



## PATIENT

Sorra Hall

## SPECIES

Canine

## BREED

Shepherd Mix

## SEX

FS

## AGE

11

## WEIGHT

23.9

## INTERPRETED BY

Sebastian Schaub, DVM  
Dr. med. vet.  
DipECVDI

## IMAGING PERFORMED BY

Kerri Hudson, DVM

## HOSPITAL NAME

Waterville Veterinary  
Clinic

## REFERRING VET

Kerri Hudson, DVM

## INVOICE

75280

## DATE

6-3-26

## PRESENTING CLINICAL SIGNS

Presented on (5/14/26) for recheck of intermittent vomiting of fluid (NOT food). No toxin exposure, no history of dietary indiscretion. No hx of eating foreign material. Vomiting started ~2 months ago: 3/10/26: 5-6-day hx of vomiting; 1 episode diarrhea. Symptomatic treatment of maropitant was tried (along with metronidazole and probiotic) and bland diet of chicken/rice. 3/11/26: P still vomiting yellow liquid (no more diarrhea), so did. P was given SQ fluids, Vit B12 injection, more (maropitant). 4/27/26 - P still intermittently vomiting yellow liquid despite giving a 3rd course of maropitant. Started omeprazole 20 mg po BID. 5/14/26 - Lost ~2 lb in past 2 months BCS 5/9). P still intermittently vomiting (usually yellow liquid, still never food) despite getting omeprazole 20 mg po BID (and sometimes maropitant). Appetite generally good. Full abdominal ultrasound done along with V/D and lateral abdominal radiographs to further assess vomiting - all images sent to EVET for interpretation. 6/2/26: vomiting of fluid about SID persisting despite starting Prednisone 1mg/kg BID on 5/15/26 for possible IBD. P has still been on omeprazole 20 mg BID and Cerenia PRN. Still has good appetite. Has lost ~10 lb since 5/14.

Abnormal PE/Chem/CBC/UA Results: 3/11/26: CBC/Chem/pancreatic lipase - all were unremarkable except very mildly increased ALT. Very brief abdominal ultrasound was done then (Liver, kidneys, urinary bladder WNL. No free abdm fluid. Gall bladder - appears slightly large (5x7cm) with bright echogenicity - possible some extra sludge but is not looking like duct disease (and total bilirubin was WNL on Chem panel). 5/14/26: Evet x-ray report: Whilst there is no evidence of an obstructive pattern, chronic IBD cannot be excluded. Mild or chronic pancreatitis, as well as hepatopathy cannot be ruled out and further investigation is advised.

## RADIOGRAPHIC STUDY OF THE ABDOMEN

A complete radiographic positive contrast passage of the gastrointestinal tract is provided for review.

## RADIOGRAPHIC FINDINGS

### Abdomen plain

Along the lumbar spine, multifocal mild spondylosis formation is seen. The intervertebral disc spaces T11/T12 to T13/L1 are narrowed.

No abnormalities of the extraabdominal soft tissues are noted. The abdominal wall is smooth and thin. The serosal detail is maintained throughout the peritoneal and retroperitoneal space.

The hepatic volume is mildly increased, the caudoventral hepatic margins are rounded and are protruding caudally beyond the costal arch. The gastric axis is deviated caudally. The hepatic parenchyma has a homogeneous soft tissue opacity.

The splenic head is in the anticipated position and within normal limits for size and opacity. The splenic body and tail are considered normal for position, size, shape and opacity.

Both kidneys are seen and present with normal size, shape, delineation and opacity. The urinary bladder is in its anticipated position. No radiopaque calculi are noted throughout the upper and lower urinary tract.

The stomach is in its anticipated position and is empty.

The small intestinal loops are of even diameter and non-dilated, a small amount of gas is seen within the small intestinal loops and considered within normal limits.

The colon is seen in the expected position and presents with appropriate content.



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The esophagus is mild to moderately distended by gas.

### Abdomen post contrast

Contrast media is appreciated in the caudal segment of the esophagus up to 1h post contrast administration – the esophagus is mild to moderately dilated.

The stomach is adequately distended by contrast stained material and presents normal emptying – the small intestinal tract is filled with contrast within 30 minutes post contrast administration. The gastric wall reveals without abnormalities. The contrast column in the small intestinal tract presents mild serrating margins.

Contrast media is appreciated in the oral segment of the colon within 4h post contrast administration. The small intestinal tract still contains a significant amount of contrast.

## RADIOGRAPHIC DIAGNOSIS

- Mild irregular mucosal multiple intestinal segments
- Delayed intestinal transit
- Dilated esophagus
- Mild hepatomegaly
- Spondylosis deformans

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The mild serrating margins of the contrast column in the gastrointestinal tract is suggestive for enteritis – possibly supporting the diagnosis of inflammatory bowel disease versus infectious origin.

The dilated esophagus can be indicative for megaesophagus versus aerophagia (e.g. stress) versus esophagitis. Check clinically if there are signs of regurgitation rather than vomiting.

Potentials for the hepatomegaly include metabolic hepatic disease/steroid induced hepatopathy ± hepatitis or less likely diffuse neoplastic infiltration. Ultrasound can be used for specification and will allow FNA sampling as advanced minimally invasive diagnostic tool.



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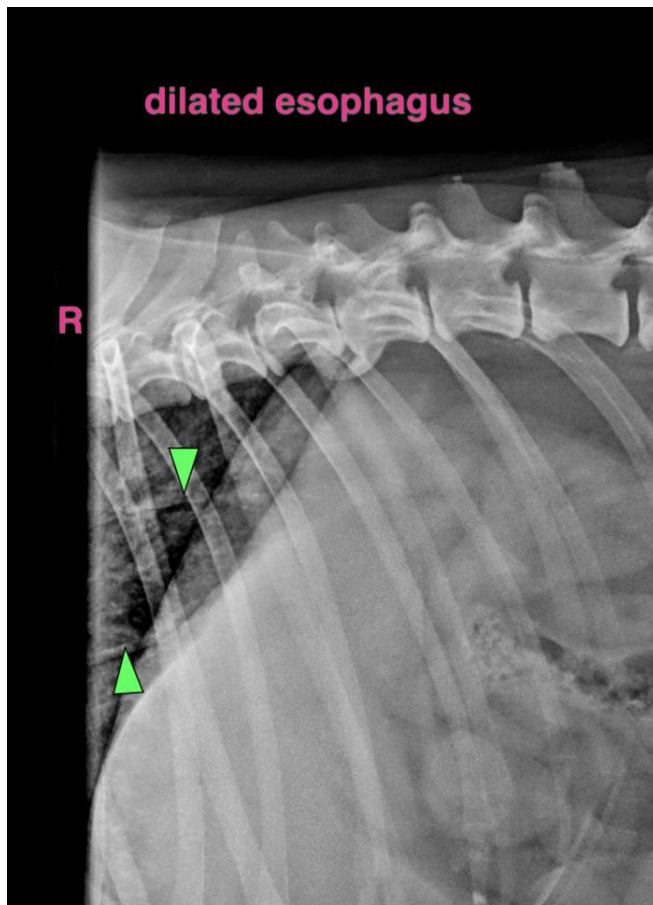
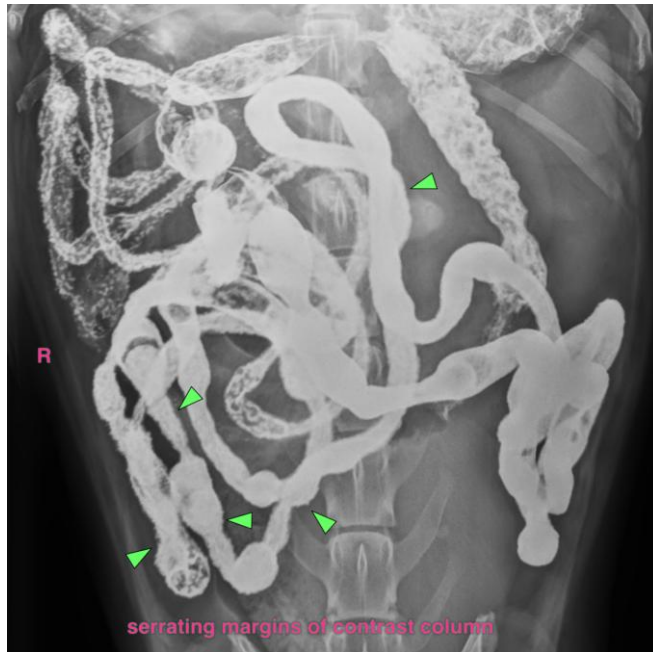
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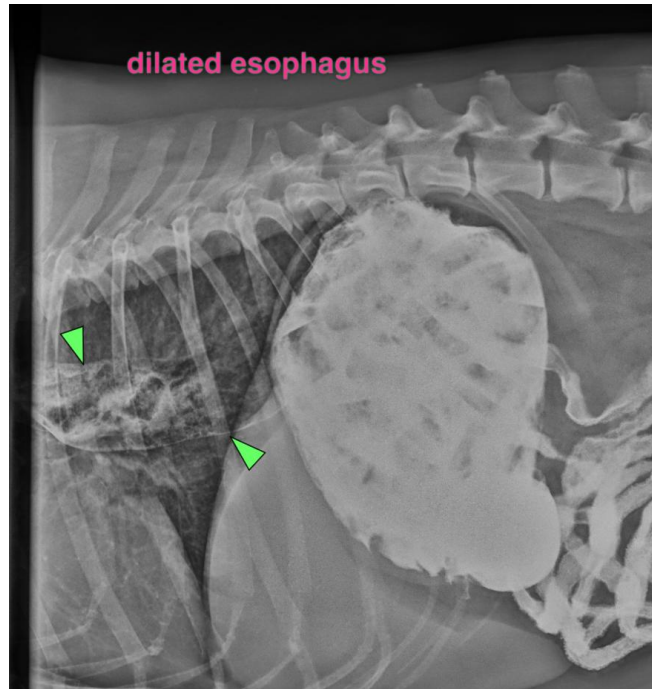
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

**Sebastian Schaub**, Sebastian Schaub, DVM, Dr. med. vet. DipECVDI  
[info@sonopath.com](mailto:info@sonopath.com)