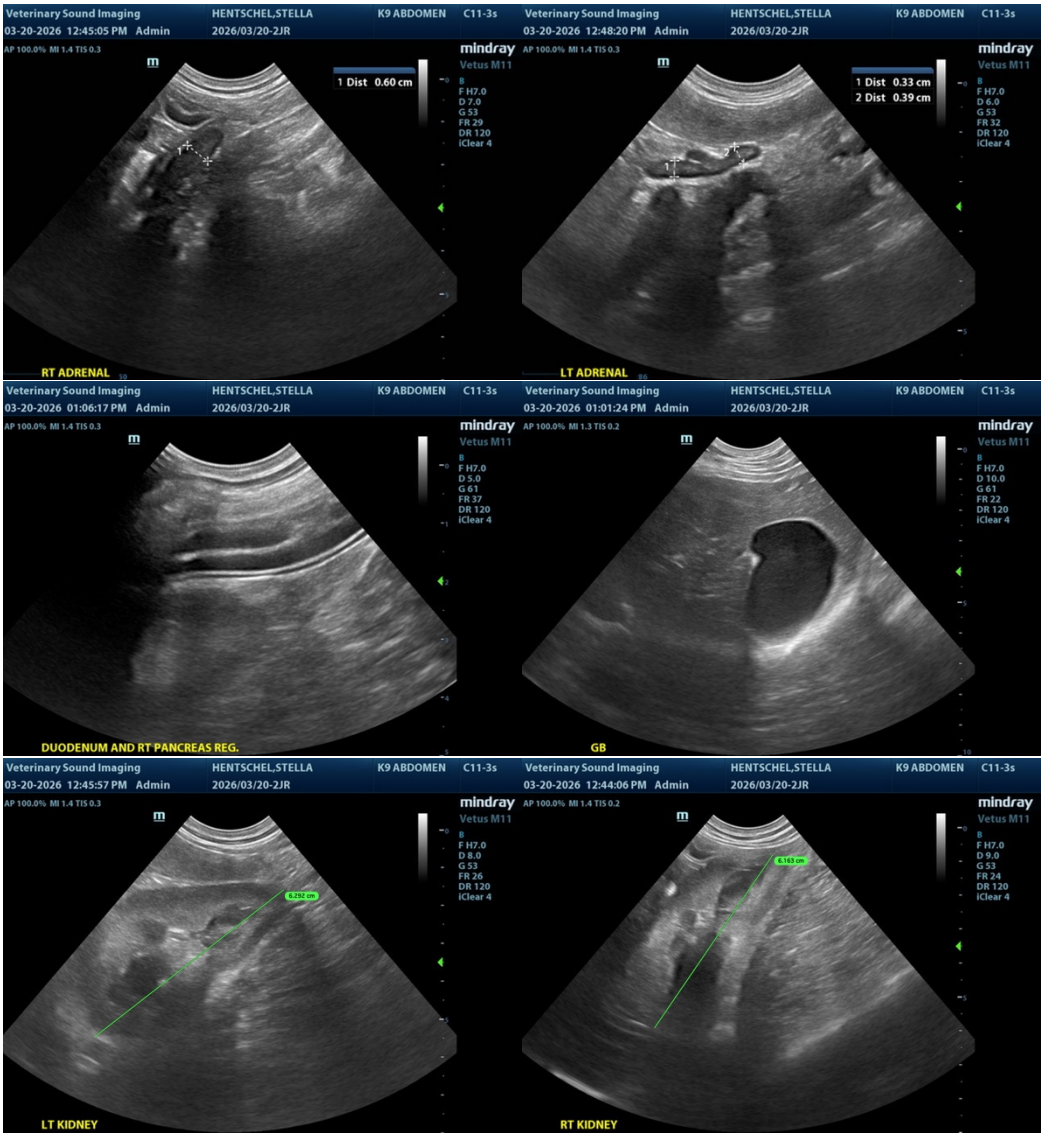
recurrent gastrointestinal signs.



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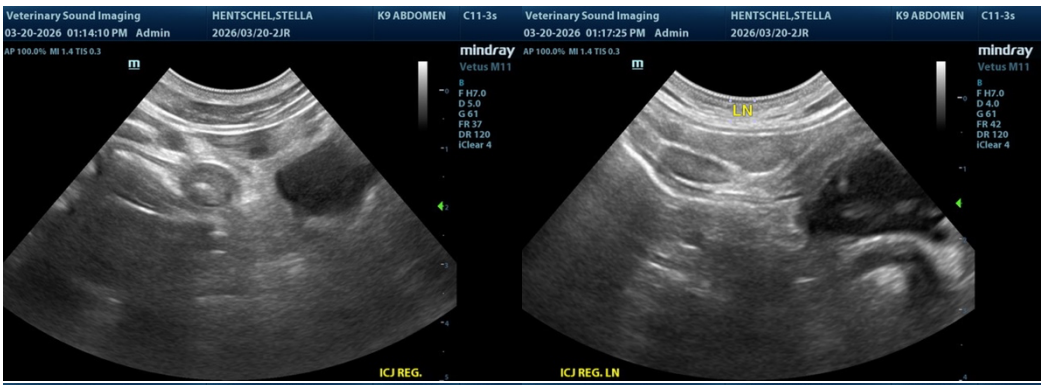

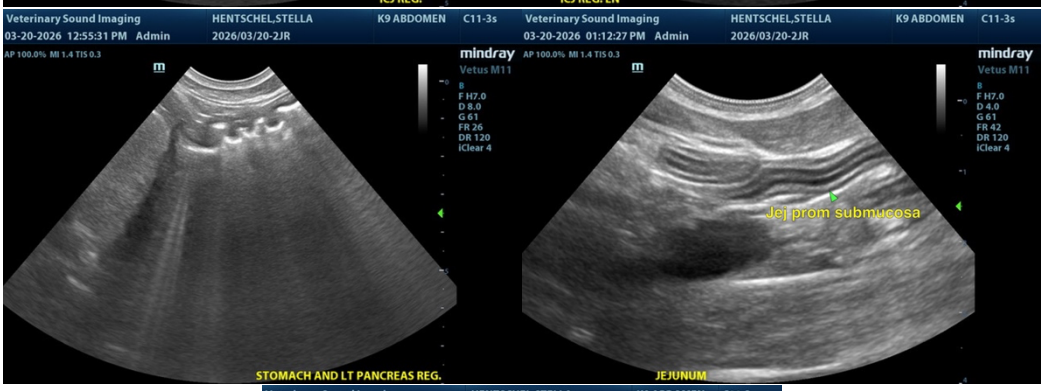

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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