



PATIENT

Rigby Welty

SPECIES

Canine

BREED

Lab

SEX

Neutered Male

AGE

3.5 Years

WEIGHT

31 kg

INTERPRETED BY

Tam Mengine, DVM,
DABVP (canine/feline
practice)

IMAGING PERFORMED BY

Melissa Randolph

HOSPITAL NAME

Shores Veterinary
Emergency Center

REFERRING VET

Dr. Logan Law

INVOICE

72803

DATE

12/28/25

PRESENTING CLINICAL SIGNS

*Rigby has a history of ingesting foreign objects. Previously swallowed a 3-foot long rope that required endoscopic removal at Lancaster. For the past 36 hours, patient has been vomiting. He is eating and drinking still but vomits about 30-45 minutes after. He vomited 3 times today (12/27) - primarily bile. Recently had access to small toys from a dog advent calendar, and client suspects he may have ingested one of the small toys, though no ingestion was witnessed. Normally eats inappropriate items but typically vomits once and recovers, or passes small objects without issue. Has been vomiting currently. prior medical history of Neospora caninum as a puppy (with long term ataxia, head tremor) and is deaf. was seen at another ER and transfer to Shores for concern for gi fb. admitted for iv fluids with KCl , buprenorphine, and cerenia. *concern for vomiting/anorexia - r/o small intestinal foreign body, functional ileus, gastroenteritis, partial obstruction, other

Abnormal PE/Chem/CBC/UA Results: PE: painful, slightly reactive on cranial abd palp CBC/CHEM: WNL EPOC: K 3.4 L, CI 103 L rads: stomach non-distend, small volume gas, partially outlining rugal folds; pylorus is gas opaque in the left lat projection SI: theres a short gas-filled seg of SI that is mod distended, measuring up to 2x height of L5, thought to represent the duod; caudal part of this segment becomes soft tissue opaque & poorly discernible; there is a crescent-shaped gas bubbles in the lumen of an SI seg in the right ventral abd, at L2; the remaining SI WNL. mild increased soft tissue opacity and reduced serosal margin detail in right CR abd, no evidence of abd distent. Repeat rads: Seg dilation of the SI, causing 2 Pop of SI, suspicious for mech obst. Mild dilation of the stomach. Abn material in the SI at L3

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine, and no luminal sediment is present. The ureteral papillae, trigone and pelvic urethra (visible to 1.0 cm) are of normal appearance, and the ureters are not visible (normal). No masses, calculi or mucosal irregularities are noted.

The visualized areas of prostate and surrounding tissue appear normal. Unfortunately, the prostate is not fully visualized likely due to its intrapelvic location. Correlate with rectal exam findings.

The kidneys are of normal size and shape and exhibit appropriate corticomedullary differentiation with a normal 1:3 cortex to medulla ratio. There is no evidence of nephrolithiasis, mineralization, pyelectasia, cystic change or hydronephrosis. The proximal ureter is not visible (normal). Left measures 6.4 cm. Right measures 6.5 cm.

Adrenal Glands

The left adrenal gland is identified in its normal location. It is of normal size and shape with appropriate parenchymal echogenicity and normal phrenic vasculature. The left adrenal gland measures 5.7 mm at the cranial pole and 5.3 mm at the caudal pole. The right adrenal gland is not distinctly visualized, but the region appears unremarkable.

Spleen

The spleen is of appropriate size and has a normal, homogenous parenchyma with a smooth, continuous capsular surface. The splenic vasculature is normal with no evidence of congestion or thrombosis, and blood flow through the splenic hilus appears normal.



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Liver

The liver is of appropriate size and shape, with sharp borders and a mildly coarse parenchymal echotexture that is hypoechoic to the spleen. The portal and hepatic vasculature are of normal size and appearance with no evidence of congestion or thrombosis.

The gallbladder is moderately distended with anechoic contents. The wall was thin and continuous with no focal lesions. The cystic and common bile ducts are normal / not visible.

Gastrointestinal

The stomach is mildly distended with fluid. The gastric wall is 4.1 mm with normal deviations due to rugal folds, and exhibits appropriate wall layering. The pylorus is of normal appearance.

The visualized portions of the duodenum, jejunum, and ileum are of normal thickness with intact wall layering that exhibits the appropriate 1:3 muscularis to mucosa ratio. Intestinal motility appears normal. There is a 4.0 cm segment of bowel observed that contains anechoic shadowing material. However, it is unclear whether this material is within the small or large bowel.

The visible portions of the colon are of normal thickness (1.9 mm) with intact wall layering. The ileocecal junction is not seen.

Pancreas

The areas of the limbs and body of the pancreas are isoechoic to the surrounding mesenteric fat, with normal capsular appearance. There is no evidence of peripancreatic inflammation. The pancreatic duct appears normal.

Free Abdomen

There is no evidence of free fluid within the peritoneal cavity. The omentum and intra-abdominal fat are of appropriate echogenicity. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

PRIMARY FINDINGS

- Shadowing material within the bowel, without definitive evidence of obstruction

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is no definitive pathology noted on Rigby's ultrasound today. There are some segments of bowel that contain shadowing material (see attached pictures), as might be seen with a foreign body, but is unclear whether these represent small or large bowel (if in the large bowel, this would be incidental) and also there are no dilated small bowel loops seen that would suggest obstruction. The pylorus is not visualized due to patient's size / deep chested-ness, and so the possibility of a pyloric obstruction is not excluded.

I would recommend 12 hours of fluid therapy and supportive care, followed by recheck ultrasound if the patient's symptoms persist.



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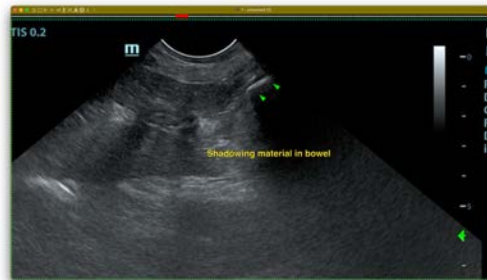
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Tam Mengine, DVM, DABVP (canine/feline practice)

info@SonoPath.com