

**PATIENT**Bodhi Brockner  
50542A**SPECIES**

Canine

**BREED**

Hound X

**SEX**

Neutered Male

**AGE**

3 Years

**WEIGHT**

26.3 kg

**INTERPRETED BY**R. McKenzie Daniel,  
DVM, DABVP  
(Canine and Feline)**IMAGING PERFORMED BY**

Tom McNeill

**HOSPITAL NAME**

SVS Imaging CT

**REFERRING VET**Madison Vet  
Specialists – Dr. Maller**INVOICE**

37558

**DATE**

5/10/22

**PRESENTING CLINICAL SIGNS**

On Sunday, Bodhi began acting very lethargic, producing loose stool, vomiting, and not eating. Bodhi's owner were concerned and took them to their primary care DVM. The doctor's were concerned about a foreign body ingestion. They performed x-rays, gave subcutaneous fluids, and an anti-nausea medication. After not seeing anything on the x-rays, they sent Bodhi home. Today, his symptoms became more severe and Bodhi's owners took him back to their primary care DVM. After performing another round of x-rays, the DVM identified a blockage in his digestive tract and referred them to MVS.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN****Urinary System**

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes were noted.

No overt pathology in the area of the residual prostate.

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 6.3 cm. The right kidney measured 6.6 cm.

**Adrenal Glands**

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.48 cm at the cranial pole and 0.62 cm at the caudal pole. No overt pathology in the area of the right adrenal gland.

**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**

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. 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 intact, but potentially mildly prominent wall layering in the area of the pylorus. Minor retained non-specific ingesta/chyme exhibiting subtle progressive distal acoustic shadowing noted in the area of the antrum and pylorus, yet without overt evidence of mechanical pyloric outflow obstruction. Pylorus wall measured 0.56 cm.

The upper duodenum exhibited moderate retained fluid extending caudally into the area of the distal duodenum or potential upper jejunum. Strongly shadowing echoes including linear like echo with

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secondary probable distal duodenal to upper jejunal plication was present. Concurrent segments of empty normal appearing small intestine exhibiting 1:3 muscularis/mucosa ratio were present and likely distal to the upper small intestinal shadowing to linear like echo to echos. Minor regional peri intestinal reactive mesentery noted adjacent to the upper small intestine along with intermittent minor subjectively benign/reactive per intestinal mesenteric lymph nodes. No overt evidence of peritoneal free fluid.

Normal visible colon wall layers were present with apparent formed 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**

Focal to intermittent, mildly prominent to enlarged medial iliac lymph nodes were present. Example measured 2.3 cm x 0.66 cm. The lymph node was essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). These lymph nodes were not consistent with inflammatory or neoplastic criteria, and likely incidental.

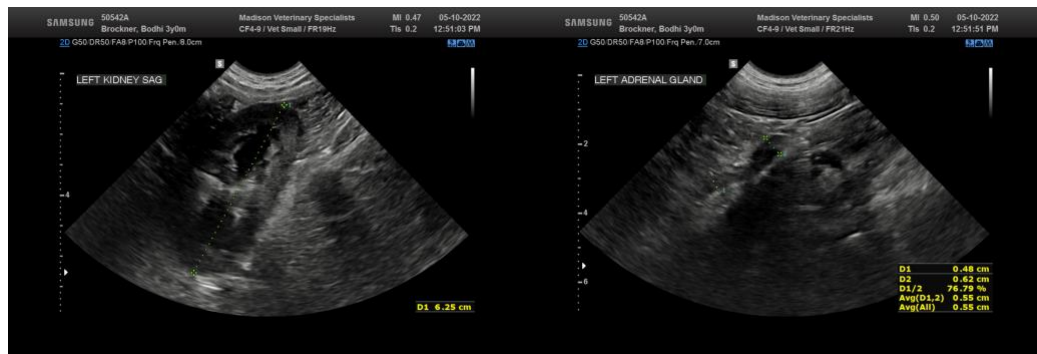
**ULTRASONOGRAPHIC FINDINGS**

- Shadowing to linear like echo/echoes in subjective mid to distal duodenum to upper jejunum with secondary mild proximal duodenal obstructive pattern.
- Mild non-specific retained gastric ingesta/chyme
- Mild peri intestinal reactive mesentery and intermittent subjectively benign/reactive peri intestinal mesenteric lymph nodes.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

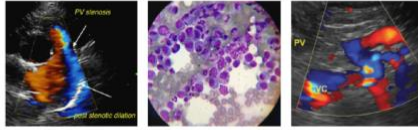
The shadowing to linear like echos are consistent with foreign material, likely in the upper small intestine with secondary duodenal obstructive pattern and concurrent overtly normal, non-obstructive small intestine, likely distal. Obvious anchorage of foreign material within the pylorus was not definitively evident, yet the possibility of a mild amount of retained foreign material within the stomach cannot be definitively excluded.

Exploratory laparotomy with expectation toward enterotomy in the area of the upper small intestine along with gross inspection of the generalized gastrointestinal tract, including the stomach, is recommended. No overt evidence of peritonitis.



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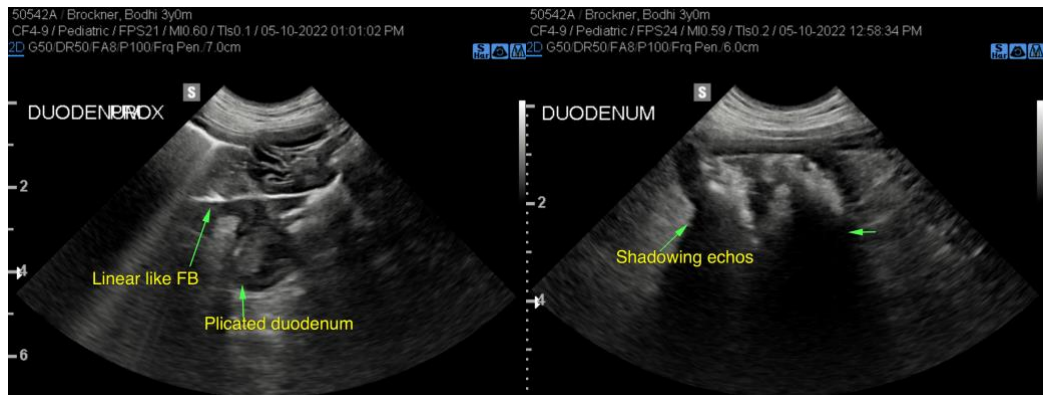
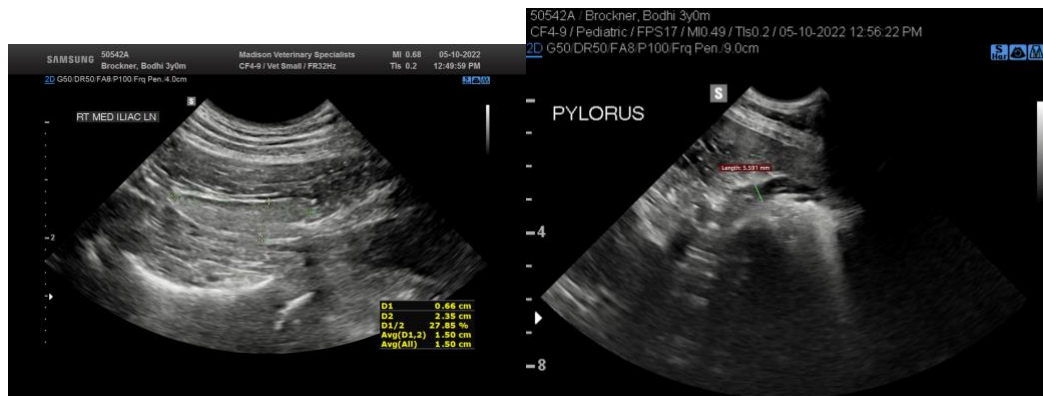
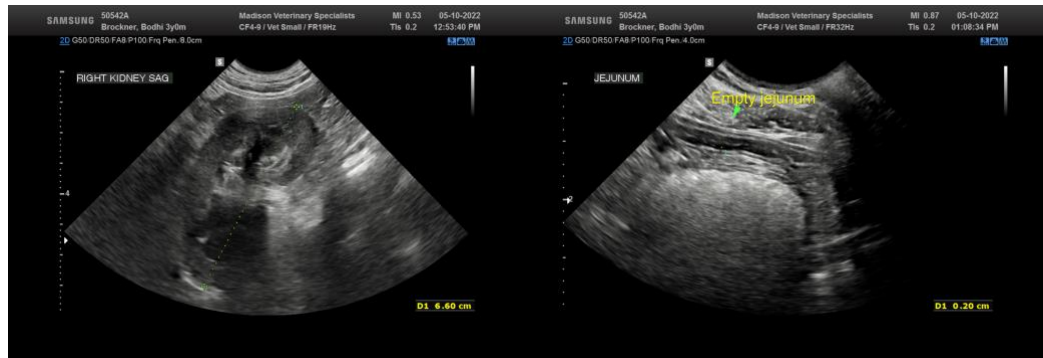
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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