



PATIENT

Sullivan Kuschel

SPECIES

Canine

BREED

Boston Terrier

SEX

MN

AGE

10yr

WEIGHT

27.3lb

INTERPRETED BY

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

IMAGING PERFORMED BY

Chrissy Krell DVM

HOSPITAL NAME

Isaacson Veterinary
Hospital

REFERRING VET

Chrissy Krell DVM

INVOICE

24551

DATE

04/21/2026

PRESENTING CLINICAL SIGNS

- Chronic vomiting/regurgitation since April 10th, notable ptyalism - Keeping some food down but frequent regurgitation (client estimated 10 x a day) - Clear fluid produced in large amounts regardless of food content - Weight loss of 8 ounces since April 17th - History of pancreatitis (previous episode after getting into chicken coop)

- Currently on metronidazole - On Nexgard Plus for heartworm prevention

- Soft stools but not diarrhea at this time - Lethargic, stands with head hanging - Lives with horses and cows, exposure to bird feeders and bird droppings

- XR Consult 1. There is no distention of small intestines to suggest obstruction, no plication to suggest a linear foreign body, and no radiopaque foreign material is evident. Possible etiologies of vomiting such as gastritis, gastroenteritis, pancreatitis and non-radiopaque foreign material are not completely excluded. The lack of any appreciable intestinal dilation does not exclude a small intestinal or pyloric obstruction.

Abnormal PE/Chem/CBC/UA Results: PE: heavy ptyalism, some regurgitation noted during exam, QAR, lethargic, two small ~0.8cm diameter dermal raised hairless masses on the head noted (recently emerged in the past few months). bilateral submandibular lnn prominent, two smaller masses ventral cervical region palpated about 2.5 cm in length mobile. 4/13/2026 labs: CBC: hemoconcentration Hct 62.3 (37.3-61.7), lymphopenia 0.93 (1.05-5.10), eosinopenia 0.04 (0.06-1.23) CHEM17: mildly elevated ALP 287 (23-212) Pancreatic Lipase: WNL SDMA: WNL 4DX: negative

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN AND LIMITED CARDIAC

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 mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. Bilateral areas of pinpoint to focal medullary mineral were present. The left kidney measured 5.5 cm in length. The right kidney measured 5.8 cm in length.

The area of the aortic trifurcation was free of pathology.

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 0.70 cm width in the caudal pole. The right adrenal gland measured 0.56 cm width in 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

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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 mild non-organized debris. 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 stomach contained mild to moderate variably echogenic non-shadowing ingesta with no evidence of obstruction to pyloric outflow or foreign material. The ventral gastric body measured 0.39 cm in width. The ventral pylorus wall measured 0.50 cm in width.

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The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine contained segmental mild non-shadowing duodenal and segmental jejunal ingesta without obstructive pattern to the level of the colon.

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

Pancreas

The pancreas was normal in size and contour with isoechoic to heterogeneous remodeled parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

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Free Abdomen

No omental masses, overt omental lymphadenopathy or peritoneal effusion was present.

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Non-homogenous enlarged neck / cervical vs mandibular lymph nodes were present. An example of a lymph node measured 3.1 cm x 2.0 cm.

Cardiac

Rapid view of the heart revealed no evidence of pericardial masses or effusion in the visible window.

IMAGING PERFORMED BY

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ULTRASONOGRAPHIC FINDINGS

Primary

- Overall structurally unremarkable gastrointestinal tract with non-shadowing gastroduodenal and segmental jejunal ingesta- most consistent with food echogenicity
- Mild heterogeneous remodeled pancreas
- Mild non-organized gallbladder debris
- Age-related / adrenal changes -benign
- Cervical /neck vs mandibular lymphadenopathy

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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No overt evidence of mechanical gastrointestinal obstruction, i.e. foreign body, intestinal mass, stricture or other. Correlation with most recent meal ingestion is recommended. Chronic pancreatitis may be suspected if cranial abdomen/ subxiphoid discomfort on palpation. A GI panel to include PLI/TLI/Cobalamin/Folate is recommended.



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Empirically smaller more frequent feedings of a canned bland or hydrolyzed diet, gastric protectant protocol i.e., Omeprazole 1 mg/kg PO SID as empirical therapy for possible esophagitis, +/- empirical coverage for helicobacter with clinical monitoring over the next 10 to 14 days may prove beneficial.

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Sonographic reassessment indicated if non-responsive or progressive upper gastrointestinal signs. FNA cytology of accessible cervical /neck or mandibular lymph node is indicated for further clarification. A sedated oral exam may be considered if not done.

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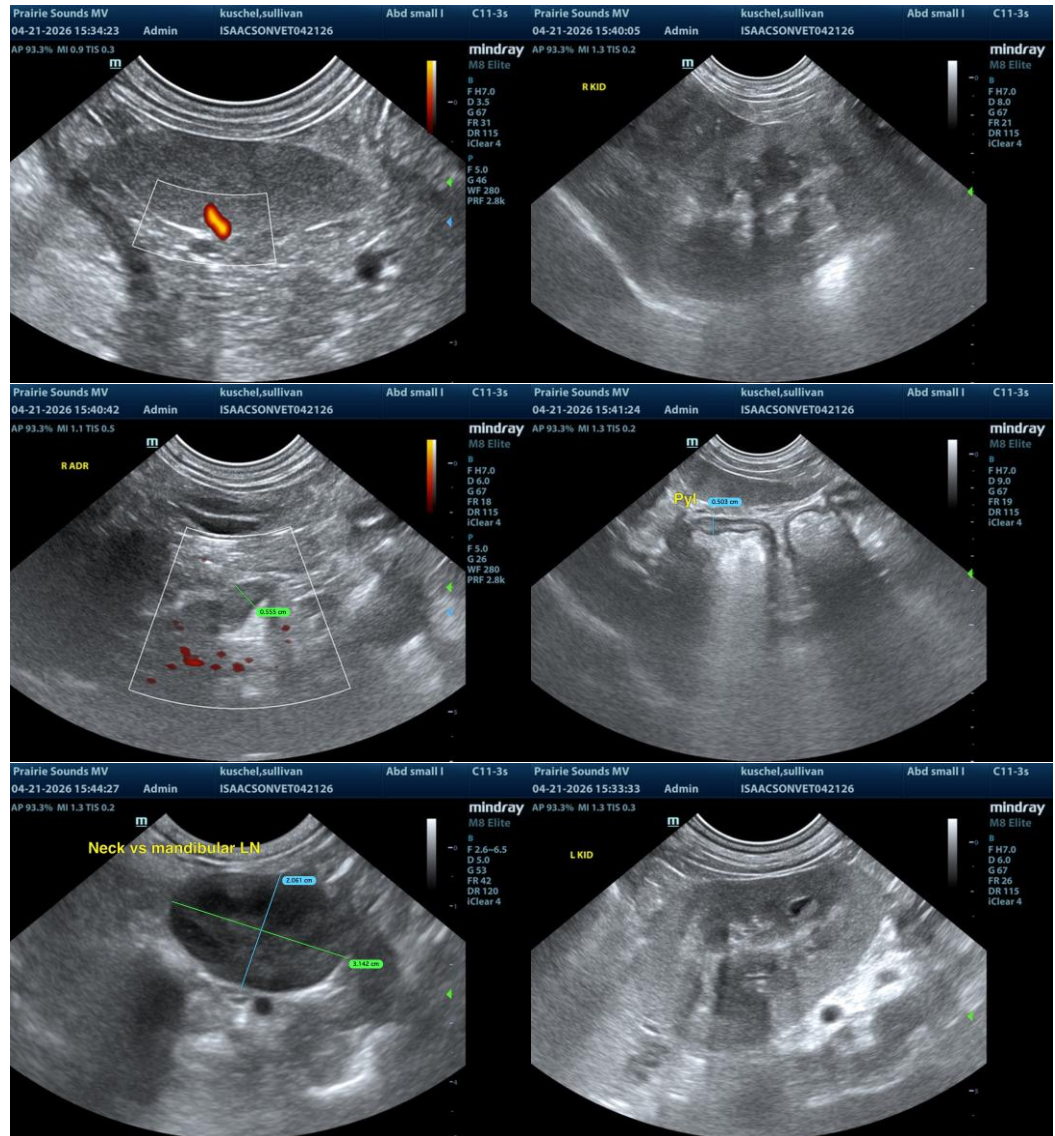
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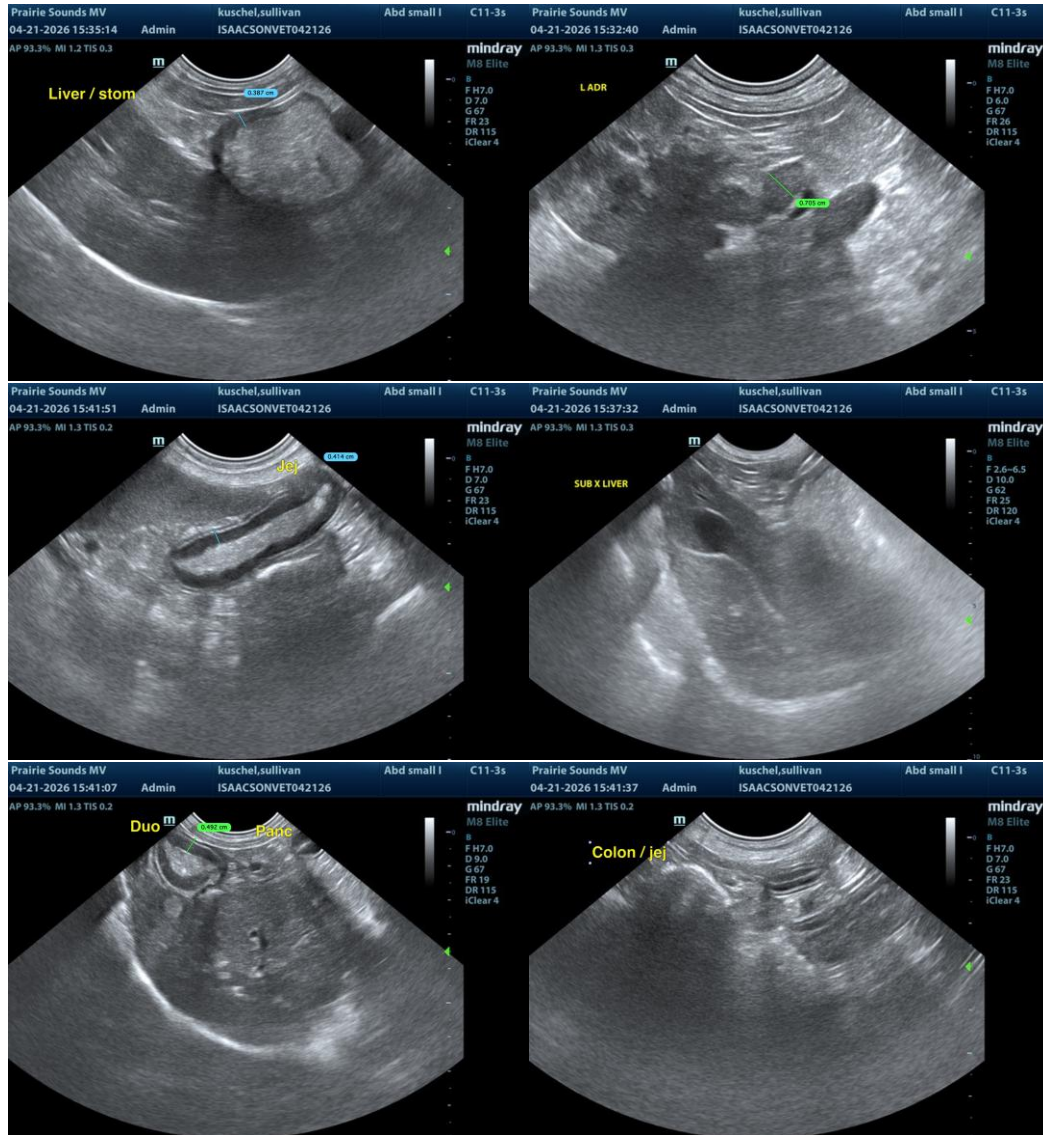
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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