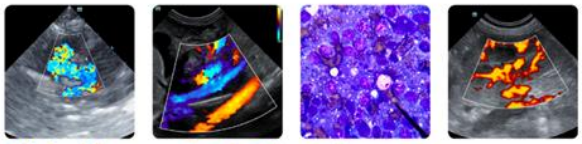




**PATIENT**

Riley Lervold

**SPECIES**

Canine

**BREED**

Labrador Retriever

**SEX**

FS

**AGE**

5yr

**WEIGHT**

58.5lb

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Ruth Loomis

**HOSPITAL NAME**

Brookswood Animal Clinic

**REFERRING VET**

Michelle Cloud

**INVOICE**
24675

**DATE**
04/28/2026

## PRESENTING CLINICAL SIGNS

O reports that p has always had some soft stool after she exercises or gets excited. In the last year - o feels that p has been having some more of these episodes that aren't correlated with exercise or stress. P is also wanting to eat more grass in the middle of the night. Diarrhea is larger volume, soft, light brown, no blood/mucus - sounds consistent with more small bowel diarrhea.

Abnormal PE/Chem/CBC/UA Results: normal superchem/cbc/T4/UA negative fecal GI panel - Folate 3.1 (low) Cobalamin 276 (low end) Normal cortisol, TLI and PLI

## 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 6.2 cm in length. The right kidney measured 5.4 cm in length. Probable underestimation of right kidney size.

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 0.52 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 0.55 cm width at the caudal pole.

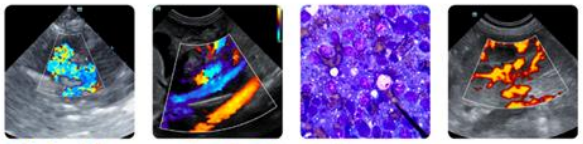
### *Spleen*

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 non-distended in size with thin walls and mild non-organized debris. The cystic and common bile ducts were normal.

### *Gastrointestinal*





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The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material.

The small intestine presented intact borderline to mild thickened duodenojejunal wall owing to propensity for borderline to mild thickened duodenojejunal mucosa layer. The duodenum wall measured 0.60 cm width. The jejunum wall measured up to 0.53 cm width. No obvious pathology visualized at the level of the ileocolic junction.

Normal visible colon wall layers were present with soft 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 evidence of peritoneal effusion was present.

Intermittent mildly prominent to enlarged jejunocolic lymph nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). An example measured 2.1 cm in diameter.

## ULTRASONOGRAPHIC FINDINGS

### Primary

- Enteropathy
- Soft fecal matter in colon
- Intermittent mild jejunocolic lymphadenopathy suggestive of benign criteria, i.e. reactive hyperplasia or possible mild lymphadenitis
- Mild gallbladder debris (non-mucocele)

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Decreased cobalamin level is consistent with distal small intestinal disease while the decreased folate although non-specific, may suggest concurrent upper small intestinal disease. The small intestine exhibited intact, overall mild mural changes, which although non-specific are suggestive of inflammatory criteria such as IBD or other inflammatory disease. Generalized considerations may include concurrent dietary indiscretion or hypersensitivity, infectious disease, concurrent mild pancreatitis, occult parasitism, less likely occult neoplasia.

Empirically, a limited antigen or hydrolyzed diet trial with potential long term dietary therapy, prophylactic deworming (Panacur 50 mg/kg SID x 5 consecutive days with repeat protocol in 3 weeks even if fecal testing is negative), high colony count probiotic (Proviable or Visbiome), cobalamin supplementation pending assessment of cobalamin level +/- antibiotic trial with consideration for adverse effects on normal GI flora with long term antibiotic use and as needed gastrointestinal support with assessment of clinical response may prove beneficial. Intestinal biopsies may be indicated if GI signs continue despite empirical therapy.

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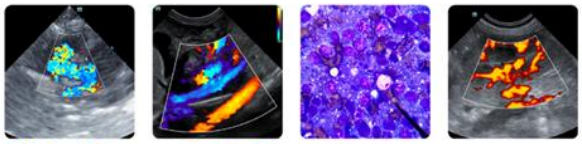

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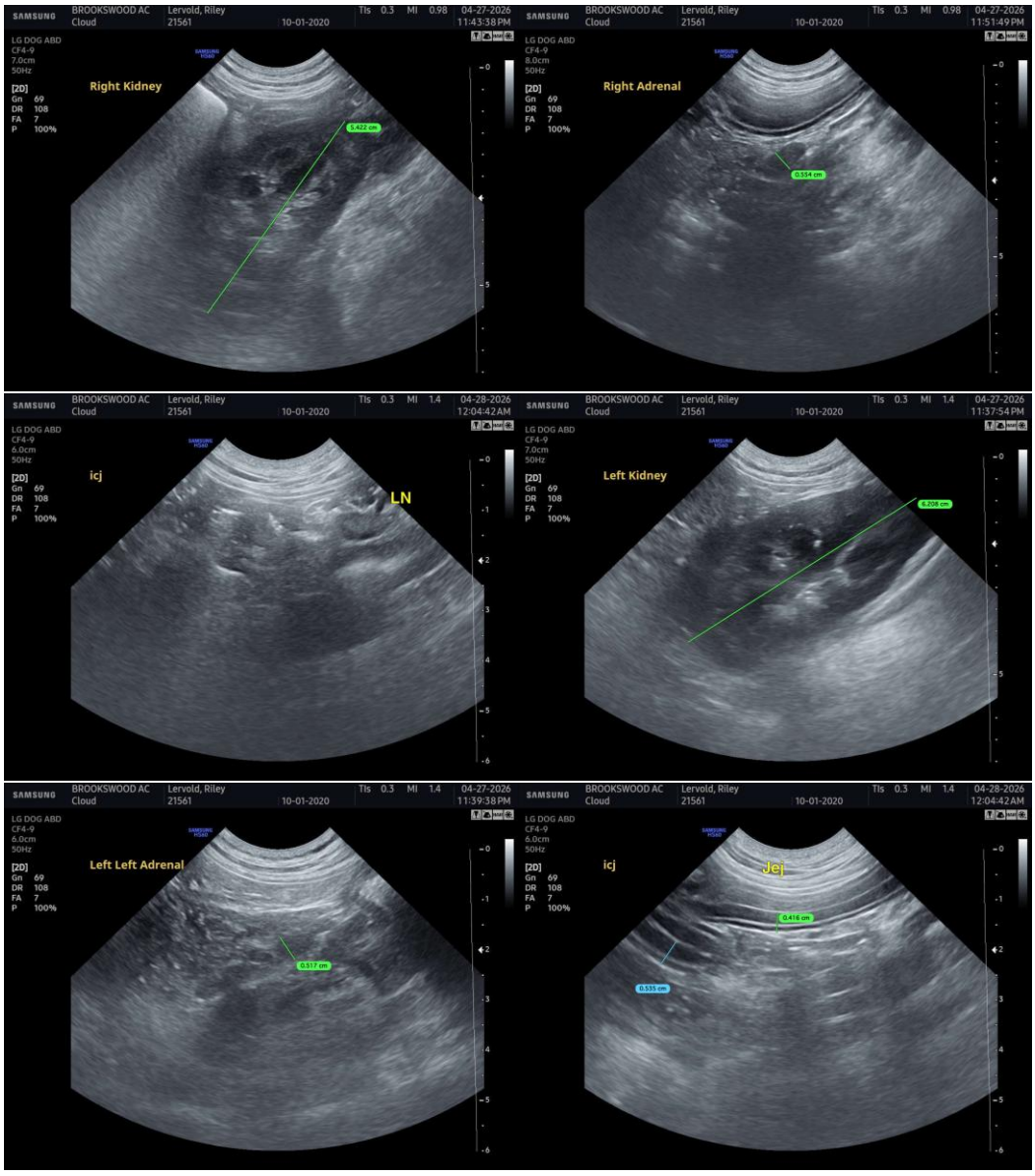

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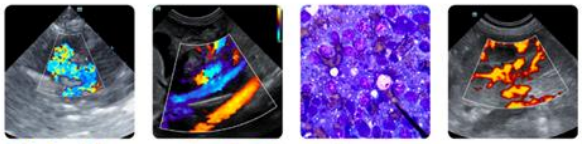

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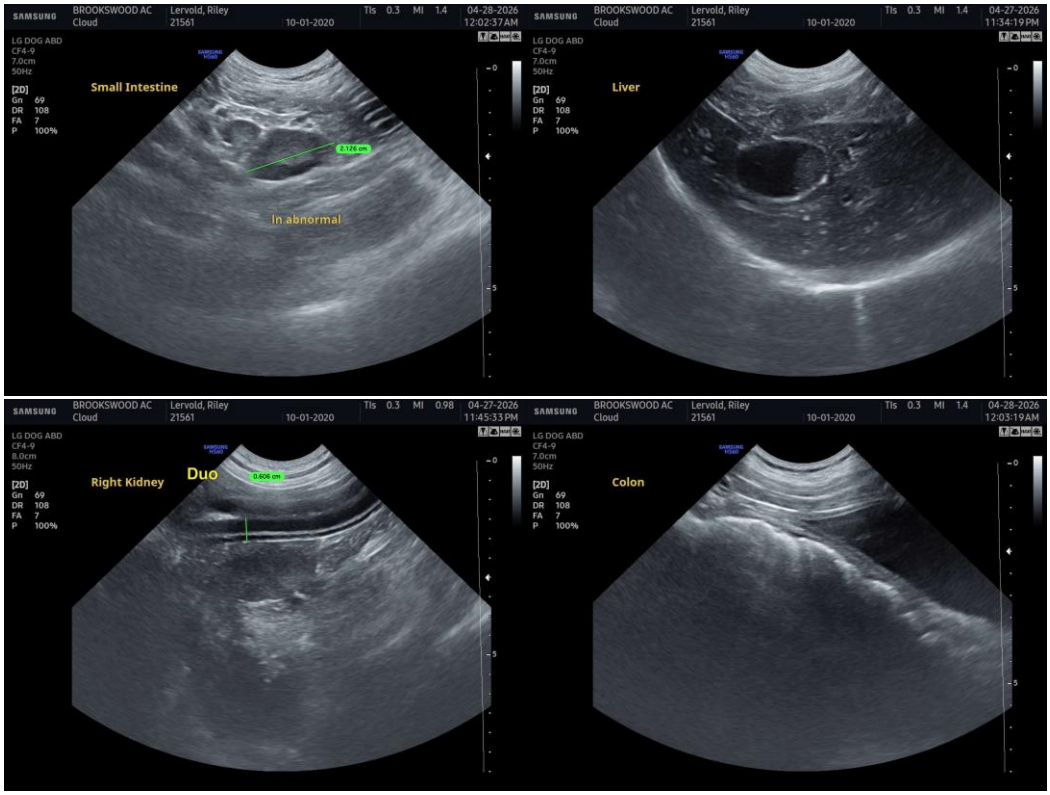


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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