



**PATIENT**

Lacey Price

**SPECIES**

Canine

**BREED**

Staffordshire Bull Terrier

**SEX**

Spayed Female

**AGE**

4 Years 8 Months

**WEIGHT**

38 Pounds

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Carly Pate

**HOSPITAL NAME**

VCA McKenzie AH

**REFERRING VET**

Dr. Wayland

**INVOICE**

44548

**DATE**

1/26/23

**PRESENTING CLINICAL SIGNS**

P presented for exam on 1/23 for vomiting and regurgitation, regurgitation sounds more probable- daily occurrence, not always an abdominal press present, happens more often after drinking water and running around. No abnormalities noted on physical exam.

Abnormal PE/Chem/CBC/UA Results: CBC - Monocytosis mild.; Chemistry profile - AST 600+ ALT 1300+; Thyroid hormones - WNL; Urinalysis - Bilirubin 2+. PT/PTT WNL. Liver aspirate cytology pending.

**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 (6.04 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 is not clearly visualized, most consistent with congenitally absent or dystrophic kidney.

**Adrenal Glands**

The left adrenal gland is normal in size measuring 0.47 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 0.48 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. There is a 0.50 cm shadowing focus most consistent with an area of mineralization.

**Liver**

The liver is borderline small, with normal echogenicity and smooth peripheral margins. The parenchyma is mildly heterogenous in echotexture with subtle, indistinct focal mottling. 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 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.

**Gastrointestinal**

The stomach contains minimal luminal contents. It measures at a normal thickness of 0.35 cm 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 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. Jejunum wall measures 0.34 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.

**PRIMARY FINDINGS**

- Borderline small heterogeneous liver – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy.
- Absent right kidney – The right kidney was not clearly visualized on today’s exam, likely due to it being congenitally absent or severely dystrophic.

**SECONDARY FINDINGS**

- Small shadowing focus in the spleen – Findings are most consistent with a small area of mineralization.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The liver subjectively appears slightly small and heterogeneous. Correlate this with abdominal radiographs, liver values, and possibly a liver function test, as this could be within normal limits for this dog, particularly if it is deep chested.

There is a small pinpoint focus of mineralization in the spleen. This is likely incidental. Consider continued monitoring.

The right kidney was not clearly visualized on today’s exam despite a thorough examination of the area of the right kidney. This likely represents a congenitally absent or severely dystrophic kidney. Correlate with abdominal radiographs.

No cause of vomiting or regurgitation is noted on today’s exam. Consider fluoroscopic barium swallow (or using serial radiographs), testing for myasthenia gravis, hypothyroidism, Addison’s disease, additionally consider esophagostomy and upper GI endoscopy.



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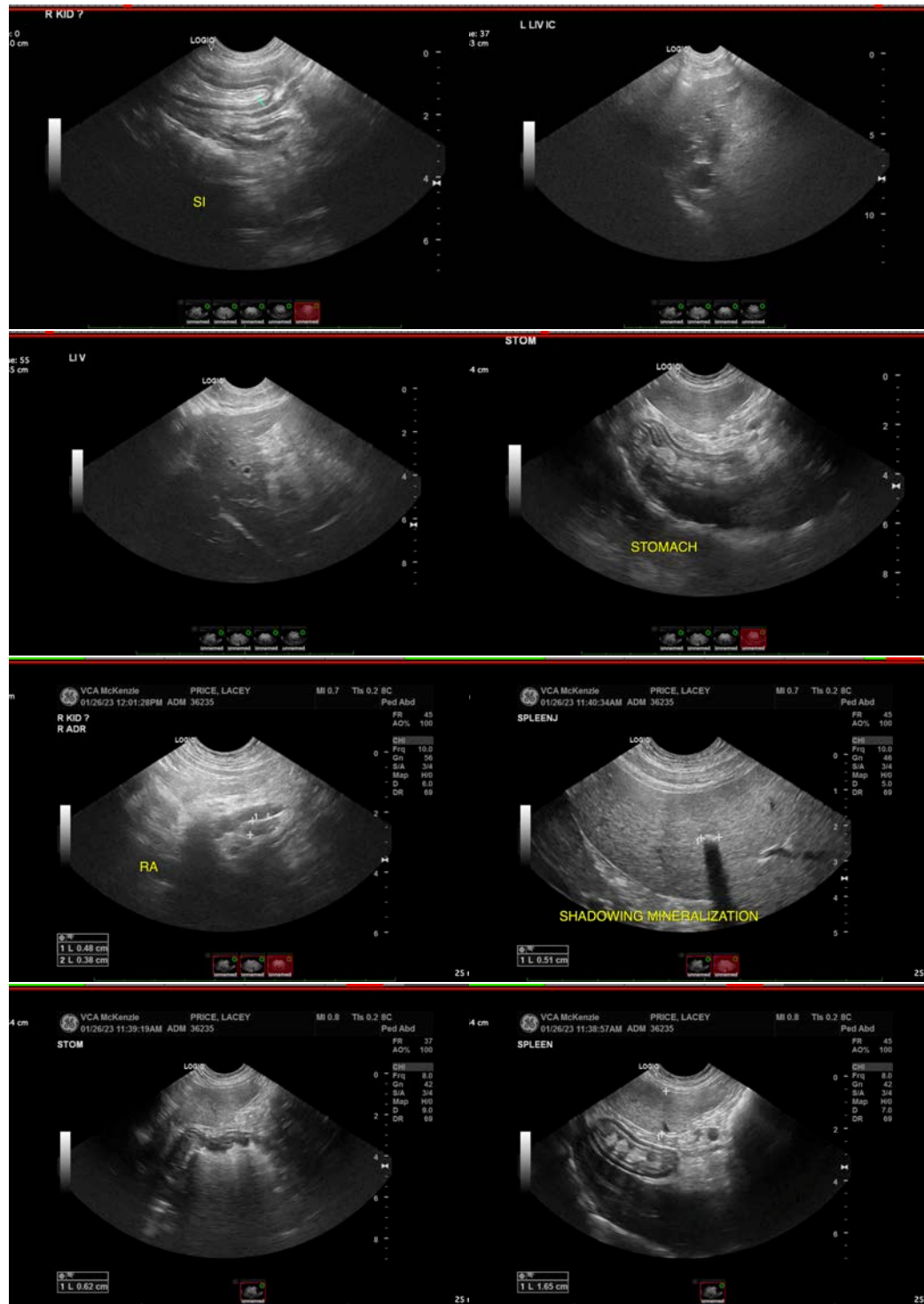
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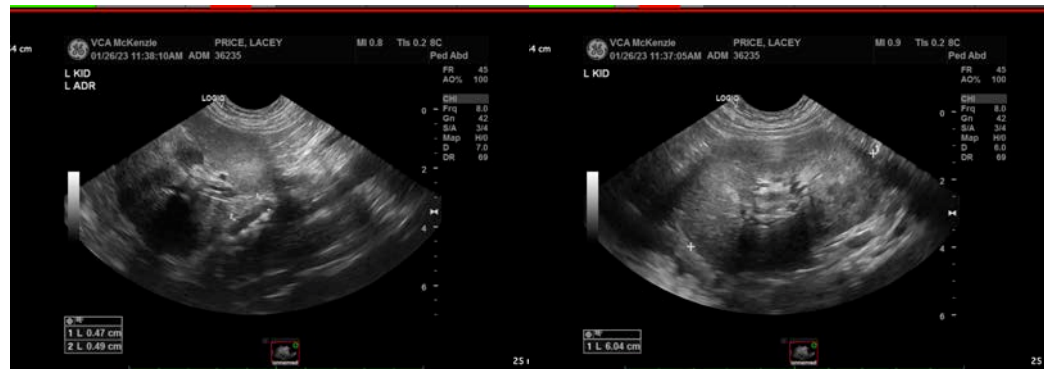
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

kathleen.sennello@sonopath.com