



**PATIENT**

Tucker Hunter

**SPECIES**

Canine

**BREED**

Bulldog

**SEX**

Neutered Male

**AGE**

10

**WEIGHT**

55.3 Pounds

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Dr. Danielle Lanz

**HOSPITAL NAME**

New Holland Vet  
Hospital

**REFERRING VET**

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**INVOICE**

44484

**DATE**

1/25/23

**PRESENTING CLINICAL SIGNS**

Presented 1/10 for lethargy, hyporexia, intermittent diarrhea. Treated supportively with omeprazole. Then treated with prednisone for suspect PLE with low albumin levels. Started eating and is doing much better but will occasionally have intermittent diarrhea. Presented 1/21 for seizing. Had another seizure 1/22. Started on Kepra 7mg/kg no seizures since.

Abnormal PE/Chem/CBC/UA Results: Ca 8, K+ 5.5, Na 143, TP 3.8, Alb 1.9, Globulin 1.9 Cholesterol 124, CK 241 UA; WNL BW with GI panel: pending from today.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder is moderately distended with anechoic urine. The Bladder wall is diffusely mildly thickened (0.75 cm), and the mucosa is mildly irregular. The trigone, ureteral papillae, and visible urethra (to a depth of 2cm) appear normal with no evidence of severe mucosal irregularities, masses or cystic calculi. Findings are most consistent with bacterial cystitis or lack of urine distension. Recommend urinalysis and culture.

The prostate is normal in size (0.83 cm) and shape for this neutered male dog. The parenchyma is homogenous and the external margins are smooth. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (5.47 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (5.79 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

**Adrenal Glands**

The region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.

The region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.

**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.



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The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and primarily anechoic. The cystic and common bile ducts are normal/not visible.

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**Gastrointestinal**

The stomach contains a large amount of shadowing ingesta. It measures at a normal thickness of <0.7cm 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. No masses or focal lesions were observed.

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The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall thickness is moderately increased. Duodenum wall measures 0.52 cm. Jejunum wall measures 0.58 cm with submucosal speckling visualized. Bowel loops follow a typical curvilinear path. Some areas have reduced detail of wall layering. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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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.

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**Pancreas**

The area of 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.

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**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.

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**ULTRASONOGRAPHIC FINDINGS**

- Subjectively thickened urinary bladder wall – The bladder mucosal changes could be consistent with cystitis or artifactual due to lack of adequate luminal distension. Bladder neoplasia cannot be ruled out but is considered unlikely in this patient.
- Large shadowing ingesta within the gastric lumen – Correlate with the feeding history and abdominal radiographs. If the patient was adequately fasted consider such differentials as delayed gastric emptying, a partial outflow tract obstruction (none seen) or ingested foreign material.
- Diffusely thickened small intestine with submucosal speckling – The bowel wall thickening could be consistent with inflammation, edema, or infiltrative neoplasia. Bright mucosal speckling has been postulated to represent dilated lacteals or focal accumulations of mucus, cellular debris, etc.. in the mucosal crypts.

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The small bowel appears diffusely thickened. Layering appears largely intact. No focal bowel lesions were observed. Per the history, this patient has a protein losing enteropathy (provided liver function is normal and there is no proteinuria present). The most common differentials being severe IBD, lymphangiectasia, or lymphoma. These are differentiated based on GI biopsies. Unfortunately, a response to Prednisone is not easy to differentiate, as all of these processes have the possibility of initial



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response to steroid therapy.

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Ideally, the steroids would be tapered, and endoscopic GI biopsies obtained, so as to best get an idea of prognosis and the best treatment strategy. If that is not an option, then consider an anti-inflammatory dose of steroids (0.5-1.0 mg/kg per day), symptomatic treatment for gastroenteritis, and depending on what disease process is present, you could consider either a novel protein/hydrolyzed protein diet or an ultra-low-fat diet (you can consult with a veterinary nutritionist to formulate a homemade novel protein/ultra-low-fat diet in some cases).

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Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.

**SEX**

Neutered Male

The urinary bladder wall appears somewhat irregular and thickened on today's scan. This could largely be due to a lack of full urine distention, but consider a urinalysis and culture.

**AGE**

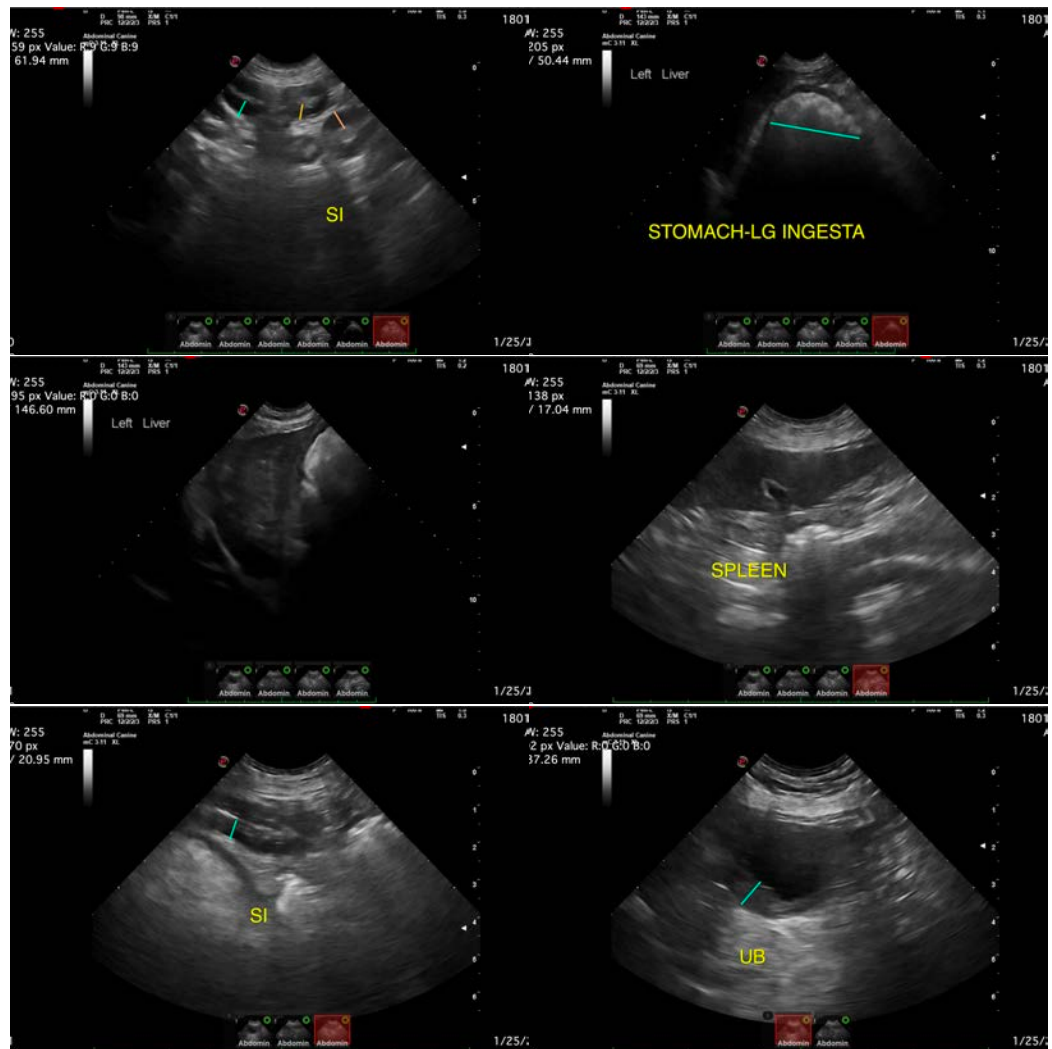
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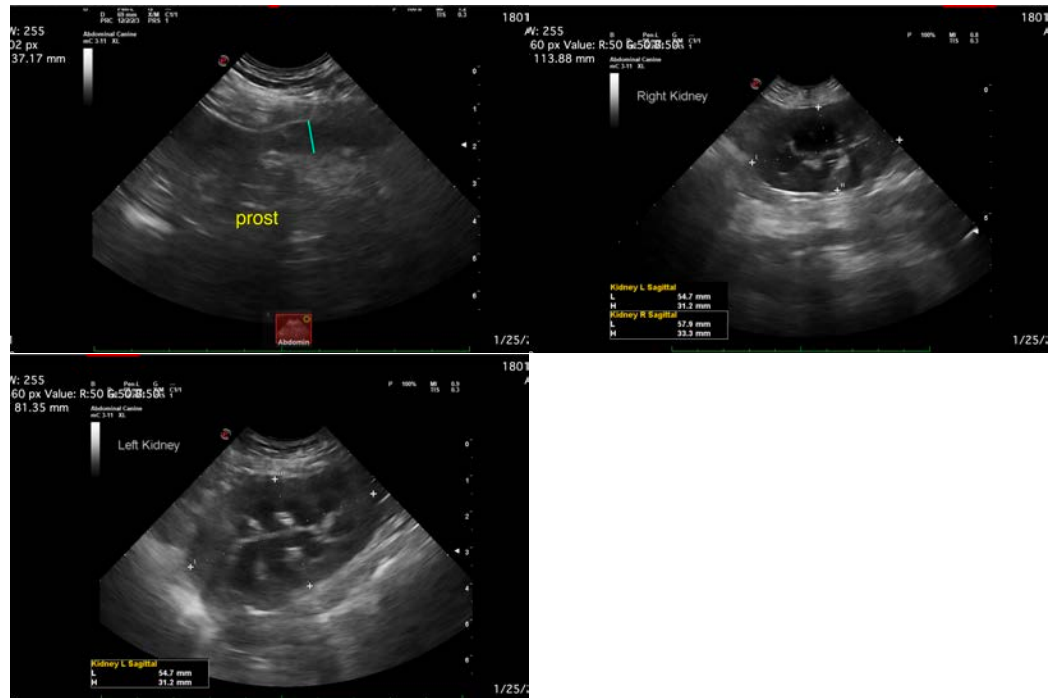
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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