

**PATIENT**

Cleo Goodin

**SPECIES**

Canine

**BREED**Staffordshire Bull  
Terrier**SEX**

Spayed Female

**AGE**

9 years

**WEIGHT**

55.2 lbs

**INTERPRETED BY**Kathleen Sennello  
DVM, MS, Diplomate  
ACVIM (Small Animal  
Internal Medicine)**IMAGING  
PERFORMED BY**

Amy Mayhew LVT

**HOSPITAL NAME**

SVS Imaging Michigan

**REFERRING VET**Animal Care of  
Waterford**INVOICE**

95330

**DATE**

1/10/20

**PRESENTING CLINICAL SIGNS**

Previous history of towel ingestion. Recent history of vomiting, lethargy. RDVM has concerns for renal disease.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN****Urinary System**

The urinary bladder is moderately distended with anechoic urine. The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (5.91 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. Numerous cortical cysts and mild pyelectasia at 0.33 cm were noted. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (6.03 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of perinephric inflammation or effusion. Numerous cortical cysts were noted. There is no evidence of nephroliths, pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

**Adrenal Glands**

The left adrenal gland is normal in size measuring 0.67 cm at the caudal pole It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.84 cm at the caudal pole It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

**Spleen**

The spleen is subjectively normal in size, echotexture is homogenous, and the splenic capsule is smooth with no irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

**Liver**

The liver is subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed. The gallbladder lumen is moderately distended. The wall of the gallbladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.

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**Gastrointestinal**

The stomach contains minimal luminal contents. It largely measures as a normal thickness, but in some areas the wall is more prominent and measures up to 1.0 cm in thickness with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate and there is no impression of reduced peristaltic activity.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. The duodenum measured as normal (0.32 cm) and the jejunum measured as normal (0.33 cm). Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

**Pancreas**

The pancreas is normal and isoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

**Free Abdomen**

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

**ULTRASONOGRAPHIC FINDINGS****PRIMARY FINDINGS:**

- Decreased corticomedullary distinction in both kidneys with small cortical cysts and left-sided pyelectasia. Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis. Pyelectasia of the left kidney could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.
- Questionable gastric wall thickening. The stomach wall thickening could be consistent with inflammation, edema, infiltrative neoplasia, imaging artifact due to rugal folds, other.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

A prominent lesion to explain the vomiting and lethargy reported is not visualized. There is questionable gastric wall thickening, which could be consistent with gastritis, infiltrative disease or may represent variability due to gastric folds and lack of distension.

The changes observed in the kidneys are consistent with chronic progressive renal disease. I recommend urinalysis and culture, blood pressure evaluation and urine protein to creatinine ratio.



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You can consider a GI panel to Texas A&M for qualitative PLI, TLI, cobalamin and folate to further evaluate for the possibility of pancreatitis (not observed) or small intestinal disease. You can consider a diet trial with a novel protein/hydrolyzed protein diet and symptomatic therapy for gastritis (anti-nausea medications, Sucralfate, antacids, etc). If vomiting persists then consider reevaluation of the gastric wall with either reimaging or you can consider upper GI endoscopy or exploratory surgery.

I recommend three view thoracic radiographs and two view abdominal radiographs to correlate with the abdominal ultrasound.

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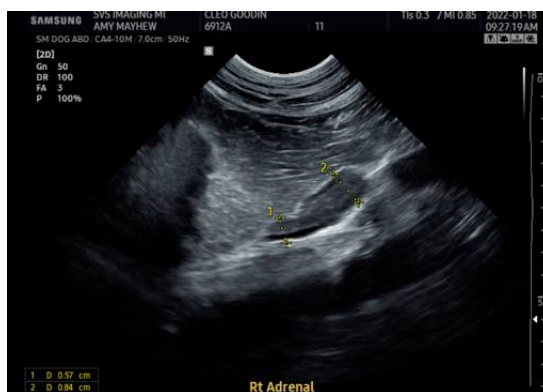
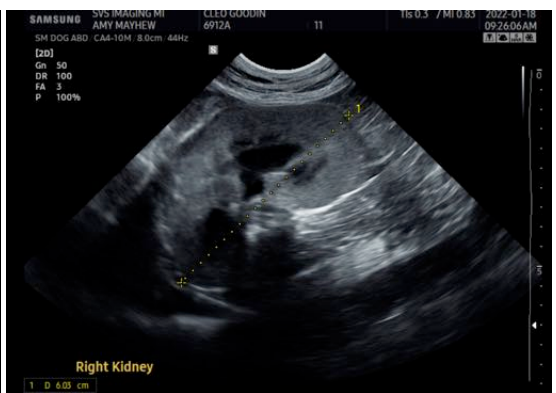
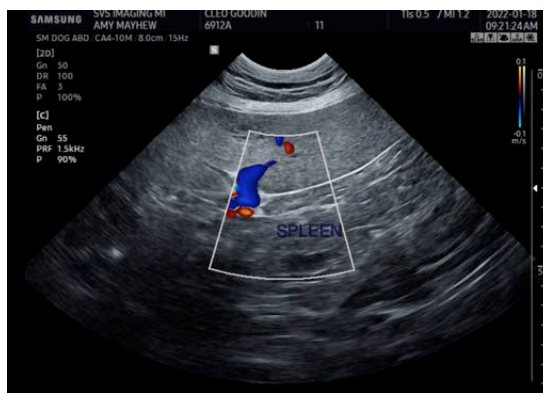
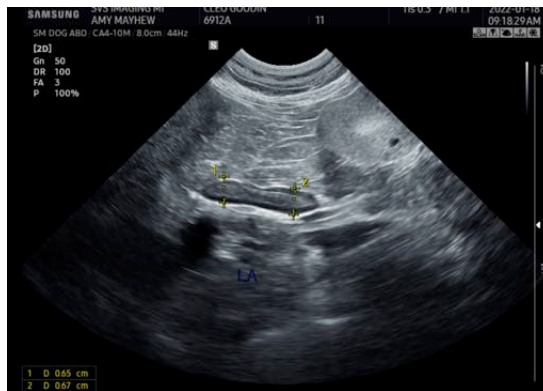
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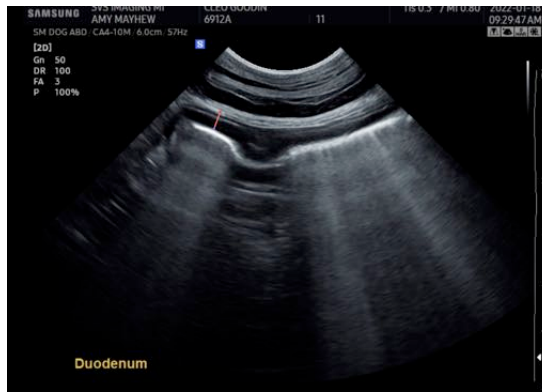
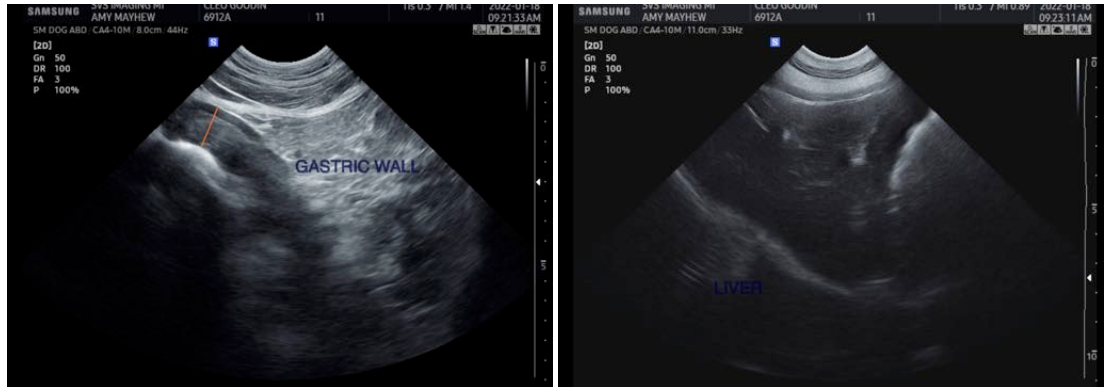
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The information and recommendations provided are based on the images presented by the referring veterinarian. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

**IMAGING PERFORMED BY**

Amy Mayhew LVT

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)

kathleen.sennello@sonopath.com

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