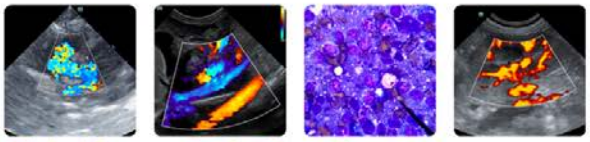




**PATIENT**

AnnaBelle Joy May

**SPECIES**

Canine

**BREED**

Maltese x

**SEX**

Spayed Female

**AGE**

5 Years

**WEIGHT**

9.7 Years

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Emily Kirk

**HOSPITAL NAME**

Shiloh Animal Hospital

**REFERRING VET**

Dr. Shana Silverstein

**INVOICE**

72105

**DATE**

1/8/26

## PRESENTING CLINICAL SIGNS

Patient presented for borborygmi, lip smacking for several months, decreased energy level. Appetite has been good with no vomiting or diarrhea. Pancreatitis has been suspected in the past.

Abnormal PE/Chem/CBC/UA Results: Cobalamin/folate/PLI were unremarkable

## 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 (3.73 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 (3.83 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 left adrenal gland is normal in size measuring 0.35 cm at the cranial pole and 0.31 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 0.36 cm at the cranial pole and 0.41 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.

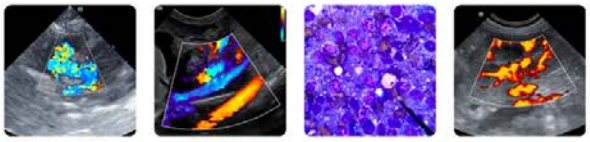
### *Spleen*

The spleen is subjectively normal in size (1.11 cm), 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 gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and likely incidental at this time. The cystic and common bile ducts are normal/not visible.





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### *Gastrointestinal*

The stomach contains mild fluid, gas and shadowing ingesta. The gastric wall is normal at 0.43 cm with a prominent muscularis layer. Gas artifact from intraluminal material interferes with full evaluation of some areas of the stomach.

The visualized areas of duodenum, jejunum and ileum have a uniform diameter with minimal fluid distension. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. Duodenum wall measures 0.35 cm. Jejunum wall measures 0.32 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The descending colon wall appears somewhat prominent, measuring at 0.22 cm with intact wall layering. Sections of colon are visualized with non-formed fecal material and gas shadowing distally.

### *Pancreas*

The right limb of the pancreas is large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with mild pancreatitis.

### *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

- Pancreatic changes most consistent with mild chronic pancreatitis in the right limb.
- Prominent muscularis layer of the stomach – Findings could be consistent with chronic gastritis.
- Mildly thickened small intestine – The mild small intestinal wall changes may be a normal variant in this patient or could be consistent with an inflammatory process (e.g., inflammatory bowel disease).
- Prominent distal colon wall with non-formed fecal material – Findings could be consistent with mild colitis.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The right limb of the pancreas is prominent and hypoechoic with some mildly reactive mesentery in the region possibly consistent with mild chronic pancreatitis. Correlate with a PLI level and consider empirical treatment for chronic pancreatitis.

Additionally, the muscularis layer of the stomach appears subjectively mildly prominent. This could be seen with mild inflammation. Additionally, the small intestine appears mildly thickened (could be normal for this individual), and there appears to be non-formed fecal material in the distal colon (possibly borderline diarrhea?).

If an underlying gastroenteropathy is suspected, you could consider the following:

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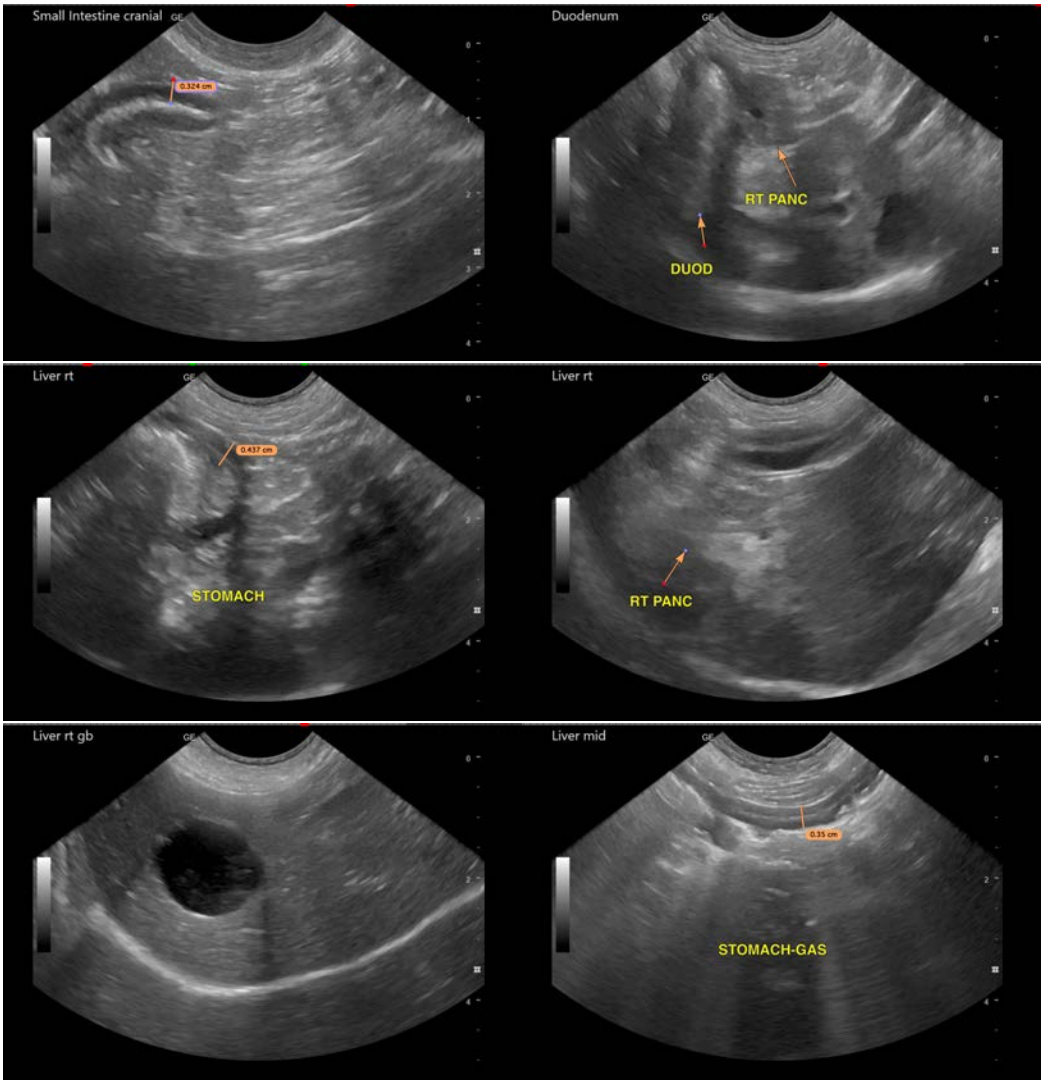
- Consider a prescription ultra low-fat combination hydrolyzed protein prescription diet (Royal Canin).
- Recommend chronic probiotic therapy.
- Consider screening for Addison's.
- If not already done, recommend empirical deworming and screening for GI parasites.

If symptoms are persistent despite these measures, upper GI endoscopy could be considered to further evaluate the upper GI tract and to obtain biopsies as well as to perform a good oral exam under anesthesia, looking for any causes of excessive licking, etc.



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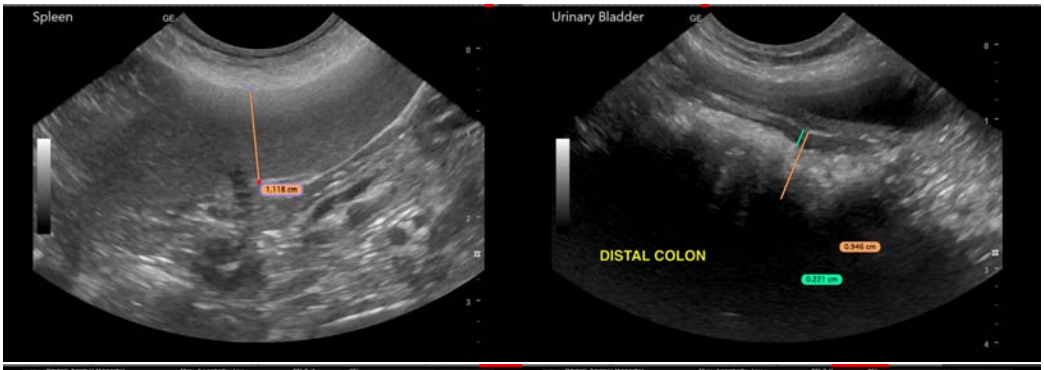



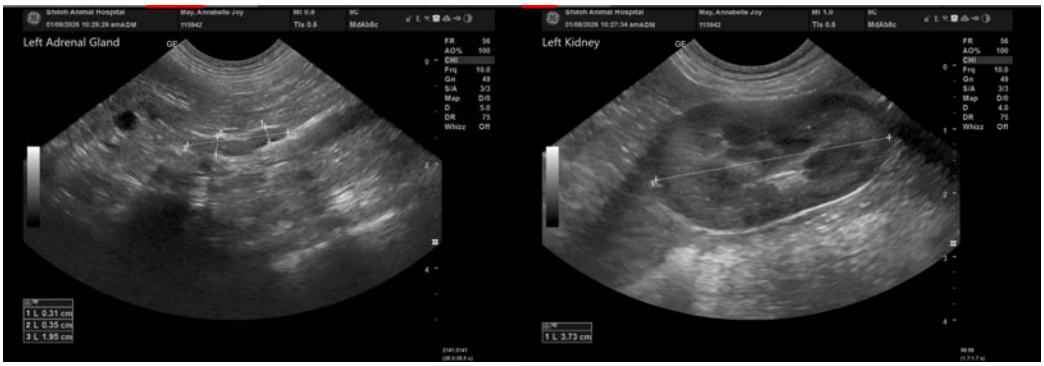


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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)

info@sonopath.com