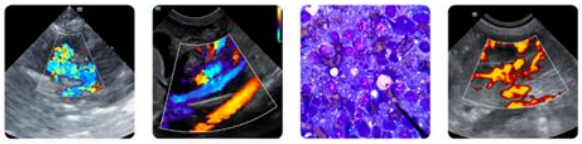


PATIENT
Claire Kowalski

SPECIES
Canine

BREED
Mix

SEX
FS

AGE
12yr

WEIGHT
22.8

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

IMAGING PERFORMED BY
Christensen

HOSPITAL NAME
Tanquility Veterinary Clinic

REFERRING VET
Christensen

INVOICE
24343

DATE
03/30/2026

PRESENTING CLINICAL SIGNS

- Owner reported that on Sunday morning Claire began vomiting (predominantly clear fluid), exhibited hyporexia despite ingesting a small amount of white rice. Became lethargic, and was panting with tail tucked. Regurgitation described into the night with just water, no rice that was ingested previously. No diarrhea reported. Went to ER last night. Review of Newton ER records: SNAP/PLI for pancreatitis normal; marked hemoconcentration consistent with hypovolemia/dehydration; hypokalemia; mild leukocytosis. Radiographs from Newton showed a large soft-tissue opacity near the stomach, read as a dilated stomach by the radiologist. In-hospital today, Claire has been on IV fluid therapy with potassium chloride supplementation and has not vomited while monitored.

Abnormal PE/Chem/CBC/UA Results: Cerenia, Famotine and IV fluids while awaiting results.

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 kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. Bilateral areas of pinpoint medullary mineral were present. The left kidney measured 4.4 cm in length. The right kidney measured 5.0 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

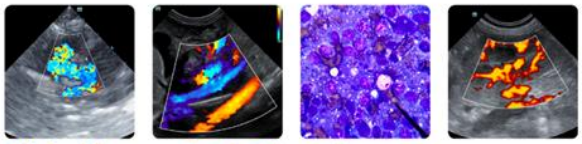
The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.54 cm width at the caudal pole. The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.47 cm width 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. 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 primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented primarily intact non-thickened wall into the area of the pyloric outflow. Mild to moderate, retained non-shadowing ingesta/ chyme was present in the stomach. Subjective mildly thickened pyloroduodenal junction to proximal duodenum visualized within the pyloric lumen with concurrent mildly thickened pyloroduodenal junction to upper duodenum wall. The remainder of the duodenum as well as the overall small intestine exhibited intact wall layering with maintained wall layer ratio and primarily empty intestinal lumen. Mild segmental jejunal ileus and intestinal gas present to the level of the colon.

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 overt lymphadenopathy or peritoneal effusion was present.

Mild peripyloric to periduodenal hyperechoic omentum.

An ill-defined non-homogenous subcutaneous mass with regional cellulitis and subcutaneous edema measuring ~ 6 cm in diameter is present.

ULTRASONOGRAPHIC FINDINGS

Primary

- Mildly thickened pyloroduodenal junction and upper duodenum visualized within pyloric outflow suggestive of possible to sliding pyloroduodenal intussusception, associated inflammatory pyloric, pyloroduodenal and upper duodenal mural changes, potential for emerging pyloroduodenal junction or upper duodenal mural mass, all potentials
- Mild to moderate retained non-shadowing gastric ingesta-no overt foreign material
- Otherwise, sonographically unremarkable primarily empty small intestine with mild segmental jejunal ileus -no overt intestinal obstructive pattern
- Unspecified subcutaneous mass with associated subcutaneous cellulitis / edema

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If available, upper gastrointestinal endoscopy is recommended for further evaluation of the pyloric outflow and potential for biopsies. Concurrent sampling of the unspecified subcutaneous mass +/- C/S is recommended. The mild to moderate retained gastric ingesta suggests that the pyloroduodenal pathology is at least partially obstructive.

If direct exploratory laparotomy is elected, biopsies +/- resection and anastomosis procedure at the level of the pyloric outflow is likely indicated. Surgical consult or referral is recommended.

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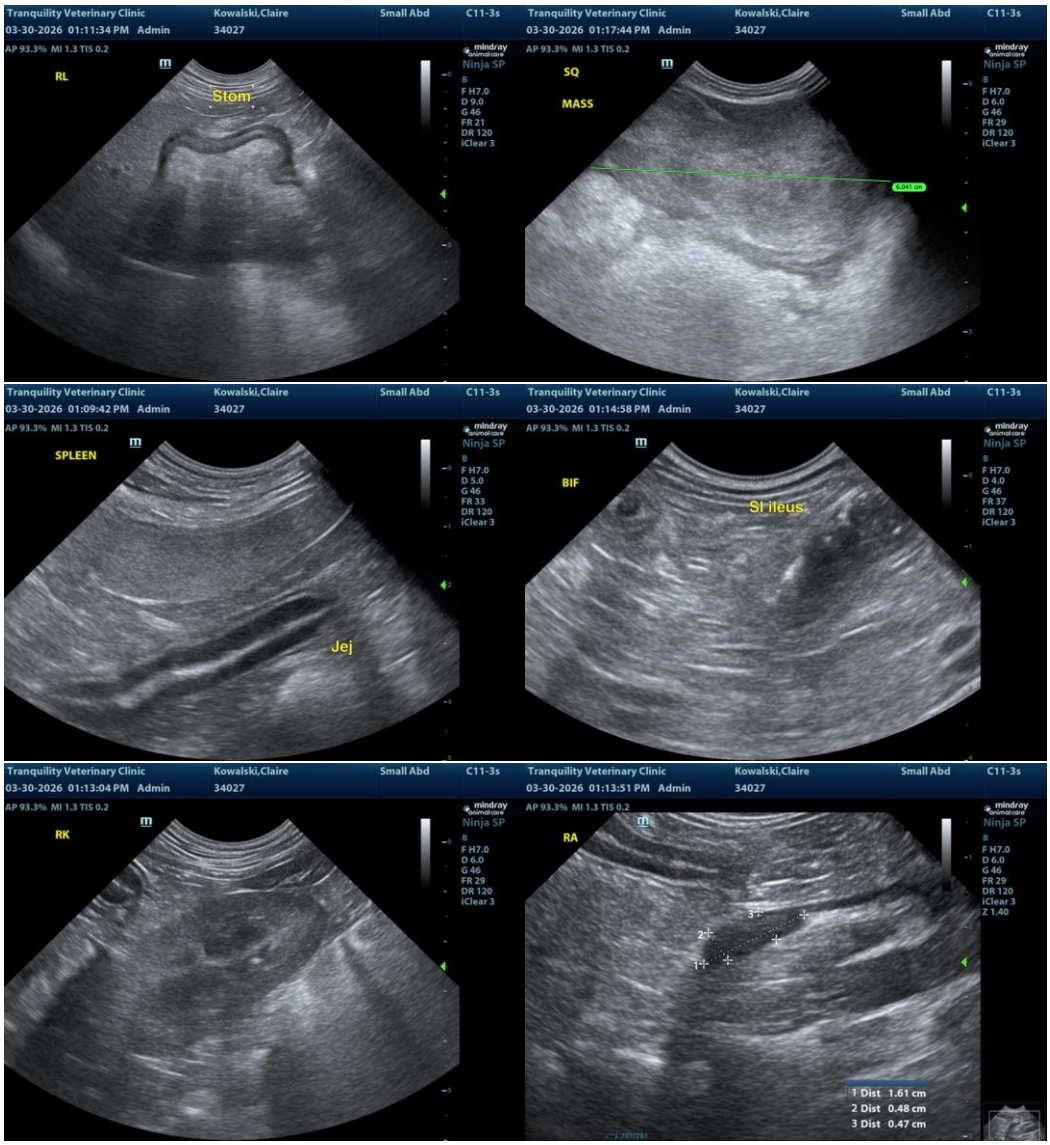
Three view chest radiographs are recommended if not done to assess for occult thoracic pathology.



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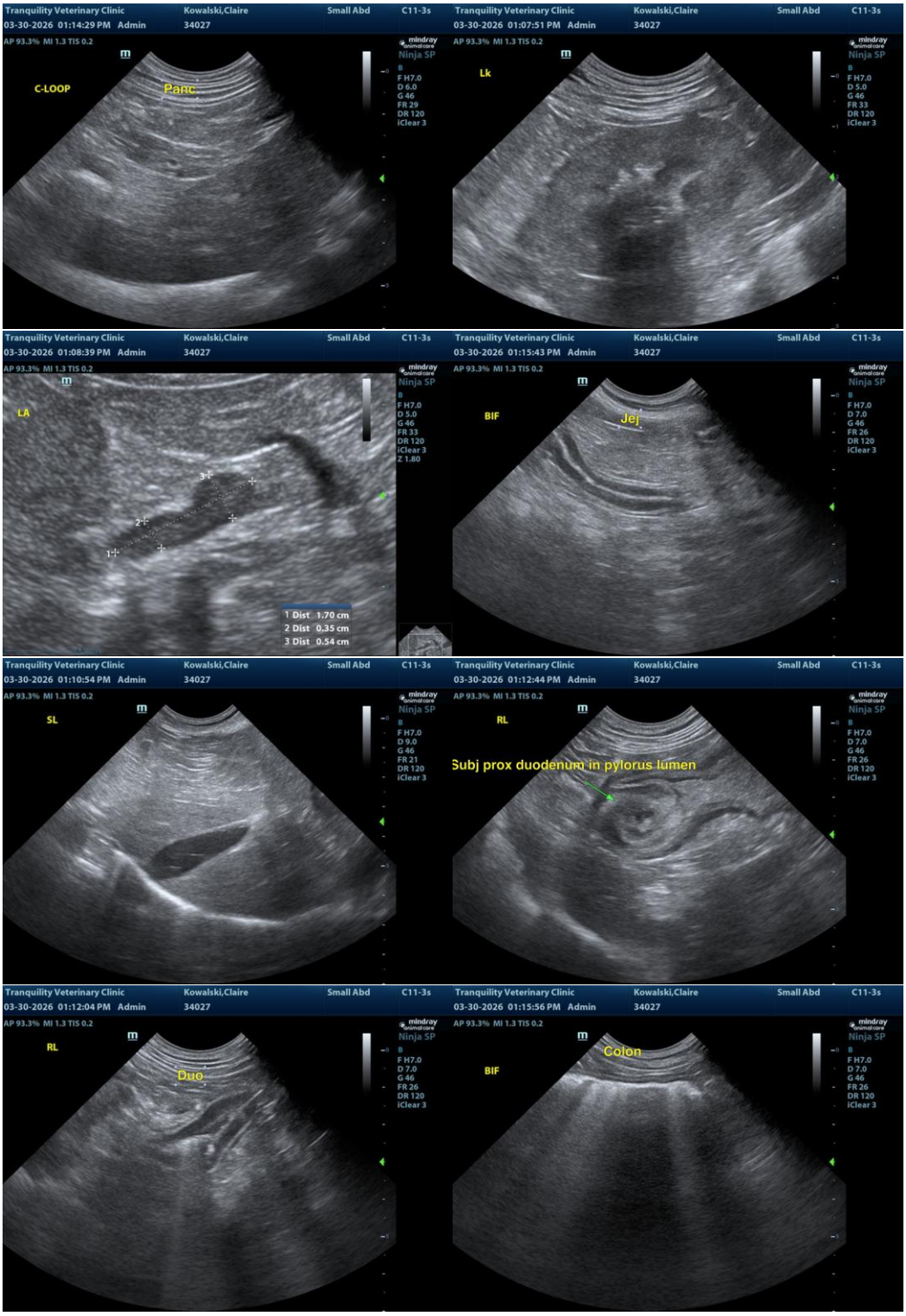
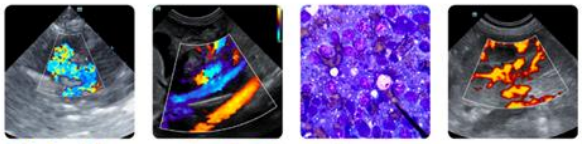


The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not



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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