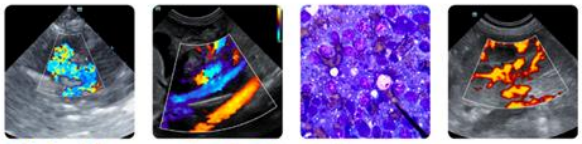


PATIENT

Remy Hoffmann

SPECIES

Canine

BREED

Goldendoodle

SEX

MI

AGE

5yr

WEIGHT

53.5lb

INTERPRETED BY

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

IMAGING PERFORMED BY

Gabriella Iannuzzi

HOSPITAL NAME

Greater Staten Island Veterinary Srerrvice

REFERRING VET

Gabriella Iannuzzi

INVOICE
24735

DATE
05/07/2026

PRESENTING CLINICAL SIGNS

Remy is an ~ 5 year old MI Goldendoodle who presented 5/6/2026 for evaluation of trouble defecating and seeming lethargic and not himself.
Owner reports that he has been posturing to defecate and he has not had a BM in 24h. He is leaking liquid/fluid from the rectum.
Since Monday he has not been able to finish his walks and need to be carried home.
Owner reports that he tends to get into things that hes not supposed- he gets into the bathroom garbage and at a ramen noodle packet.
His late normal meal was on Mon- since then he has only been eating a few treats and some pumpkin puree.
No c/s/v - prior normal 5/7/26 Recheck AXR (3v): marked ingesta within suspected proximal colon (distal portion gas distended) and SI, small stomach compared to previous but gastric content present; post defecation feces within colon, decreased serosal detail
Courtesy POCUS: mild to mod ascites (difficult to sample but slight yellow tinge fluid), no pericardial or pleural effusion noted; splenomegaly noted, focal segment of intestines questionable for target lesion (i.e intussusception), focal fluid filled segments of bowel, dense shadowing content within colon, moderate dense shadowing gastric content
Abnormal PE/Chem/CBC/UA Results: PE: empty colon, tense painful cranial abdomen Induced vomiting and marked content retrieved BP: 170 mmHg L front #5 Cytology (ascites); neutrophils, monocytes, questionable intra-cellular bacteria but not 100% conclusive 5/6/26 AXR rad review (4 views): Colonic distension with a large amount of feces concerning for constipation. The heterogeneous soft-tissue opacity in the stomach and small intestine is nonspecific and could represent undigested food and/or foreign material. Consider colitis and pancreatitis. A gastrointestinal mechanical obstruction cannot be ruled out. CBC/chem: Eos 0.0 (0.06-1.23), Baso 0.18 (0.0-0.18), nRBCs noted; Repeat AXR (R lat - post emesis): stomach was more empty, but still colon full of FM/ingesta.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

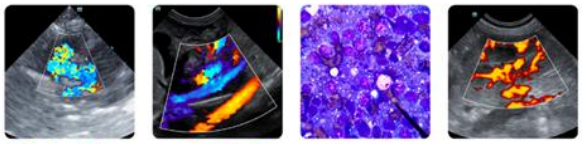
The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra exhibited normal thickness and tone. Anechoic urine was present in the lumen with no evidence of urine/lumen sediment, mineral, or calculi. The ureteral papillae were normal. The ureters were not visible which is normal. 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 6.5 cm in length. The right kidney measured 7.0 cm in length.

The area of the aortic trifurcation was free of pathology.

The prostate was enlarged in size with intact, symmetrical capsule contour. 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 ~ 3.5 cm in diameter.

Adrenal Glands



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The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.71 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 0.56 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. Normal vascular volume. 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 moderately distended with variably echogenic progressive to strongly shadowing ingesta/ content appearing to extend into the pyloric outflow.

The small intestine presented intact wall layering with overall normal muscularis/mucosa ratio. Primarily empty intestinal lumen with mild segmental ileus with retained fluid along with mild segmental primarily non-shadowing ingesta/ chyme to the level of the colon. No overt pathology at the level of the ileocolic junction.

Normal visible colon wall layers were present. The colon exhibited variable empty colon lumen with concurrent mild to possible moderate distension with formed to strongly shadowing fecal matter visualized in the transverse and descending colon to the approximate level of the colorectum.

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

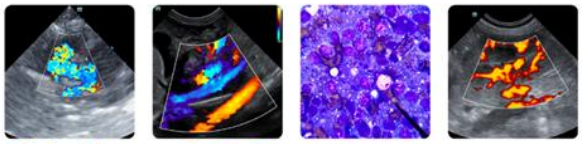
Intermittent mildly prominent to enlarged mesenteric lymph nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5).

Mild to possible moderate anechoic peritoneal effusion.

Generalized mild increased omental echogenicity.

ULTRASONOGRAPHIC FINDINGS

Primary



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- Moderate distended stomach with variably echogenic progressive to strongly shadowing ingesta/ content
- Primarily empty small intestine exhibiting intact wall layering, with mild segmental ileus / non-shadowing ingesta
- Variable distended colon containing formed to strongly shadowing fecal content with concurrent segmental empty colon, sonographically unremarkable ileocolic junction
- Mild to possible moderate volume anechoic peritoneal effusion and intermittent mild to variable mesenteric lymphadenopathy
- Normal volume liver - no evidence of hepatic congestion
- Benign prostatic hyperplasia pattern- subjective mild to moderate

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No definitive evidence of gastroenterocolic mural pathology, i.e. intussusception, mass, or stricture, without obvious evidence of intestinal obstructive pattern. Primary concern for gastric foreign material and potential passed colon foreign material indicated given patient history. Correlation with effusion analysis indicated. The mesenteric lymph nodes suggest benign criteria, i.e. reactive hyperplasia or lymphadenitis with emerging to occult lymphatic neoplastic or metastatic criteria considered unlikely. No sonographic evidence of active or significant pancreatitis. A potential non-visualized or intermittent gastrointestinal mural abnormality, i.e. sliding intussusception, not definitively excluded.

Given overall clinical picture combined with history and sonographic findings, exploratory laparotomy with gastrotomy, gastrointestinal biopsies, and potential manual manipulation of colon content should be considered in conjunction with potential inflammatory effusion.

Documented 12 hour fast, gastrointestinal support, clinical monitoring and sonographic reassessment in 12- 18 hours would be more conservative. Prostatic impingement on fecal outflow not overtly evident and considered less likely yet correlation with rectal palpation recommended.

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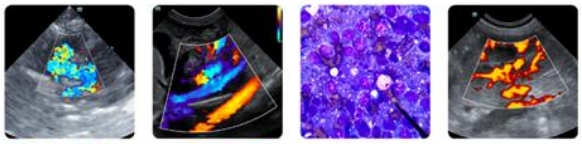

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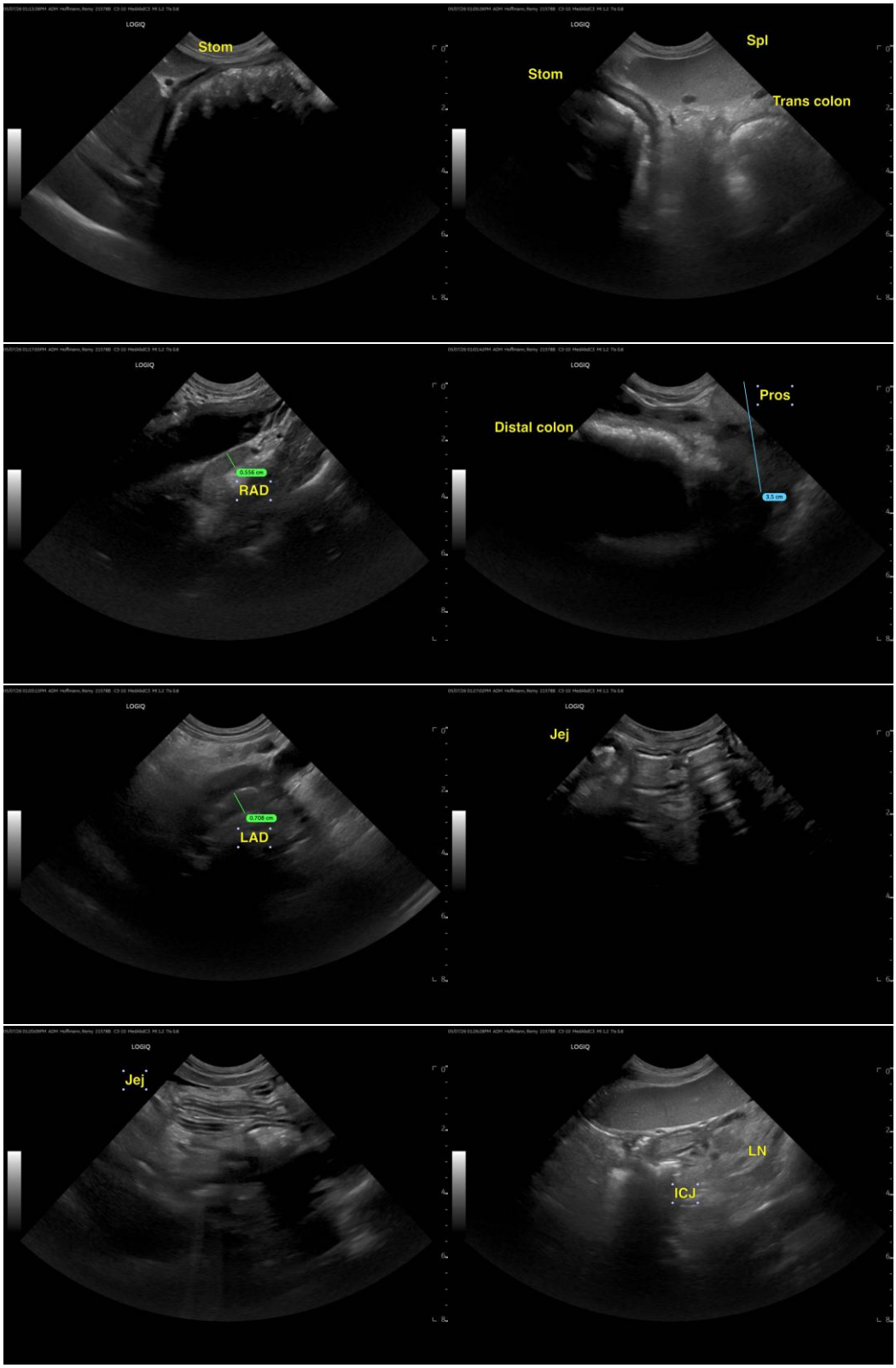

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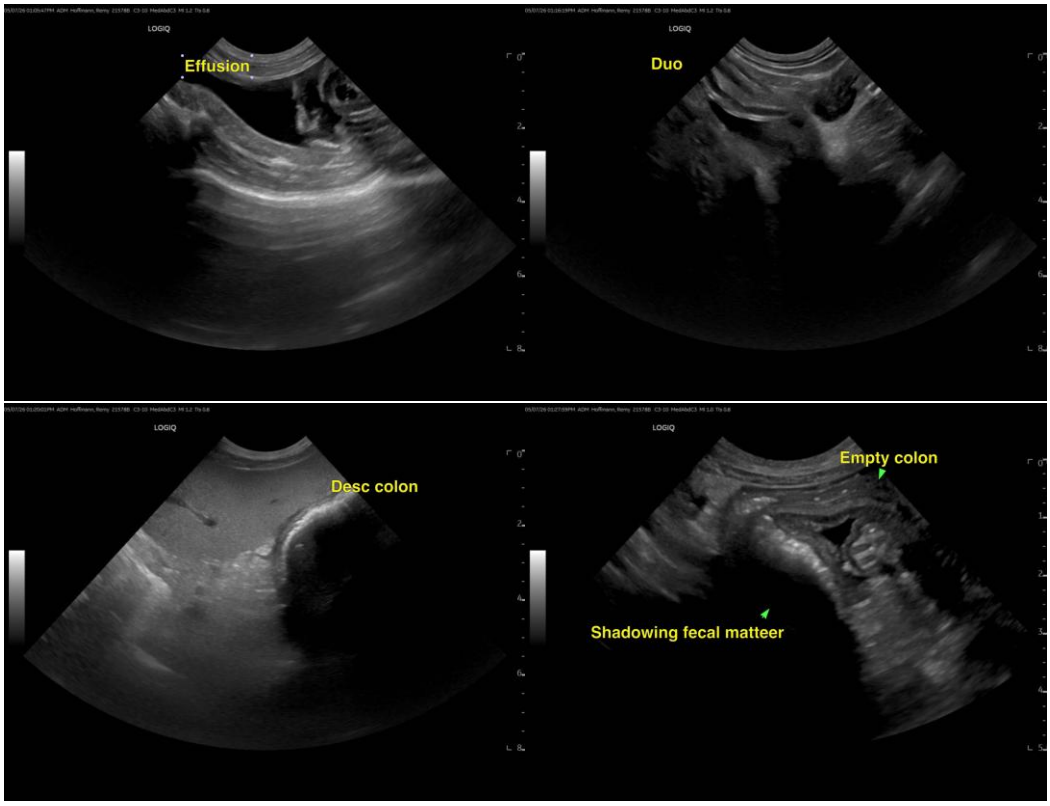

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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