

**PATIENT**

Marco Webber

**SPECIES**

Canine

**BREED**

Labrador Retriever

**SEX**

Neutered Male

**AGE**

9 Months

**WEIGHT**

27 kg

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Dr. Callihan

**HOSPITAL NAME**

Animal Emergency  
Care

**REFERRING VET**

Dr. Loeffler

**INVOICE**

24698

**DATE**

8/14/21

**PRESENTING CLINICAL SIGNS**

S: Marco, 9mo MN Labrador, presented for abdominal discomfort. He was vomiting starting with part of a bully stick and then continued to vomit unable to keep any water down. Was seen at PEC where they took some Xrays, reportedly didn't see anything, and received Cerenia at 2am. This morning he is having difficulty defecating with some blood present and there was something dangling from anus, owner pulled out about 5 inches of grassy fibrous material. He shrieked and seems to be guarding his abdomen since. He ate 1 cup food at 11am, no vomiting since. Diet: Purina Pro Plan sensitive stomach and skin Hx eating a bunch of plum pits 2 weeks ago, was seen here, vomiting was induced and Xrays performed, Metronidazole prescribed. He was back to normal the next day. A: 1. Acute vomiting, resolved with Cerenia - possibly related to bully sticks vs dietary indiscretion, GI FB, metabolic, infectious 2. Abdominal pain following pulling of stringy material from rectum - R/O gastroenteritis, intestinal plication from linear FB pull, perforation, colitis.

Abnormal PE/Chem/CBC/UA Results: PE unremarkable except liquid stool with black speck on rectal exam. IH CBC: elevated EOS 1.75, low RETIC 8.7, rest wnl IH Chem: wnl IH Lytes: mildly low Cl 108, rest wnl Lactate: 1.2 2 view abdominal radiographs: no obvious signs of obstruction or visible foreign material. \*\*Of note: he ate approx 1 cup of kibble at 11am this morning (4 hours prior to ultrasound)

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 4.0 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 changes were noted.

The residual prostate was symmetrically normal in size with uniform parenchyma and slight coarse echotexture. The prostate measured 0.93 cm diameter.

The area of the aortic trifurcation was free of pathology.

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 6.9 cm. The right kidney measured 5.8 cm.

**Adrenal Glands**

The adrenal glands were uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.38 cm at the cranial pole and 0.32 cm at the caudal pole. The right adrenal gland measured 0.38 cm at the cranial pole and 0.60 cm at the caudal pole.

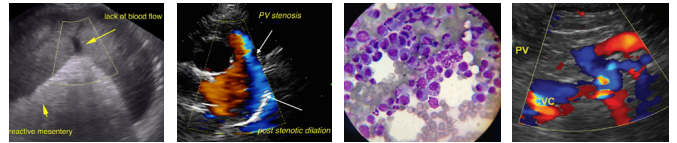
**Spleen**

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**

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**

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained moderate echogenic, nonshadowing ingesta most consistent with post prandial presentation without signs of ileus, obstruction or foreign material. No evidence of pyloric outflow obstruction. Pylorus wall measured 0.61 cm.

The small intestine presented 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. Duodenum wall measured 0.46 cm. Jejunum wall measured 0.46 cm.

Normal visible colon wall layers were present with combined soft to semiformed feces as well as areas of shadowing feces.

**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 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). Example measured 0.58 cm diameter.

No effusion.

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**ULTRASONOGRAPHIC FINDINGS**

- Gastric ingesta
- Sonographically unremarkable small bowel
- Intermittent mild reactive mesenteric lymph nodes

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

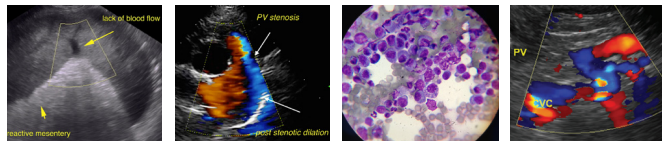
The presence of gastric ingesta may correlate with recent meal ingestion, although given the timeframe from the reported last meal, some degree of metabolic gastric stasis is suspected. The ingesta was consistent with food without overt foreign material, though technically possible mild non-obstructive foreign material intermixed with the gastric ingesta is possible, yet thought unlikely. No evidence of mechanical small bowel obstruction or foreign material. Potential for past foreign material in the colon cannot be definitively excluded, and continued monitoring of defecation is recommended. Continued supportive care and monitoring of gastric emptying is suggested.

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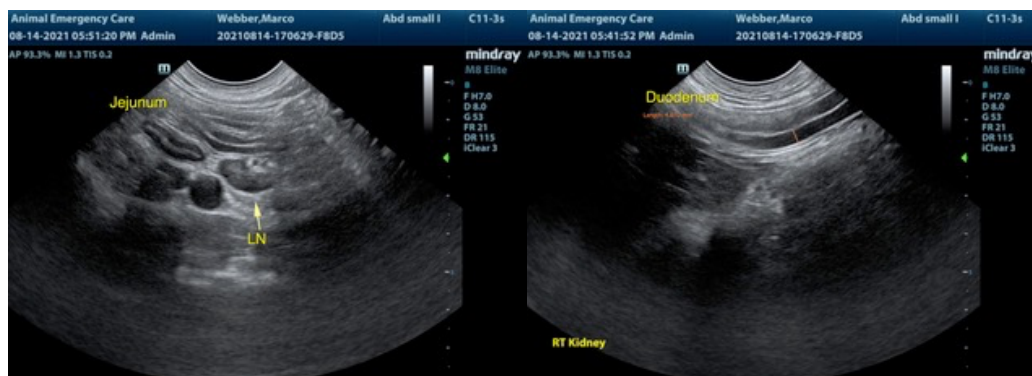
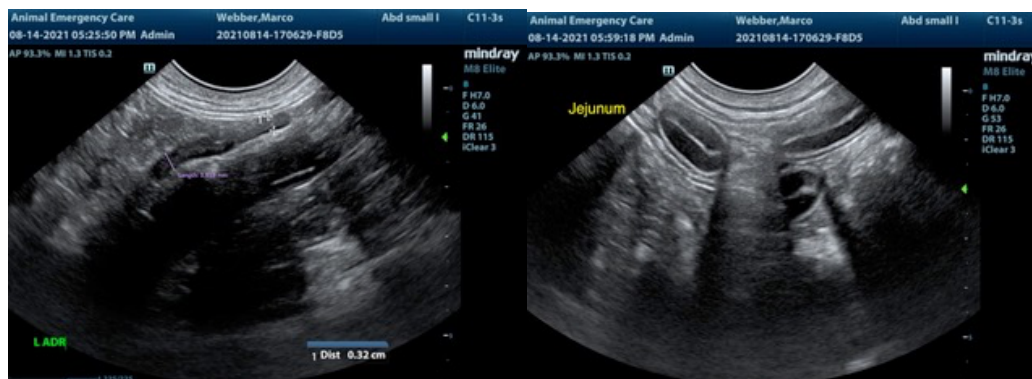
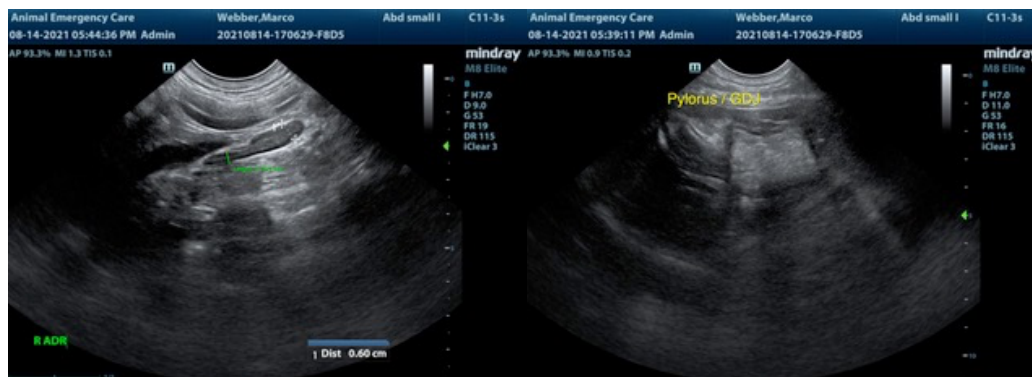
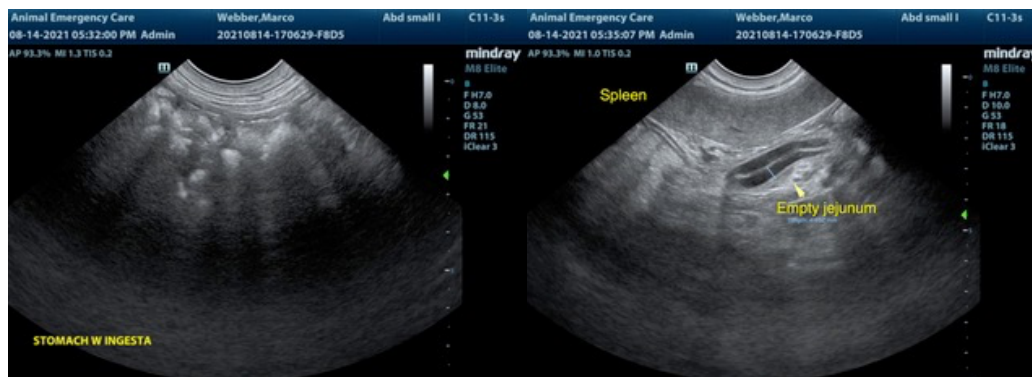
Dr. Loeffler

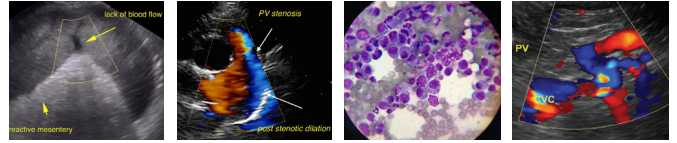
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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