



**PATIENT**

Tsukki Fender

**SPECIES**

Canine

**BREED**

Great Pyrenees

**SEX**

MN

**AGE**

2 years

**WEIGHT**

79.4 lbs.

**INTERPRETED BY**

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

**IMAGING  
PERFORMED BY**

Jenna Walsh, CVT

**HOSPITAL NAME**

Eastgate VC

**REFERRING VET**

Dr. Kelley

**INVOICE**

16485

**DATE**

3/29/23

**PRESENTING CLINICAL SIGNS**

P is not eating or drinking, P tried eating and drinking and vomited 3 times yesterday. P has not had bowel movement for a couple days. \_Nervous, nauseous (lip licking, salivating) Current Medications Hydrolyzed diet, Cerenia Tablets 160mg 4.00 Give 1/2 tablet orally once a day. Give with food. . Abdominal Radiographs: Dilation of the descending colon and rectum with a moderate amount of fecal material, with preceding gas dilation pattern. Findings consistent with constipation.

Abnormal PE/Chem/CBC/UA Results: Total protein 4.5 (5.0-7.4) ALBUMIN 2.9 2.(7-4.4) - low normal GLOBULIN 1.6 (1.6-3.6) -marginal\_ Complete Blood Count NSF fecal negative

**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 uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

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 6.8 cm in length. The right kidney measured 6.4 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 2.5 cm length x 0.52 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 2.2 cm length x 0.47 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. 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.



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***Gastrointestinal***

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The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild to moderate, variably echogenic, nonshadowing ingesta without signs of obstruction or foreign material. No evidence of mechanical pyloric outflow obstruction was noted. The ventral gastric body wall width measured 0.35 cm. The pylorus wall width measured 0.40 cm.

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The small intestine presented generalized intact wall layering with propensity for segmental to generalized prominent to mildly hyperechoic submucosa, as well as mildly prominent muscularis layers. No evidence of small intestinal mechanical / metabolic ileus with minor segmental nonshadowing intestinal ingesta / chyme.

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Sonographically normal visible colon wall layers were present. The descending colon appeared to contain formed hard shadowing fecal matter with subjective semi-formed to soft fecal matter in the proximal colon.

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***Pancreas***

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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***

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Focal to intermittent mesenteric lymph nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). An example lymph node measured 2.5 cm x 1.3 cm. No evidence of peritoneal free fluid was noted.

**IMAGING PERFORMED BY**

Jenna Walsh, CVT

**ULTRASONOGRAPHIC FINDINGS**

- Enteropathy
- Focal to intermittent mesenteric lymphadenopathy - subjectively benign / reactive
- Sonographically unremarkable colon containing variably formed fecal matter
- Intact normal gastric wall layering with mild to moderate gastric ingesta - ingesta sonographically consistent with food

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

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Although potential for patient variant, the small intestine exhibited mild mural changes including subjective prominent submucosa and muscularis layers, which may be affected in patients with inflammatory enteropathy. Minor potential for infiltrative intestinal neoplasia is possible yet is thought less likely. No evidence of mechanical obstruction or gastrointestinal foreign material was noted. Potential for mild metabolic or functional gastric hypomotility may be possible if documented NPO and in light of reported inappetence.



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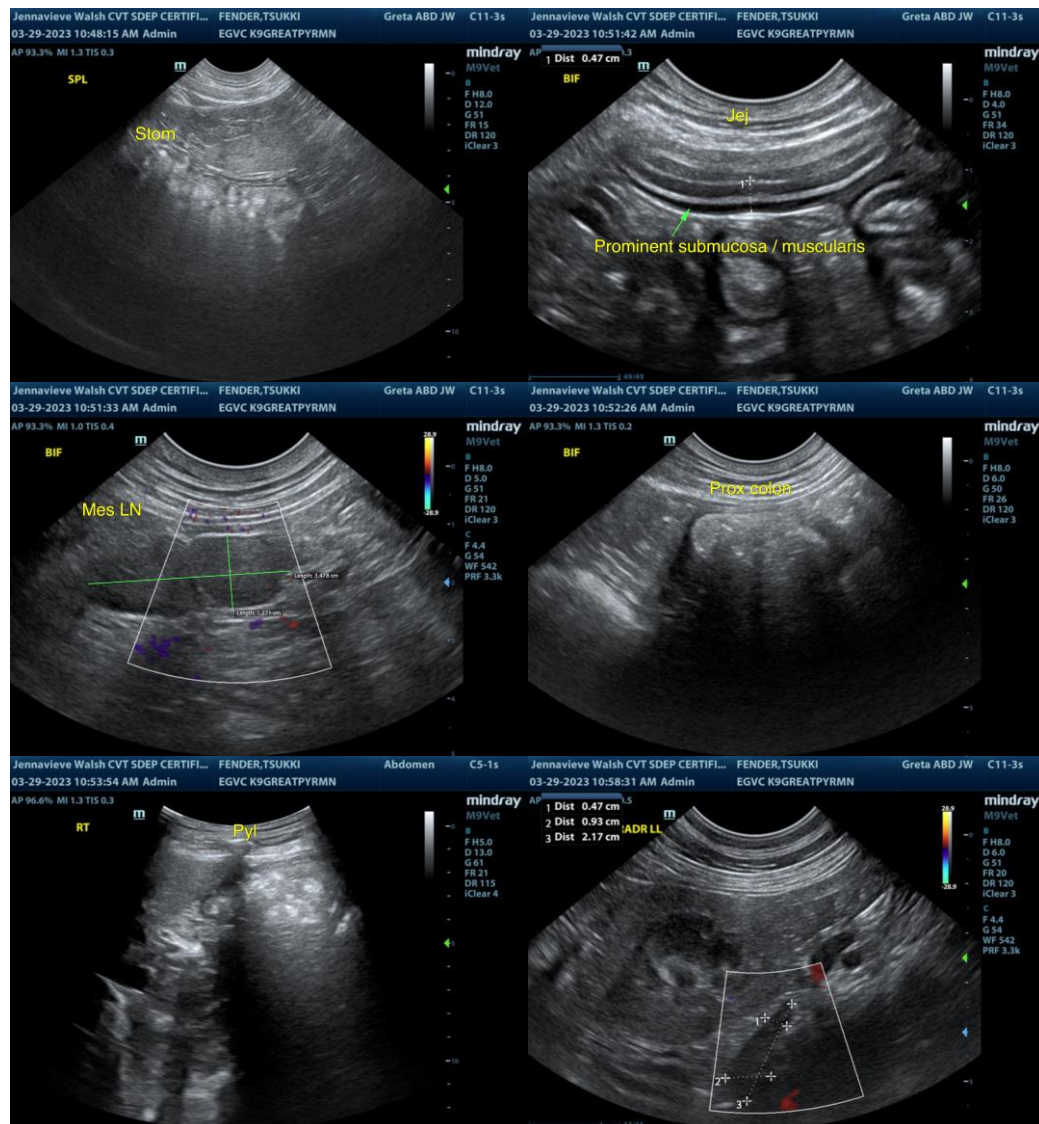
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A GI panel to include PLI/TLI/Cobalamin/Folate, three-view chest radiographs, as well as resting cortisol level to assess for or rule out occult disease as a contributing factor, is recommended. Intestinal biopsies would be required for a definitive diagnosis.

Empirically, continued hydrolyzed diet with possible smaller more frequent feedings or potential canned diet, gastroprotectants, and as-needed gastrointestinal support with an assessment of clinical response, progressive gastrointestinal signs, and/or weight loss going forward would be a more conservative approach.





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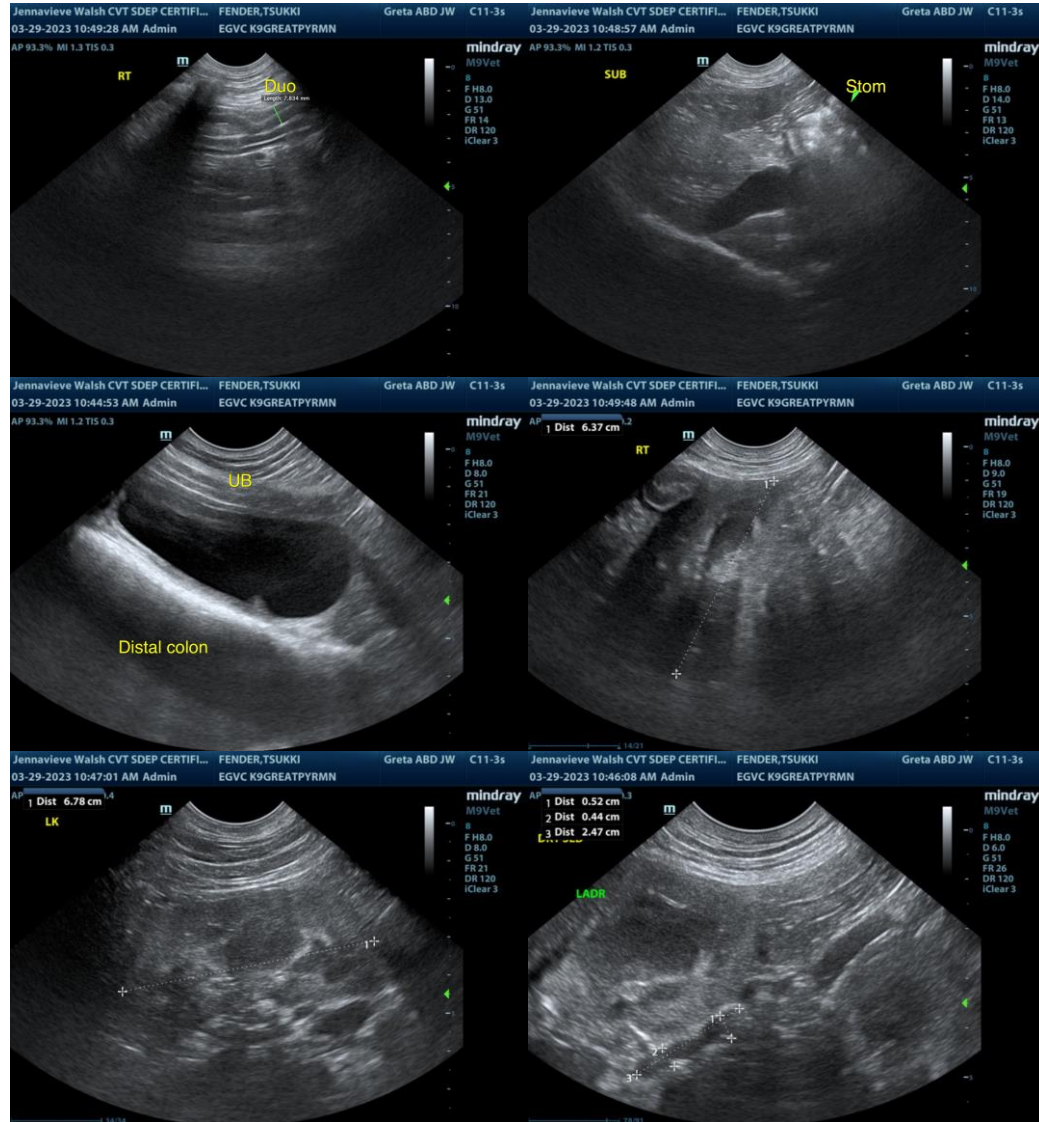
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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