



PATIENT

Riptide York

SPECIES

Canine

BREED

German Shepherd

SEX

Intact Male

AGE

5 Years

WEIGHT

32.9 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Maria Lara DVM

HOSPITAL NAME

Allure Veterinary
Hospital & Urgent Care

REFERRING VET

Maria Lara DVM

INVOICE

16117

DATE

05/12/26

PRESENTING CLINICAL SIGNS

Patient presented with a history of acute vomiting after drinking water since yesterday afternoon (5/11); vomited about 1 hour after water yesterday and about 20 minutes after water today, unable to keep anything down, uninterested in food today. Diarrhea today. Patient has a history of FB ingestion in the past.

Abnormal PE/Chem/CBC/UA Results: Patient has tacky mucous membranes, elevated CRT, is lethargic and painful on abdominal palpation. BUN 28 - 7 - 27 mg/dL (H) Amylase 273 - 500 - 1,500 U/L (L) Lipase 116 - 200 - 1,800 U/L (L) Rad. Report: Conclusions: A gastric foreign body is identified. While it is unlikely to be the sole cause of the clinical signs, it may be contributing to gastroenteritis. There is concern for segmental small intestinal dilation, but a definitive mechanical obstruction is not evident, and a radiopaque foreign body is not seen.

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.

Normal size and margination was 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 6.5 cm in length. The right kidney measured 6.5 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 0.56 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 0.63 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. 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.



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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 evidence of retained fluid, ingesta or foreign material.

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The small intestine presented primarily intact wall layering with 1:3 muscularis/mucosa ratio. The lumen of the small intestine was empty with no signs of ileus, obstruction or foreign material.

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Segmental to focally shadowing nonobstructive intestinal content was visualized. A segment of subjective fluid distended intestine exhibiting potential oral/aboral fluid movement was visualized in a single video cranial to the urinary bladder.

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The colon revealed generalized distention with soft to non-formed fecal matter and segmental colon gas. Possible segmental transverse shadowing fecal content.

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Pancreas

The area of the pancreas was sonographically.

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Free Abdomen

Minor caudal abdominal effusion was present. Intermittent indistinctly visualized yet subjective mildly prominent mesenteric 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 of the lymph nodes measured X cm.

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ULTRASONOGRAPHIC FINDINGS

- Generalized empty gastrointestinal tract with segmental focal shadowing intestinal content and suspect segmental fluid dilated caudal abdomen intestine cranial to the urinary bladder.
- Generalized colon distention with semi formed/soft fecal matter and lumen gas and possible shadowing transverse colon fecal content.
- Minor volume caudal abdomen effusion.
- Intermittent indistinct to mildly prominent mesenteric lymphadenopathy.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A definitive area of mechanical gastrointestinal obstruction was not obviously visualized. However, the segmental, primarily small shadowing intestinal content and suspect segmental fluid dilated caudal abdomen intestine may suggest passing to segmental partially obstructive non-obvious foreign material with potential passage of material currently within the colon. However, this could also indicate acute nonspecific gastroenteritis, i.e. infectious disease, dietary indiscretion, enterotoxin, emerging inflammatory bowel, less likely occult neoplasia, segmental intestinal necrosis, torsion or other.

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Given this presentation in conjunction with patient's gastrointestinal signs and reported abdominal pain, exploratory laparotomy with gross inspection of the gastrointestinal tract and with biopsy is considered essential despite exploratory findings is warranted. Continued hospitalization with gastrointestinal support over the next 12 to 18 hours with clinical and sonographic monitoring would be more conservative.

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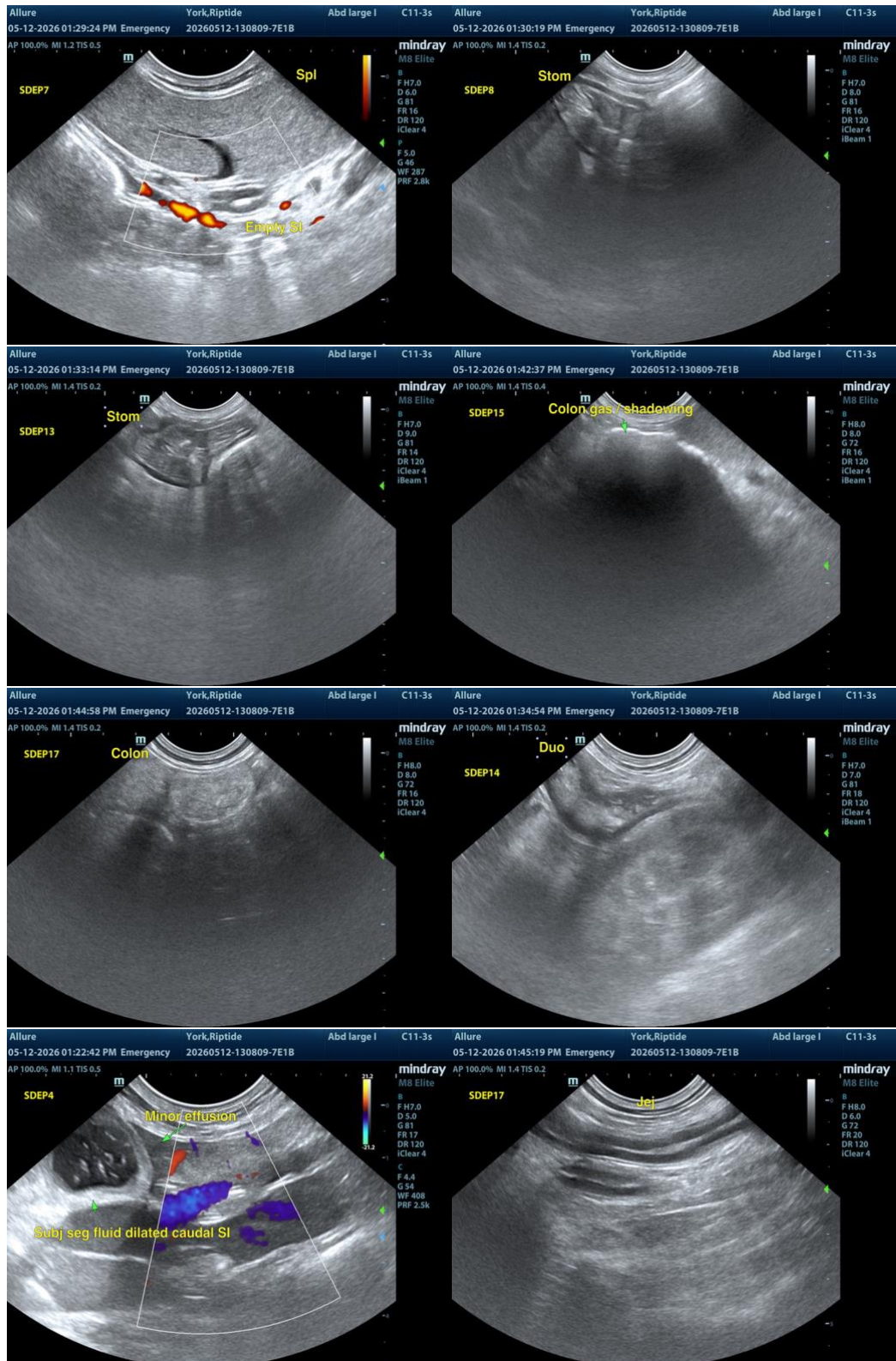
Maria Lara DVM

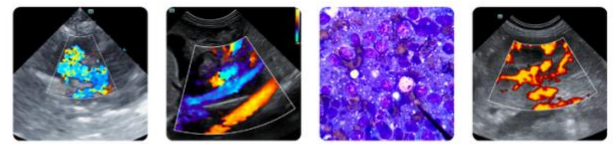
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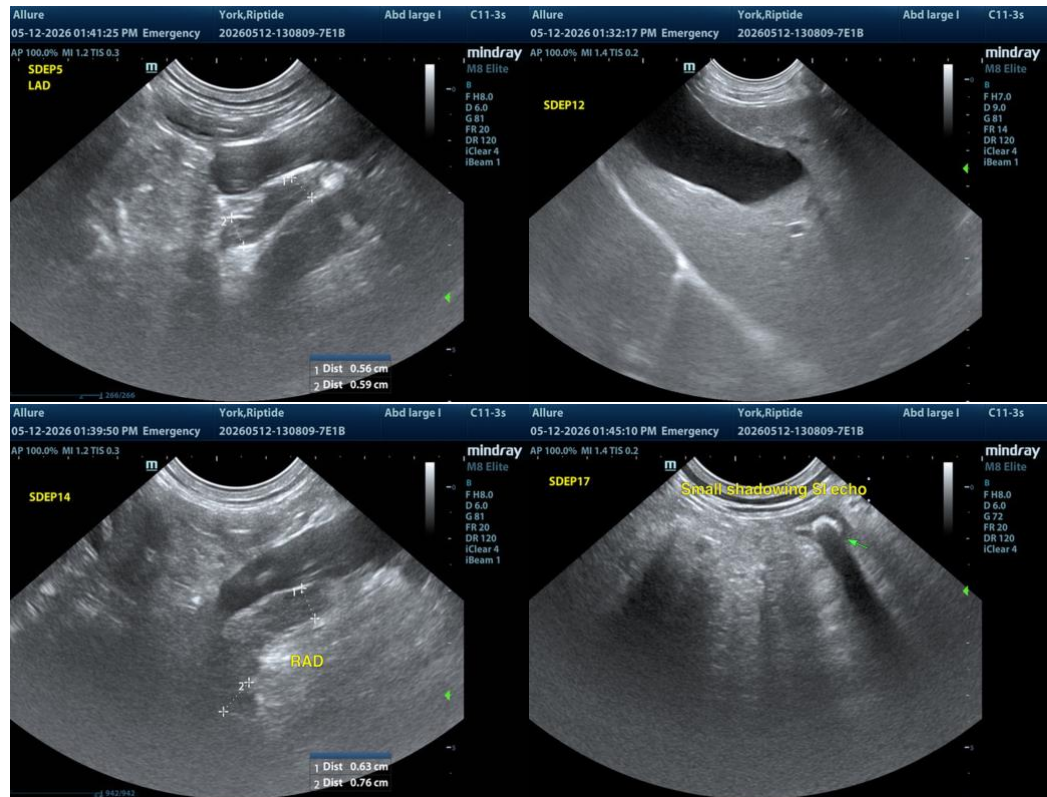
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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