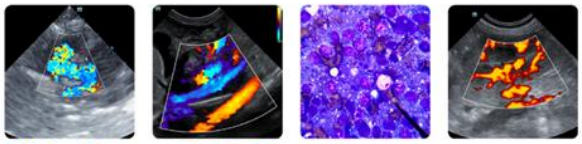

PATIENT

Pugsley Senestraro

SPECIES

Canine

BREED

Pug/Beagle

SEX

FS

AGE

11yr

WEIGHT

33lb

INTERPRETED BY

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

IMAGING PERFORMED BY

Mark Schlimgen, DVM

HOSPITAL NAME

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REFERRING VET

Dr. Robert Merrill

INVOICE
24960

DATE
05/27/2026

PRESENTING CLINICAL SIGNS

Currently diarrhea, vomiting, decreased appetite, nasal congestion. Refusing to take metronidazole. Weak, lethargic, panting. Thoracic radiographs normal. Abdominal rads enlarged liver, prominent spleen.

low dose torbi/domi for U/S

Abnormal PE/Chem/CBC/UA Results: labs yesterday: UA marked rods, 1+ granular casts, 1.020 USG, 2+ protein, 3+ bili cPLi 441 (0-200) CBC: WBC 28k, neuts 20k, mono 5.5k (0.145-0.736) SDMA >100, creat 2.3, BUN 39, phos 7.1, Na 137, K 6.4, Alb 2.3, glob 2.3, ALT 173, ALP 9,653, GGT 17, Tbili 2.2 (0-0.3)

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 mild non-dependent particulate sediment. 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 5.5 cm in length. The right kidney measured 6.0 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

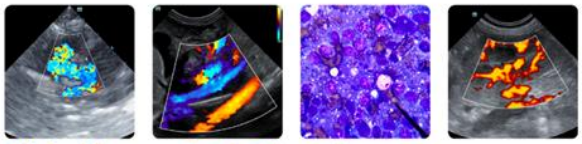
Both adrenal glands mildly enlarged in size with symmetric contour and mild non-homogenous non-mineralized parenchyma. The left adrenal gland measured 0.88 cm in width at the caudal pole. The right adrenal gland measured 0.99 cm width at the caudal pole.

Spleen

The spleen was normal in size with symmetric contour. Mild non-homogenous hypoechoic parenchyma with mildly diffuse hyperechoic parenchyma foci / striations. No visualized masses or nodules were present.

Liver/Gallbladder

The liver presented increased in size. The parenchyma of the liver was subjectively increased in echogenicity compared to the spleen and renal cortices. The echotexture of the liver parenchyma was uniform with a mild coarse echotexture. The capsule of the liver was symmetrical in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion. Normal vascular volume. No visualized masses or nodules were present. The gallbladder was non distended in size with echogenic, nonmineralized, nondependent biliary sludge. The biliary sludge was non



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organized with a hypoechoic to anechoic, irregular to interrupted rim visible between the nondependent sludge and inner wall. No signs of peripheral inflammation.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The stomach exhibited mild to moderate distention with retained variable echogenic fluid and mild to irregular strongly shadowing content measuring ~ 3.5 to 4 cm in diameter.

The intestinal walls demonstrated intact wall layering and maintained 1:3 muscularis / mucosa ratio. The mucosa exhibited mild decreased echogenicity with occasional mucosal speckling. Primarily empty lumen with mild segmental ileus pattern present without obstruction or foreign material.

The colon was indistinctly visualized and difficult to differentiate from small intestine. Subjective variably thickened descending colon with gas and subjective shadowing descending colon fecal matter /content was present.

Pancreas

The pancreas was mildly prominent in size with capsule asymmetry and mild non-homogenous hypoechoic parenchyma. Mildly prominent right limb pancreatic duct.

Free Abdomen

Generalized mild non-uniform omental hyperechogenicity with intermittent variably enlarged non-homogenous mesenteric lymph nodes. An example measured 2.0 cm x 1.0 cm exhibiting width to length ratio ~ 0.5.

Minor effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary

- Retained gastric fluid and irregular strongly shadowing lumen content
- Non-specific subjective acute enterocolopathy, exhibiting mild segmental intestinal ileus and suspect segmental descending colon lumen gas or shadowing content
- Prominent remodeled pancreas
- Hepatopathy exhibiting mild parenchyma hyperechogenicity with concurrent early immature gallbladder mucocele
- Bilateral adrenomegaly
- Non-homogenous spleen exhibiting parenchyma hyperechoic foci / striations
- Generalized non-homogenous omental hyperechogenicity with variable enlarged non-homogenous mesenteric lymphadenopathy and mild effusion

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The retained gastric fluid and irregular strongly shadowing gastric content is strongly suggestive of gastric foreign material with potential passed material currently within the subjective colon lumen. Definitive evidence of small intestinal or post-hepatic obstruction was not obvious. Generalized peritonitis potentially associated with gastrointestinal disease or chronic / chronic active pancreatitis

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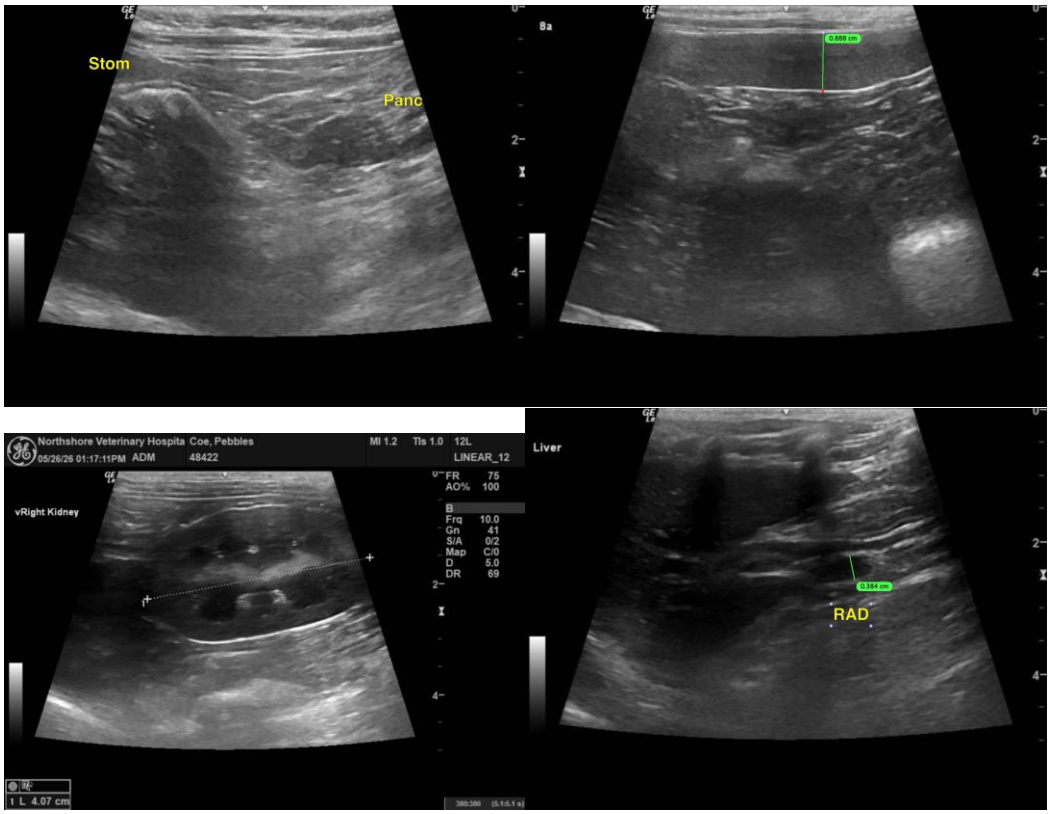
possible although neoplastic process such as carcinomatosis and lymphatic metastasis is not definitively excluded.

Further assessment may include assuming normal clotting status using 25ga needle, hepatosplenic FNA cytology and if possible, correlation with effusion analysis cytology +/- C/S if inflammatory component and accessible lymph node FNA cytology.

Hospitalization with gastrointestinal support, documented 12 to 14 hour NPO and sonographic monitoring of the gastrointestinal tract including shadowing gastric content would be reasonable. If persistent in conjunction with non-responsive or possibly progressive gastrointestinal signs or evidence of abdomen inflammation, exploratory laparotomy with gross inspection of the gastrointestinal tract, general abdomen and biopsies may be indicated.



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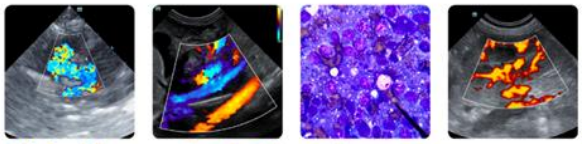

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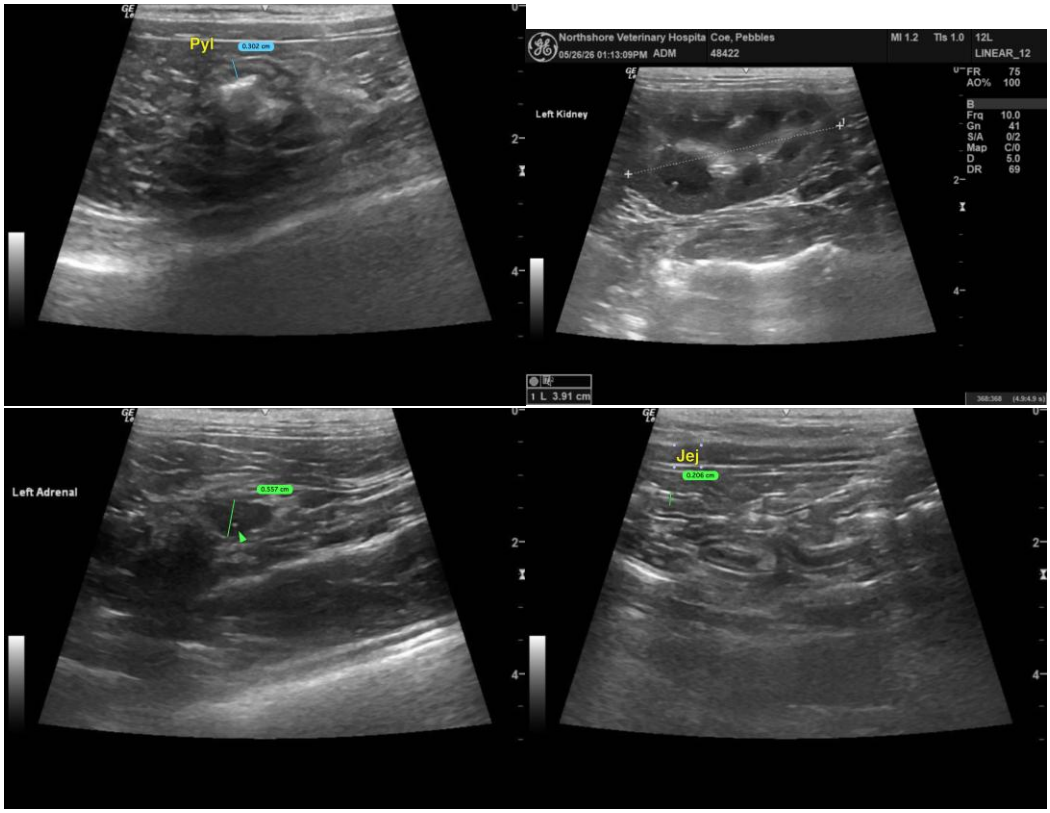

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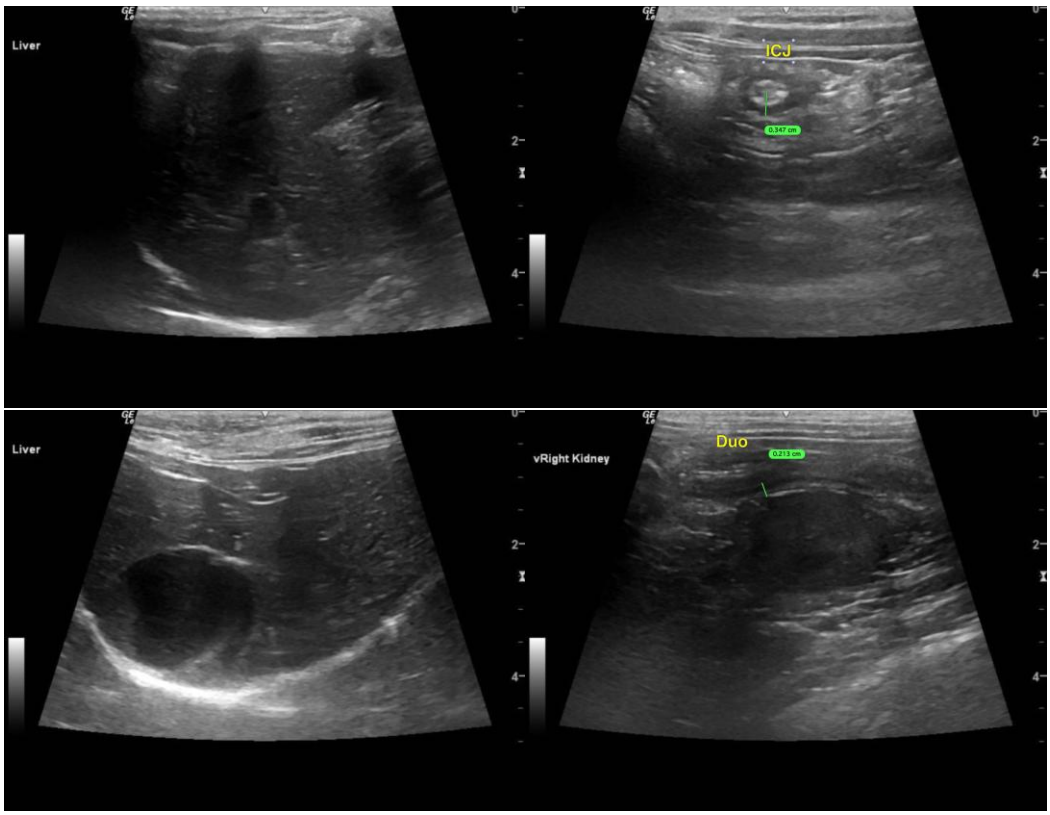

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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