



PATIENT

Murphy Morrison

SPECIES

Canine

BREED

Corgi

SEX

Neutered Male

AGE

9 Years 10 Months

WEIGHT

12.2 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Mayfield

HOSPITAL NAME

Ridgeview Veterinary
Hospital

REFERRING VET

Dr. Edmonds

INVOICE

16340

DATE

05/18/26

PRESENTING CLINICAL SIGNS

Presenting concerns: Progressive/intermittent hyporexia since approximately Christmas. Intermittent diarrhea/loose stool Mild weight loss Occasional increased water intake reported by owner Weight trend: Sept 2025: 29.6 lb Feb 2026: 27.4 lb May 2026: 26.8 lb. Intermittent loose stool: Starts formed then becomes loose. No hematochezia reported. No recent vomiting. Appetite currently improved with food toppers/home-cooked additions. No major changes in energy or mobility. History of cystine urolithiasis requiring cystotomy and castration around age 3. Complicated postoperative recovery historically. Maintained long-term on Purina urinary diet. Prior bladder ultrasound Sept 2025 showed no recurrent stones

Physical exam largely unremarkable: No palpable abdominal masses No organomegaly No abdominal pain No peripheral lymphadenopathy – New hypoproteinemia/hypoalbuminemia: Total protein: 4.9 g/dL (low) Albumin: 2.4 g/dL (low) - Previous Sept 2025 chemistry was normal: Total protein: 6.7 Albumin: 3.8 - Globulin currently normal at 2.5 - Renal values normal: Creatinine 0.6 SDMA 5.8 UA: USG 1.034; Trace protein only; Inactive sediment - Significant renal protein loss considered less likely - Pancreatic lipase: 179 U/L (not supportive of pancreatitis) - CBC: Mild neutrophilia; Mild thrombocytosis - T4 normal

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 2.0 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 change were noted.

The area of the residual prostate appeared normal and free of pathology.

No evidence of medial iliac or sublumbar lymphadenopathy or masses.

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 – cm in length. The right kidney measured – cm in length.

Adrenal Glands

The adrenal glands were mildly enlarged at the caudal pole in light of body weight with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.75 cm width at the caudal pole. The right adrenal gland measured 0.76 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



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The liver presented normal in size, contour and vascular volume with primarily homogenous parenchyma. Intermittent discrete to mildly hypoechoic noncapsule deforming intraparenchymal nodules with an example measuring 1.7 cm in diameter.

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The gallbladder was non-distended in size with thin walls and primarily anechoic luminal content. 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 pylorus wall measured 0.41 cm wall width.

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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. A segment of intestine exhibited irregularly thickened wall with asymmetrical contour and mild segmental intestinal corrugation. Variably thickened associated wall layering with indistinct to loss of wall layer detail and mild non-obstructive segmental ileus, subjectively involving the distal colon and likely extending into the proximal jejunum, measuring potentially 6.0 cm in length with wall width 0.9 cm. By comparison, normal upper to mid duodenum wall measuring 0.37 cm, normal jejunum wall measuring 0.34 cm. Several peri-intestinal to mid abdomen, asymmetrically enlarged to swollen hypoechoic lymph nodes with mild surrounding hyperechoic omentum with an example measuring 3.9 cm x 1.2 cm.

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

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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.

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Free Abdomen

No peritoneal effusion was present.

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ULTRASONOGRAPHIC FINDINGS

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- Segmentally thickened irregular small intestine exhibiting indistinct/loss of wall layering and mild associated non-obstructive ileus-subjectively involving distal duodenum/upper jejunum.
- Mild to swollen asymmetrical hypoechoic peri-intestinal/mid abdomen mesenteric lymph nodes.
- Intermittent to variable discrete to hypoechoic liver nodules.
- Non-specific mild bilateral adrenomegaly.
- Normal area of pancreas.
- Normal bilateral kidneys/urinary bladder.

INVOICE

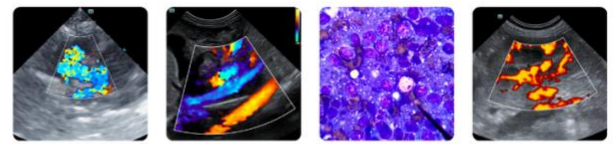
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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Although histopathology is required for a definitive diagnosis, the irregularly thickened distal duodenum/upper jejunum exhibiting indistinct to loss of wall layering and associated lymphadenopathy is highly concerning and most suggestive of neoplastic criteria i.e. round cell neoplasia, carcinoma or other with sonographic evidence of regional lymphatic and suspect hepatic metastasis.



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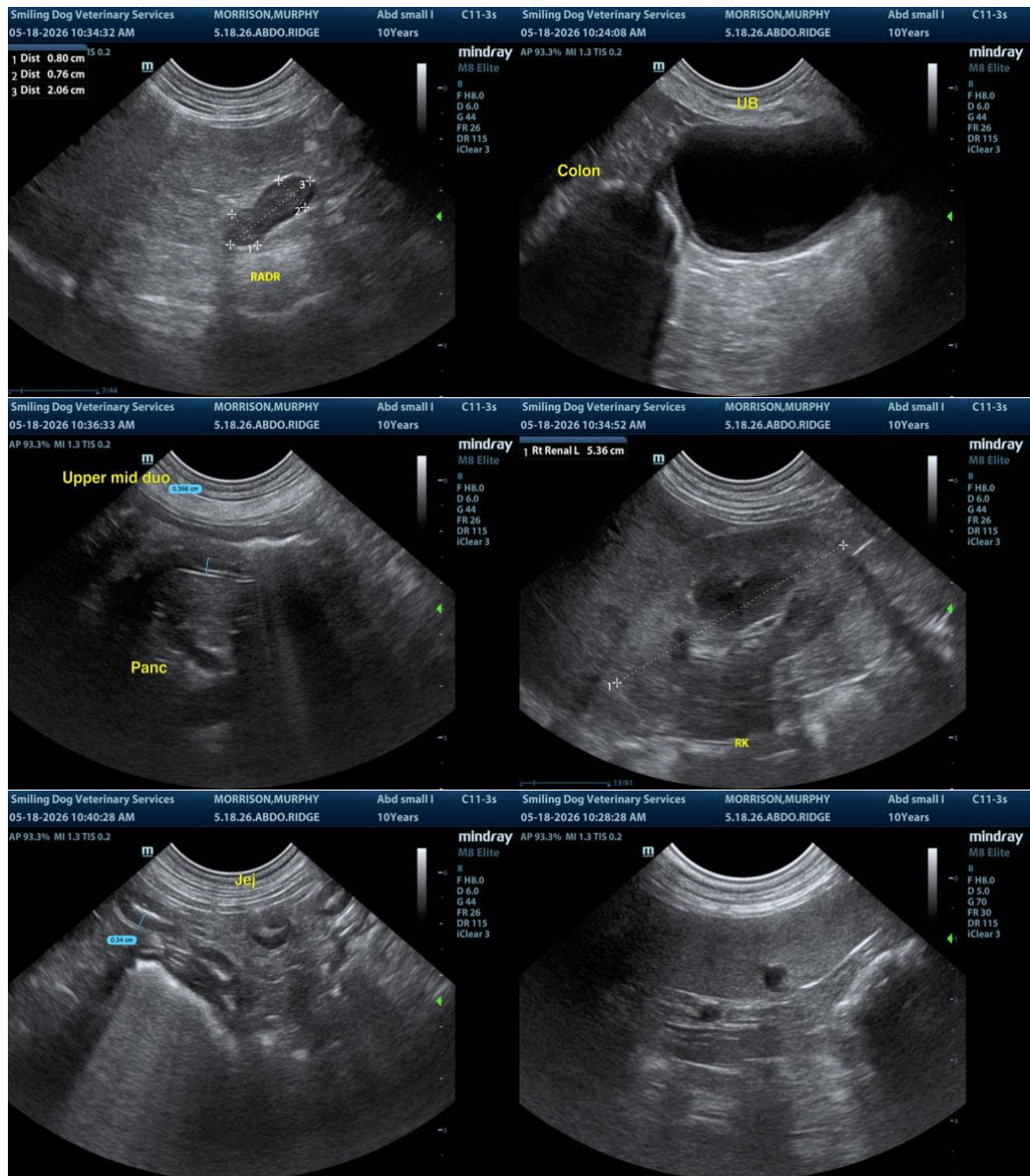
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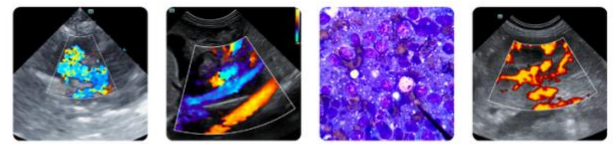
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Assuming normal clotting status and if accessible, FNA cytology of accessible lymph node and hepatic nodule +/- thickened intestinal wall is recommended for further clarification. Three view chest radiographs are recommended. The duodenojejunal lesion did not appear to be mechanically obstructive. Surgical and/or oncology consult is recommended. Pending additional diagnostics, gastrointestinal support is indicated.





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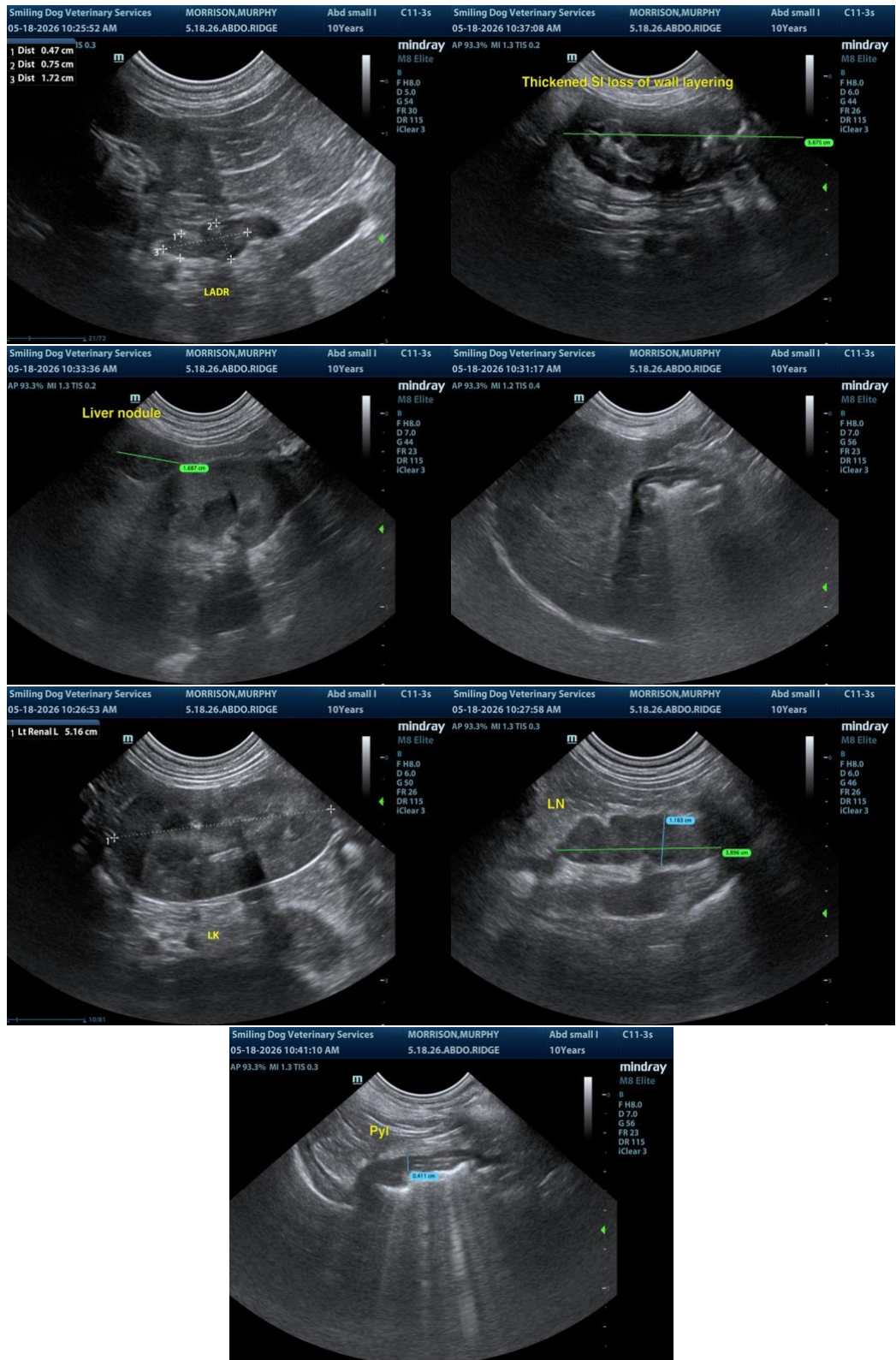
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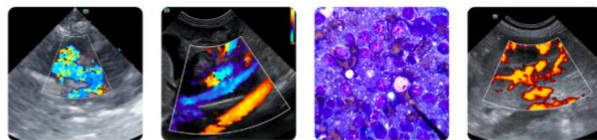
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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