



PATIENT

Beans Easterling

SPECIES

Canine

BREED

Labrador Mix

SEX

MN

AGE

3yr

WEIGHT

43kg

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. Cara Sinopoli

INVOICE

24459

DATE

04/11/2026

PRESENTING CLINICAL SIGNS

P presented after starting to vomiting 2 days ago; went to rDVM 4/9 - received Cerenia. Returned to rDVM 4/10 since continued vomiting through Cerenia. concern for fb. P transferred here. Regurgitated this morning, tense and mildly uncomfortable on cranial abdominal palpation
Abnormal PE/Chem/CBC/UA Results: 4/9 rDVM: CBC: WBC 19.14K H, neut. 14.2K H, mono 2.59K H Chem: WNL Pancreatic lipase: 199 N 4/10 ON: EPOC: pO2 77.9 (H), cSO2 94.0 (H), pH 7.307 (L) PCV/TS: 45%/7.2 Rad Report: The stomach contains a mild amount of fluid and gas. No abnormal gastric distention is identified. On the left lateral radiograph, the pylorus contains normal gas with no evidence of foreign material. The intestinal tract is of normal shape, size, content and distribution.. A mild amount of fecal material is noted within the descending colon. Additionally, a well-defined mineral opaque foreign body measuring approximately 5 cm x 0.6 cm is seen intermixed with fecal material within the descending colon. . No evidence of 2 populations of bowels or intestinal plication

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, 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 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 7.1 cm in length. The right kidney measured 7.3 cm in length.

The area of the aortic trifurcation was free of pathology.

The area of the residual prostate appeared normal and 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 0.59 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 0.65 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



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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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The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild variably echogenic non-shadowing ingesta sonographically suggestive of food echogenicity with no signs of obstruction or foreign material.

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The small intestine presented overall intact wall layering with maintained muscularis/mucosa ratio. Overall empty intestinal lumen. Mild segmental intestinal ileus and lumen gas to the level of the ileocolic junction. The ileum and ileocolic junction exhibited thickened, mildly hypoechoic wall with intact indistinct wall layer detail. The ileocolic wall measured 0.60 cm in width.

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The proximal, transverse and segmental descending colon walls presented intact yet mild thickened wall layering. Mildly thickened colon wall measured 0.38 cm. Non-formed fecal matter in the proximal, transverse to upper descending colon with variably shadowing fecal matter in the distal colon at the level of the urinary bladder. Within the proximal colon lumen, subjective distal to the ileocolic junction, an indistinctly marginated shadowing proximal colon lumen echo was present, measuring 1.6 cm in diameter.

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Pancreas

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The area of the pancreas was sonographically normal.

Free Abdomen

No evidence of significant peritoneal effusion was present.

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Mildly swollen non-homogenous colic lymph nodes were present; an example measured 1.7 cm in diameter.

Peri ileocolic hyperechoic omentum was present.

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ULTRASONOGRAPHIC FINDINGS

Primary

- Nondistended stomach with nonshadowing ingesta
- Segmental small intestine ileus and gas to level of ileocolic junction
- Variable shadowing fecal matter in descending to distal colon - may correlate with radiographic findings
- Thickened ileocolic junction and proximal to transverse colon, non-formed fecal matter and shadowing echo proximal colon - suggestive of moderate to significant ileocolitis and suspect concurrent proximal colon foreign body
- Inflamed peri-ileocolic omentum and colic lymphadenopathy

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No obvious evidence of stomach or small intestine foreign body. Continued gastrointestinal support with empirical therapy for ileocolitis and monitoring of fecal output +/- enema is indicated. Occult neoplasia thought unlikely given history. If persistent clinical signs, exploratory laparotomy with



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possible manual manipulation of fecal material and biopsies should be considered.

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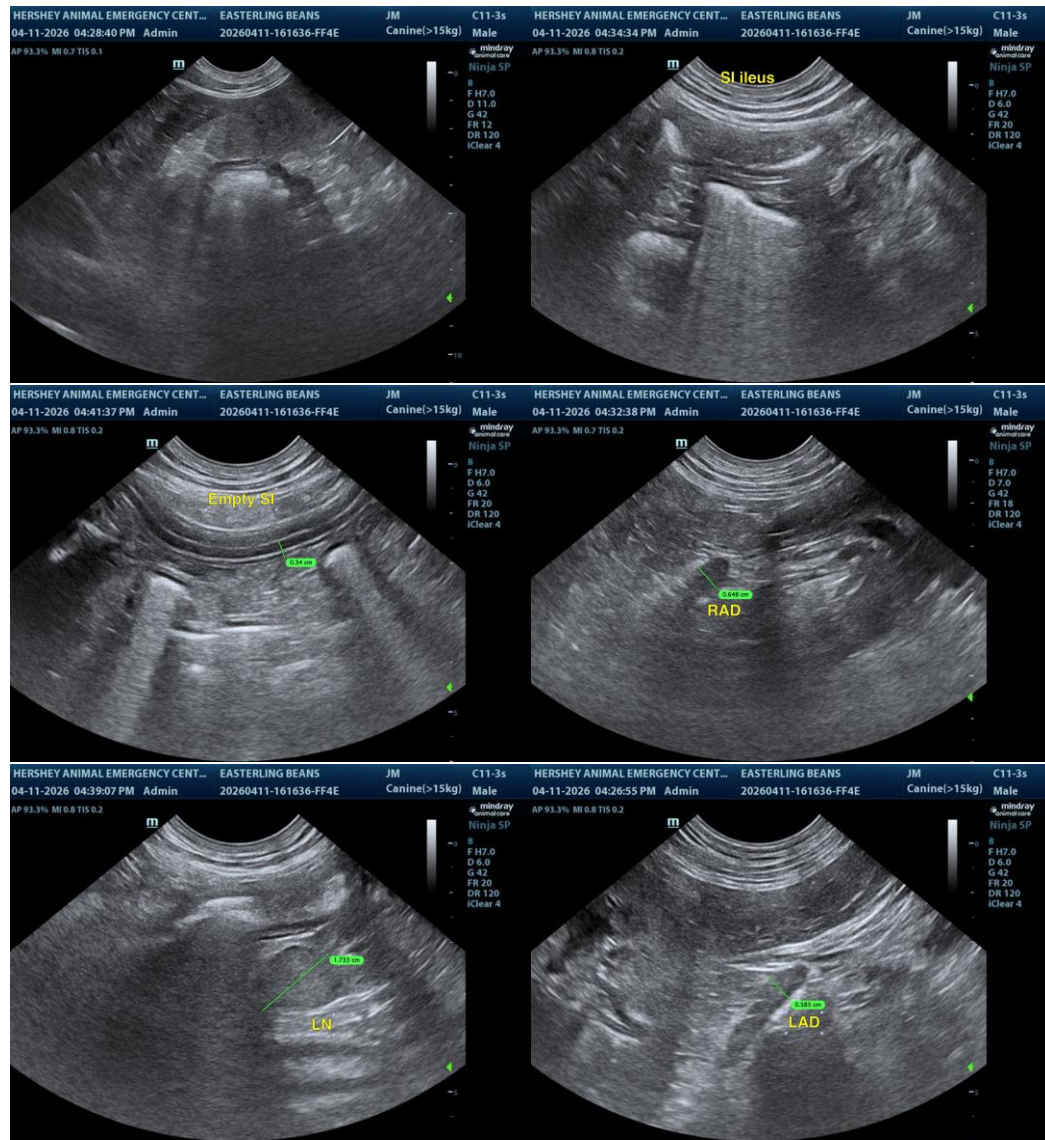
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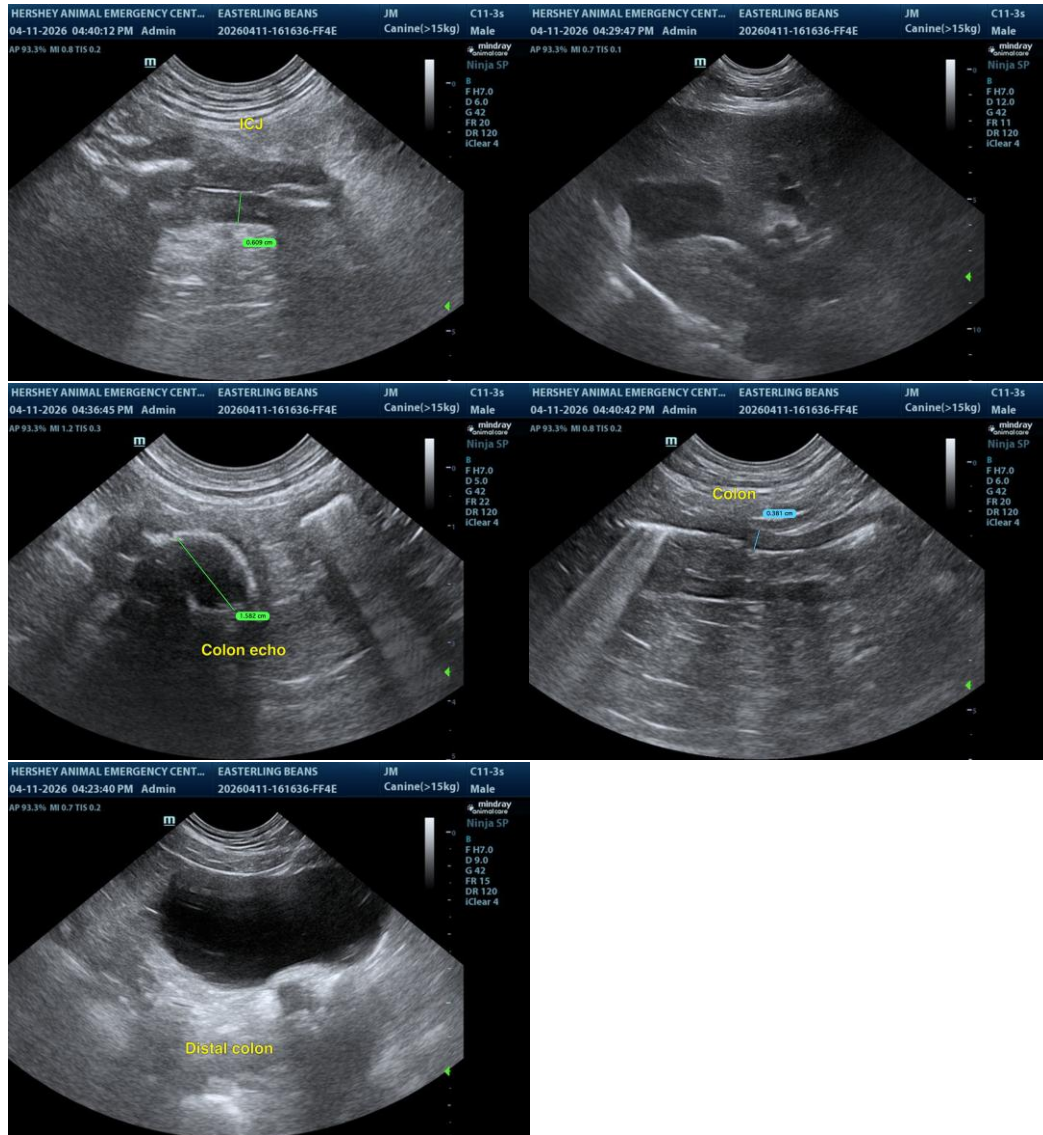
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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