

## PATIENT

Griffey Oliver

## SPECIES

Canine

## BREED

American Bully

## SEX

Neutered Male

## AGE

11 Years

## WEIGHT

88 lbs

## INTERPRETED BY

R. McKenzie Daniel,  
DVM, DABVP (Canine  
/ Feline Practice)

## IMAGING PERFORMED BY

Quinn Robinson RVT

## HOSPITAL NAME

Hess Ridge Animal  
Hospital

## REFERRING VET

Michael Skarie DVM

## INVOICE

16112

## DATE

05/12/26

## PRESENTING CLINICAL SIGNS

Patient presented for acute, severe hematemesis. No known toxin or foreign body exposure per owner aside from potentially eating dirt while family was gardening. Has been on carprofen chronically for ~ 1 year.

HCT: 33.7% (previously 48.1 on 7/29/25) Reticulocytes WNL: 21.7K/uL Creatinine: 1.9 mg/dL BUN: 67 mg/dL Amylase: 1905 U/L

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *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 uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic change were noted.

The prostate was moderately enlarged in size with nonhomogenous echogenic parenchyma exhibiting microcystic parenchymal changes. No evidence of mineralization. The margins of the gland were intact and able to be differentiated from the surrounding tissue. The prostatic parenchyma was mildly echogenic to heteroechoic without parenchymal mineralization. The prostate measured approximately 6.0 cm in diameter.

Normal renal size with asymmetrical margination was present in both kidneys. The renal cortex presented uniformly increased in echogenicity with uniform echotexture. The renal cortex appeared to be hypertrophied resulting in an altered cortex: medulla ratio. Loss of corticomedullary border demarcation was also present along with bilateral mild pyelectasia. The left kidney measured 7.5 cm in length. The right kidney measured 8.0 cm in length.

### *Adrenal Glands*

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.81 cm width at the caudal pole.

The right adrenal gland was not definitively visualized.

### *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. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was non distended in size with mild gravity dependent nonorganized biliary sludge. The cystic duct and common bile ducts were normal without evidence of dilation.



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## *Gastrointestinal*

The stomach presented variably thickened stomach wall extending into the pylorus exhibiting decreased mural echogenicity and regional loss of gastropyloric wall layer detail. The stomach contained a mild amount of progressive to strongly shadowing content appearing to extend into the area of the pyloric outflow without definitive evidence of obstruction to pyloric outflow. Thickened ventral gastric body wall measured up to 1.3 cm wall width. The thickened ventral pylorus wall measured 0.92 cm wall width.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. Subjective mildly thickened duodenum wall without evidence of loss of duodenal wall layer detail. Generalized empty intestinal lumen without mechanical/metabolic ileus or intestinal shadowing content to the level of the colon. The duodenum wall measured up to 0.67 cm wall width.

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 parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

## *Free Abdomen*

No visualized significant omental lymphadenopathy or peritoneal effusion was present. Mild perigastric hyperechoic omentum.

## ULTRASONOGRAPHIC FINDINGS

### *Primary Findings*

- Variably thickened stomach wall exhibiting mural hypoechogenicity and regional loss of gastric wall layer detail, mild retained progressive to strongly shadowing gastric content.
- Sonographically unremarkable intestinal tract with subjective mild thickened intact duodenum wall.
- Heterogeneous remodeled pancreas.
- Chronic renal changes exhibiting mild bilateral pyelectasia.

### *Secondary Findings*

- Enlarged nonhomogenous mildly cystic prostate gland.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Acute gastritis with wall edema and potential for non-obvious ulceration giving shadowing gastric content, infectious gastropathy, emerging to occult gastric neoplasia and a small amount of non-obstructive gastric foreign content are all potentials.

No evidence of overt gastrointestinal mural pathology or active pancreatitis with mild nonspecific intact duodenal thickening. Upper gastrointestinal endoscopy if available, is warranted for further assessment and clarification of the gastric anterior content and potential for biopsies.

Broad-spectrum gastroprotectants, empirical therapy for helicobacter, documented 12-18 hour fast and sonographic monitoring of the gastric contents and clinical signs would be more conservative.



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Griffey Oliver

Exploratory laparotomy with gastro-duodenal biopsies may be indicated if persistent clinical signs, shadowing gastric content and if endoscopy is not available. Screening cortisol level to rule out occult Addison's disease is recommended.

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The prostatomegaly is of unclear clinical significance given reported male neutered status yet suggests benign prostatic hyperplasia with small prostatic cysts. Correlation with clinical history is recommended. If not intact, testosterone level is recommended.

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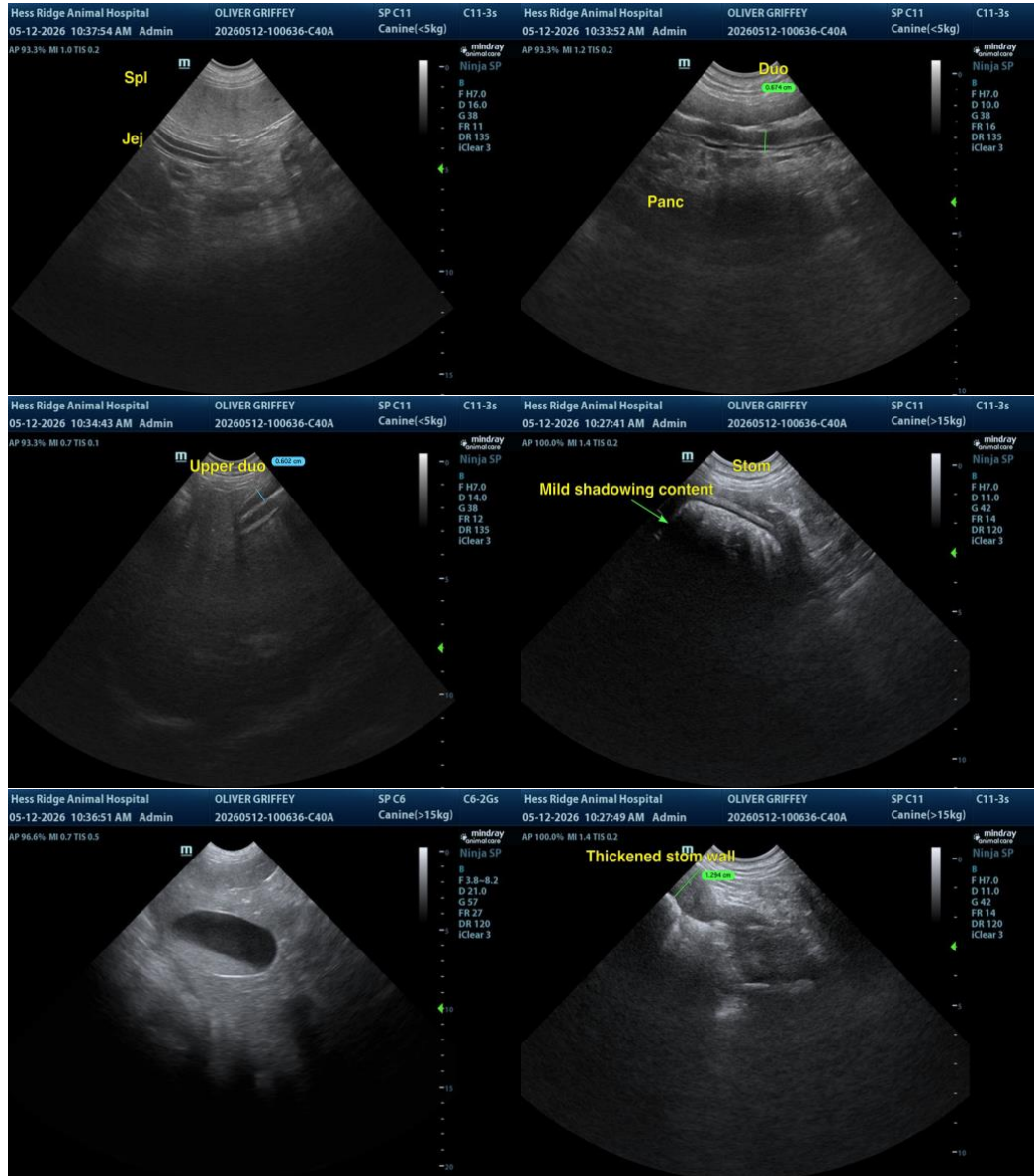
Michael Skarie DVM

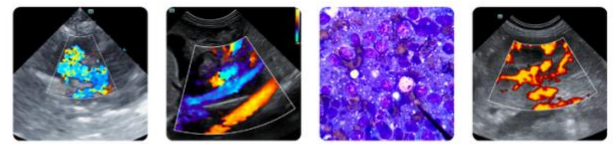
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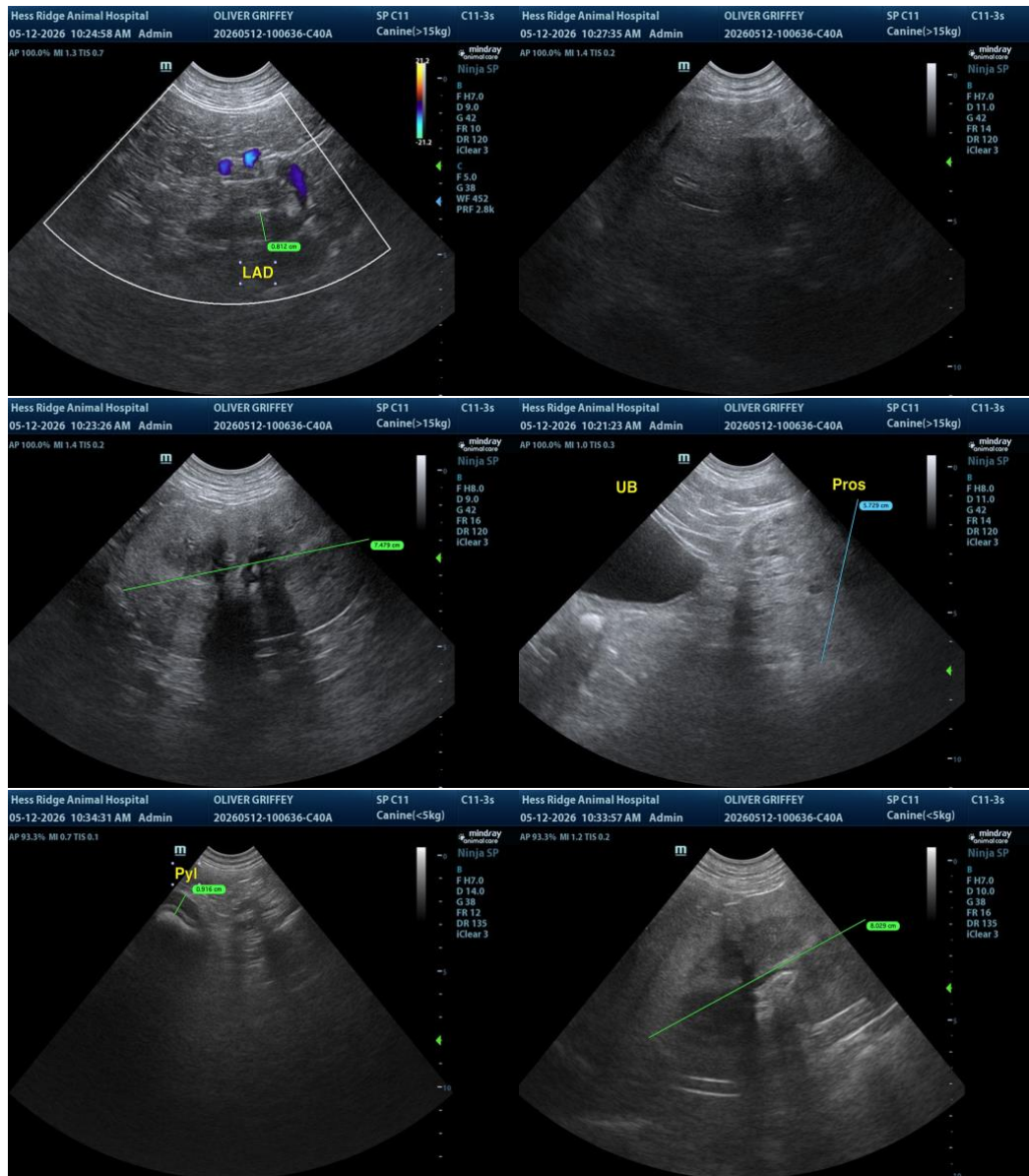
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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](mailto:info@SonoPath.com)