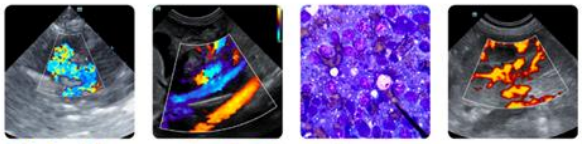


PATIENT

Faye Morrisey

SPECIES

Canine

BREED

Boxer Mix

SEX

FS

AGE

10yr

WEIGHT

23.4kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Meghan Myers

HOSPITAL NAME

Hershey Animal Emergency Center

REFERRING VET

Dr. Lydia Coogan

INVOICE
24336

DATE
03/30/2026

PRESENTING CLINICAL SIGNS

- Had a gastrotomy on 3/26 (2 socks removed)
- 3/29PM patient started leaning on pet sitter and was unsteady on her hind end. She had a bm 3/28 but has had soft stool. Drooling at home. Owner has had to tempt patient to eat and not eating all offered. Patient urinated in kennel (unusual for pt). Patient lethargic on and off and has been drinking more then normal.
- abnormal PE:
- fecal staining on fur from diarreha, mild bruising at incision site from gastrotomy

Abnormal PE/Chem/CBC/UA Results: CBC: RBC 5.6 (L) HCT 36.7 (L) Reticulocytes 9.0 (L) Neutrophils 13.75 (H) Band neutrophils PCV/TS: 48%/6.6 EPOC: pO2 58.4 (H) BE,ECF -7.2 (L) BUN 6 (L) Chem15: BUN 5 (L) ALP 1,502 (H) cortisol: 4.19 Poor serosal detail, variation in intestinal diameter with the possibility of 1 larger fluid-filled loop on the ventral aspect of the abdomen. Both of these changes merits an AUS There is a small size of the cardiac silhouette and pulmonary vasculature could be representative of hypovolemia. Peritoneal free gas is likely secondary to the laparotomy. The alveolar pattern in the left caudal lung lobe could be secondary to atelectasis versus an emerging aspiration pneumonia. The gas in the esophagus could be secondary to an esophagitis or an ileus.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder was subnormal in size owing to lack of urine distension which prohibited full evaluation of the urinary bladder walls. The trigone, cystourethral junction, and visible pelvic urethra to a depth of 3 cm 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 mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 7.6 cm in length. The right kidney measured 7.1 cm in length.

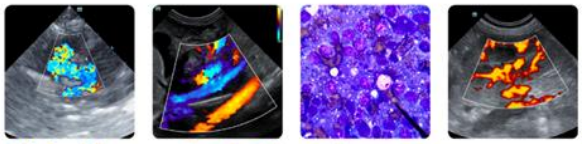
The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.50 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 0.76 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.



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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 non-distended in size with thin walls and primarily anechoic luminal content. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented mild thickened wall. Intact wall layering was maintained and distinct. The stomach contained a moderate amount of anechoic fluid. A small amount of non-shadowing ingesta /chyme in the area of the pyloric outflow was present. No obvious visualized obstructive pyloric mural pathology.

The intestinal walls demonstrated intact wall layering and maintained 1:3 muscularis / mucosa ratio. The mucosa exhibited mild decreased echogenicity with occasional mucosal speckling. A mild segmental ileus pattern is present without obstruction or visualized foreign material.

The colon walls presented intact yet mild thickened wall layering. Soft fecal matter was present in the non-distended colon lumen.

Pancreas

The pancreas presented hypoechoic to heterogeneous echogenicity compared to adjacent omental fat. Mild asymmetrical capsule margination was present with mild variable parenchymal swelling and mild peripancreatic reactivity / inflammation. No overt evidence of neoplasia.

Free Abdomen

Generalized mild hyperechoic mesentery.

No overt visualized significant or swollen mesenteric lymphadenopathy.

Mild volume peritoneal effusion.

ULTRASONOGRAPHIC FINDINGS

Primary

- Acute gastroenterocolitis pattern accentuated by subjective gastroduodenitis, moderate hypomotile stomach and segmental intestinal ileus
- Possible mild pancreatitis
- Hyperechoic omentum and mild volume peritoneal effusion
- Non-distended urinary bladder

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No overt evidence of persistent or retained gastroenterocolic foreign body or definitive area of mechanical gastrointestinal obstruction. Generalized gastroenterocolitis associated with dietary indiscretion and recent surgery accentuated in the upper gastrointestinal tract is favored. Omental inflammation and peritoneal effusion secondary to surgery or potential peritonitis is possible.

Correlation with effusion analysis cytology +/- C/S is recommended. If evidence of septic abdomen,

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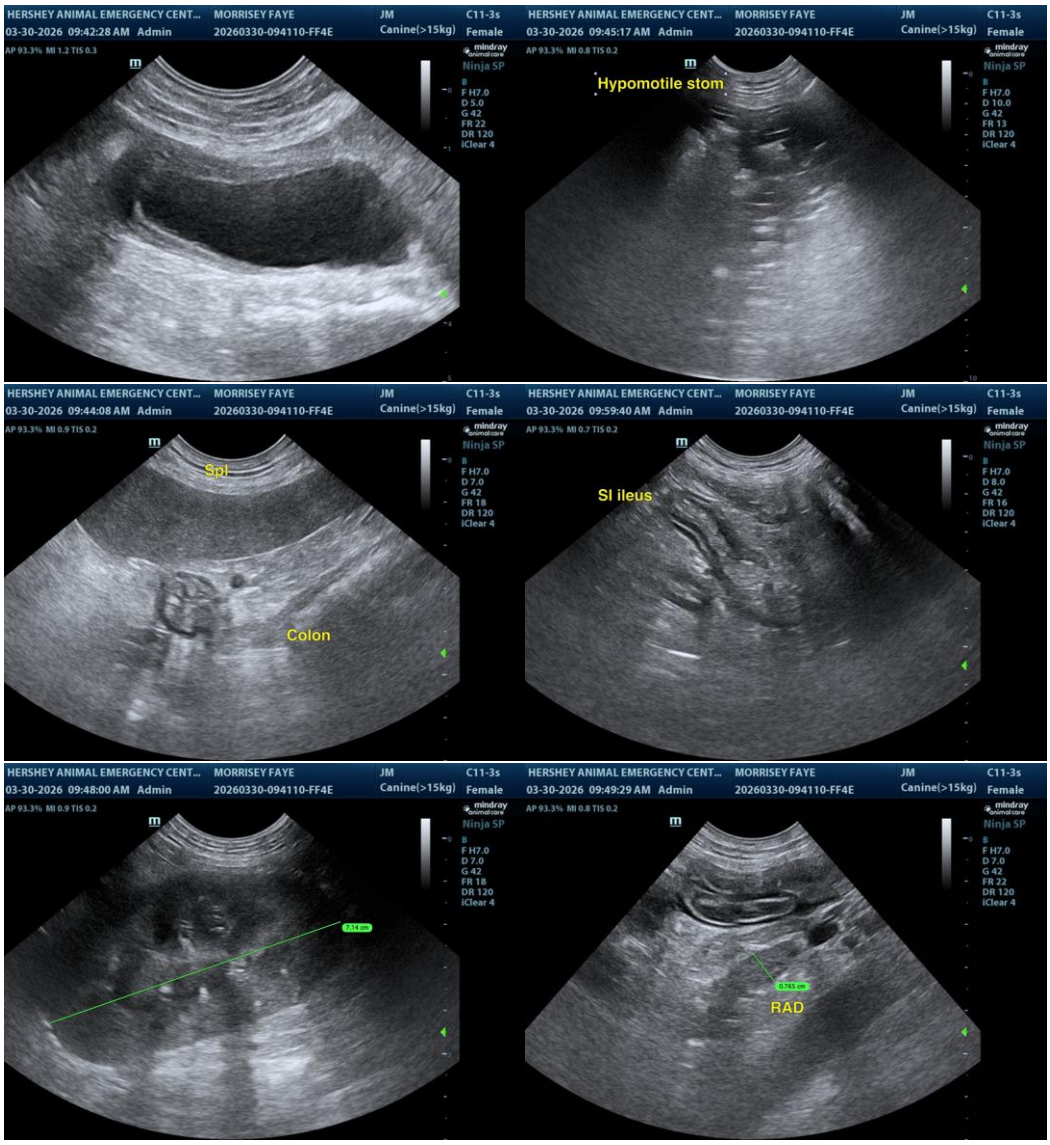
recheck exploratory laparotomy may be indicated. Otherwise, hospitalization with 24 hour gastrointestinal support including IV fluids with clinical monitoring and sonographic reassessment is recommended.



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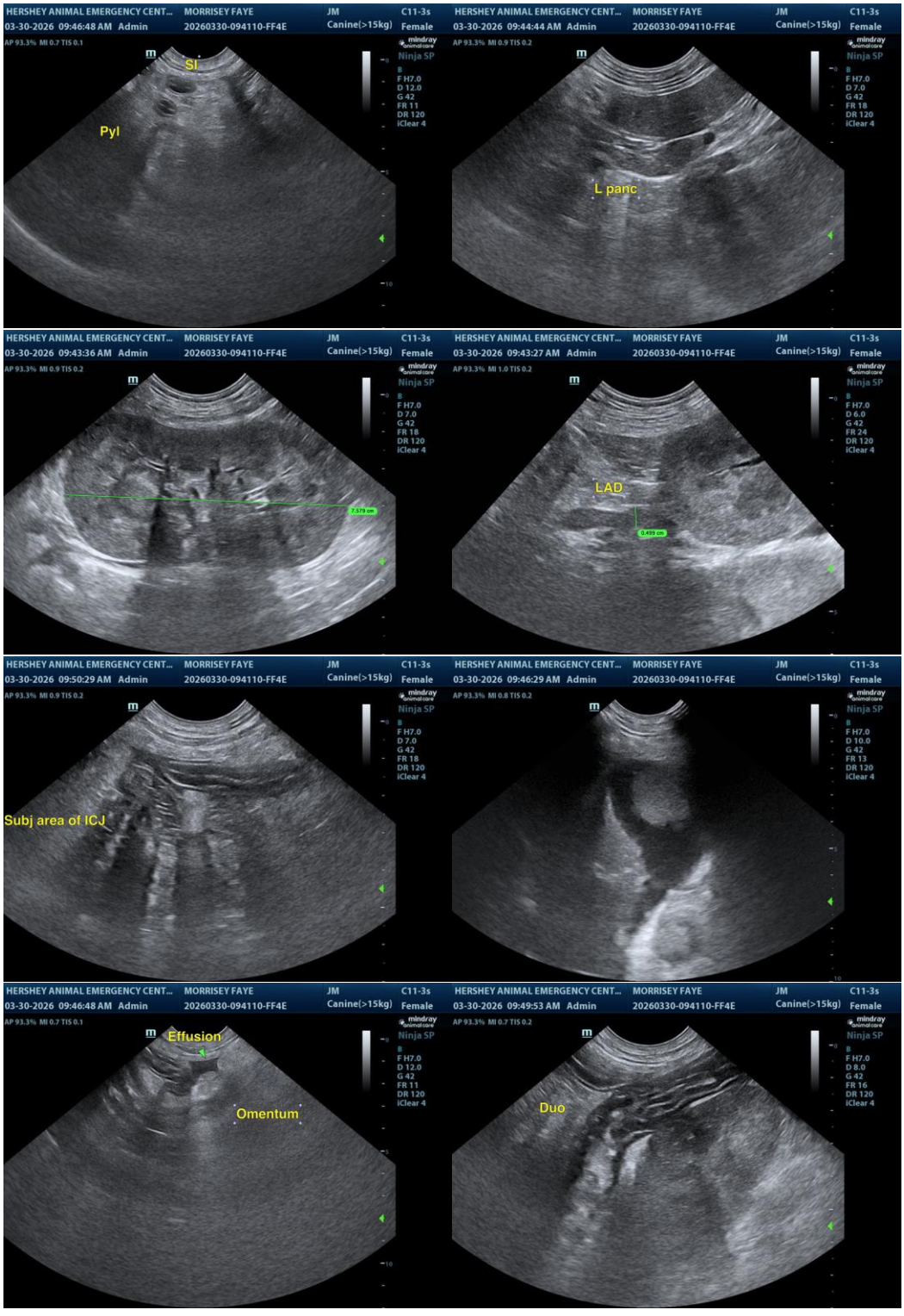
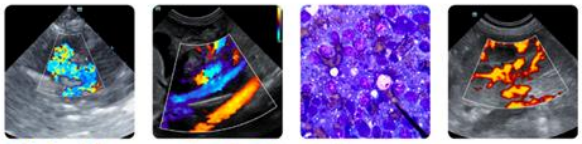


The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not



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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