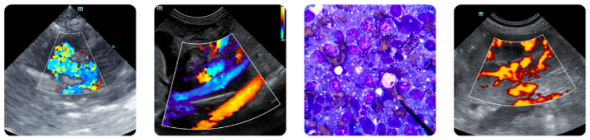


PATIENT

Harlem Poch

SPECIES

Canine

BREED

German Shepard

SEX

Male Neutered

AGE

14y

WEIGHT

39.8 kgs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Gira

HOSPITAL NAME

Petzoic Pet Hospital

REFERRING VET

Dr. Poffenroth

INVOICE

13258

DATE

3/6/26

PRESENTING CLINICAL SIGNS

History:

- 24-hour duration of vomiting (12+ times), mild lethargy, panting, history of IBD (Dx at rDVM over 5 years ago, on tylosin to treat), IVDD and IBD. Owner reports some dermatopathies. Not on any current medication but he ate an orthopedic boot about 3 weeks ago and owners only knew when he vomited a portion of the boot. Elevated ALT ALP Globulin Cholesterol T Bili on BW today in hospital, monocytosis basophilia thrombocytosis no fever. Had abdominal US years ago and had an event in which became too deep with sedation.

Abnormal PE/Chem/CBC/UA Results: Elevated ALT ALP Globulin Cholesterol T Bili on BW today in hospital, monocytosis basophilia thrombocytosis no fever.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal thickness and tone. Primarily anechoic urine was present in the lumen. Mild, echogenic to particulate non-dependent sediment was present without evidence of calculus formation. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic mural changes were noted.

The area of the residual prostate appeared normal and free of pathology.

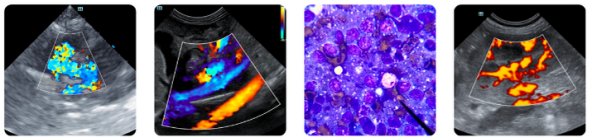
Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and moderate loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. Medullary mineral and cortical cysts were present. The left kidney measured 7.4 cm in length. The right kidney measured 7.3 cm in length.

Adrenal Glands

The bilateral adrenal glands were normal in size. Mild parenchyma heterogeneity and mild capsule asymmetry was present without suspicion for overt neoplasia. The left adrenal gland measured 0.80 cm width in the caudal pole. The right adrenal gland measured 0.81 cm width in the caudal pole.

Spleen

The spleen exhibited primarily finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. Solitary, small, non-capsule deforming, non-homogeneous, well-defined, symmetrical, hyperechoic nodule was present measuring 0.66 cm in diameter. Concurrent non-capsule deforming, non-homogeneous, hypoechoic nodule measuring 0.6 cm in diameter. 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 or neoplastic changes were not noted. The hyperechoic nodules tend to trend benign and are most consistent with benign hyperplasia or myelolipomas.



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Liver

The liver was mildly enlarged in size. The liver parenchyma was mild, nonuniform and hypoechoic to the spleen with a mild coarse echotexture and subjective mild to benign parenchymal remodeling. The hepatic and portal vasculature were normal in appearance without signs of congestion. The gallbladder exhibited a mild, irregular thickened hyperechoic wall and was non-distended in size. Mild, non-organized, primarily gravity dependent, hyperechoic debris were present. The common bile duct was not visualized.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild to moderate, variably echogenic, non-shadowing ingesta without signs of obstruction or foreign material.

The small intestine presented mild to variable, primarily intact thickened wall with propensity for mildly prominent to hyperechoic submucosa layer. Segmental, mild to variable, non-shadowing duodenojejunal ingesta with concurrent empty jejunal segments likely distal. Segmental indistinct to potential loss of segmental jejunal mural detail mid abdomen. Duodenum wall measured 0.53 cm and mildly thickened jejunum wall measured 0.56 cm width. Non-thickened jejunum wall measured 0.39 cm width.

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

Pancreas

The pancreas was prominent in size with capsule asymmetry and heterogeneous remodeled parenchyma.

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). Mild peri intestinal hyperechoic omentum and no evidence of peritoneal effusion noted.

PRIMARY FINDINGS

- Chronic hepatopathy pattern – subjective benign
- Suspect chronic cholecystitis with non-organized bile debris (non-mucocele)
- Mildly thickened duodenojejunal exhibiting segmental indistinct mid abdomen jejunal wall layering, non-shadowing gastrointestinal ingesta with concurrent empty intestinal segments suspected distal
- Prominent non-homogeneous remodeled pancreas
- Chronic renal changes exhibiting cortical cysts

SECONDARY FINDINGS

- Small benign hyperechoic splenic nodule – most consistent with myelolipoma

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the presence of gastrointestinal ingesta despite reported vomiting, metabolic or functional

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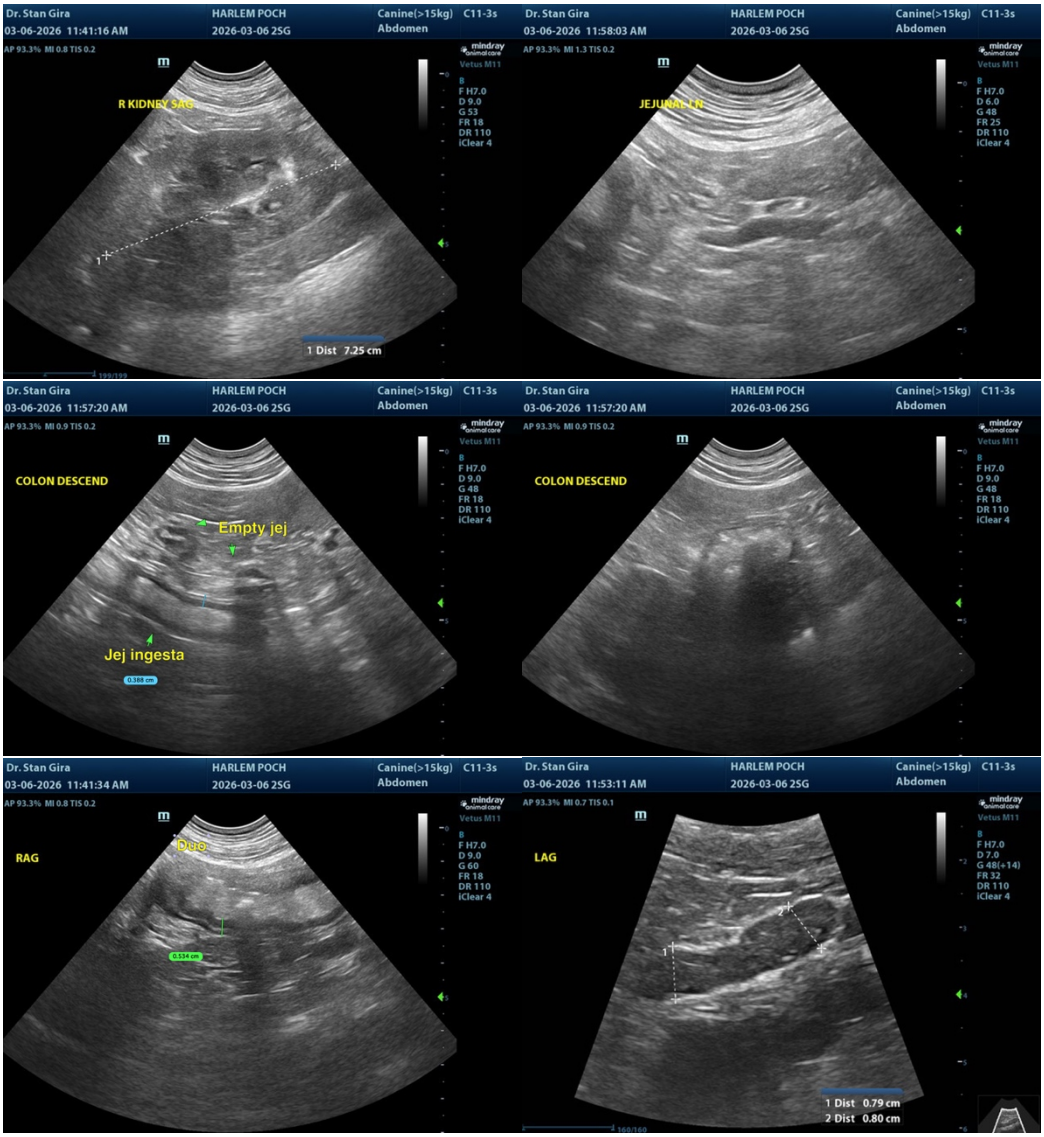
gastrointestinal ileus secondary to chronic gastrointestinal disease or chronic pancreatitis vs non-obvious mechanical intestinal obstruction, i.e. foreign body given patient history or mural pathology is possible. Primary concern for non-obvious mechanical intestinal obstruction indicated given concurrent empty small intestinal segments suspected distal. Correlation with current clinical signs is recommended. Hospitalization with gastrointestinal support including IV fluids, documented 12-hour fast and sonographic reassessment of the gastrointestinal tract is recommended. Exploratory laparotomy with intestinal biopsy is considered essential and should be strongly considered if persistent gastrointestinal ingesta or gastrointestinal signs.



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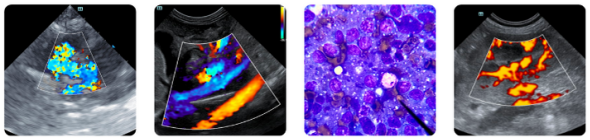

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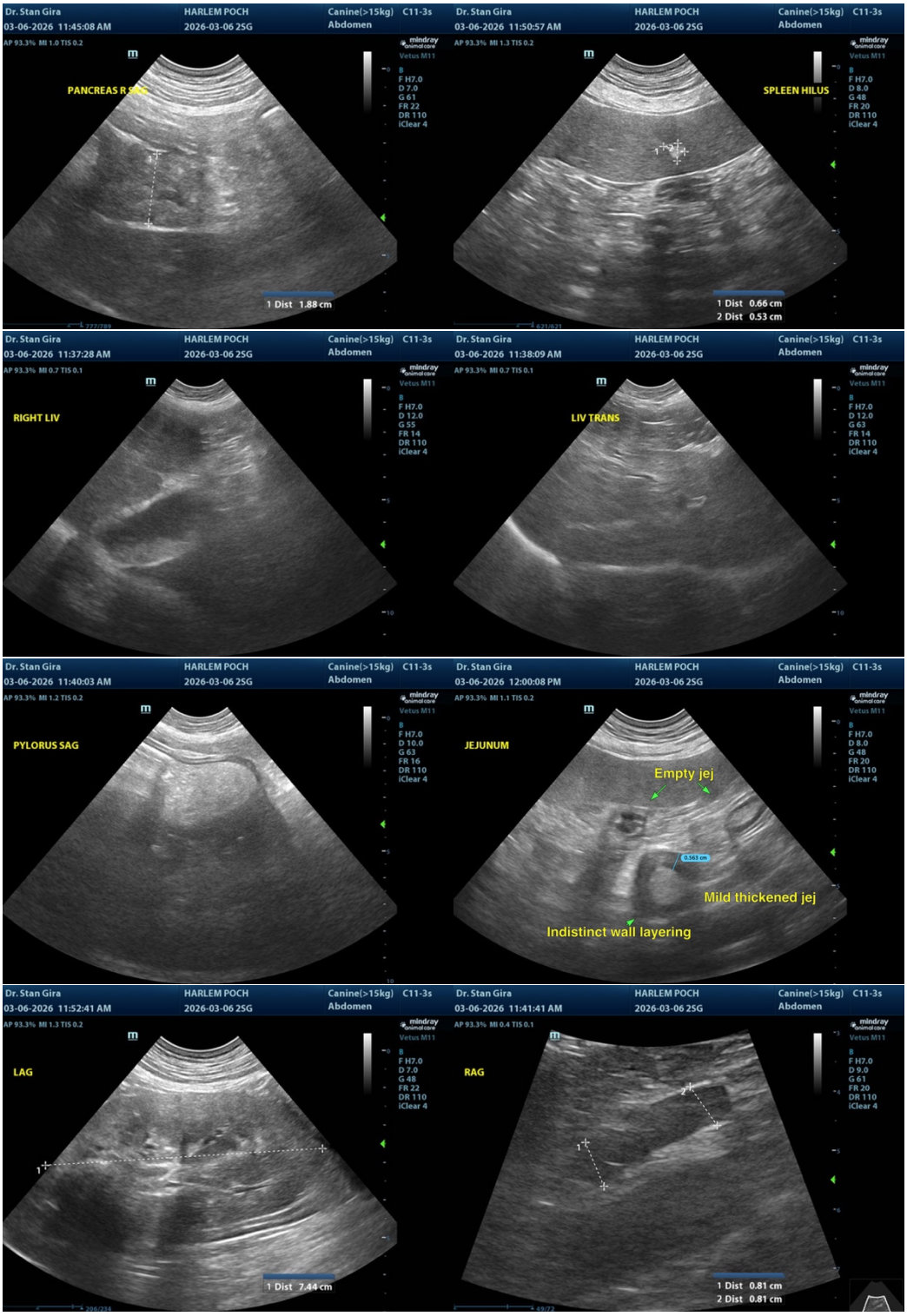

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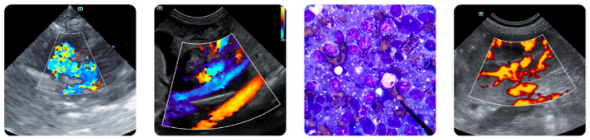

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@sonopath.com