



PATIENT

Winnie Stewart

SPECIES

Canine

BREED

Frenchie

SEX

Spayed Female

AGE

5

WEIGHT

21.4

INTERPRETED BY

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

IMAGING PERFORMED BY

Jenn

HOSPITAL NAME

Rockaway Animal
Hospital

REFERRING VET

Dr. Maniar

INVOICE

10730

DATE

11/12/2025

PRESENTING CLINICAL SIGNS

Came for second opinion from AERA, vomiting /gagging.

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 (3.7 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 pinpoint mineralizations noted. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.96 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 are occasional pinpoint mineralizations noted. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.55 cm at the cranial pole and 0.58 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 plump in size measuring 0.77 cm at the cranial pole and 0.8 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 and the echotexture is homogenous. The splenic capsule is smooth with no visible irregularities. The blood flow through the hilus and splenic parenchyma appears normal. There is a hypoechoic nodule visualized near the hilus measuring 0.3 cm x 0.36 cm.

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. There is a moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach is moderately dilated with fluid and irregular shadowing material most consistent with normal ingesta and gas. It measures at a normal thickness of 0.51cm with some variability due to the



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presence of rugal folds. The distinction of the gastric wall layering is adequate and there is no impression of reduced peristaltic activity. Shadowing ingesta interferes with full evaluation of the stomach and some areas of the cranial abdomen.

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 (0.33 cm in wall thickness) and the jejunum measured as normal (0.27 cm.) Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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 prominent and mottled in the left limb. 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

- Small, hypoechoic splenic nodule. There is a non-cavitated, hypoechoic splenic nodule visualized. Differentials include lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.
- Pancreatic changes in the left limb, most consistent with chronic pancreatic remodeling +/- chronic pancreatitis.
- Moderate gallbladder debris. The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting but seems unlikely to be causing a current issue. Recommend continued monitoring.
- Moderate shadowing ingesta visualized within the gastric lumen. Correlate with feeding history. Possible differentials include delayed gastric emptying, or partial outflow tract obstruction (outflow tract not clearly visualized.)

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized associated with the GI tract. The stomach has a large amount of shadowing ingesta which interferes with full evaluation of outflow tract and some of the other areas. The gastric wall is slightly prominent but not overtly thickened. Possibly consistent with mild gastritis.

It's not stated if this is acute or chronic in nature. If this is acute, recommend treatment for non-specific gastroenteritis and close continued monitoring. If the patient is not improving as would be expected, consider repeat imaging (radiographs +/- ultrasound.) Additionally, correlate with



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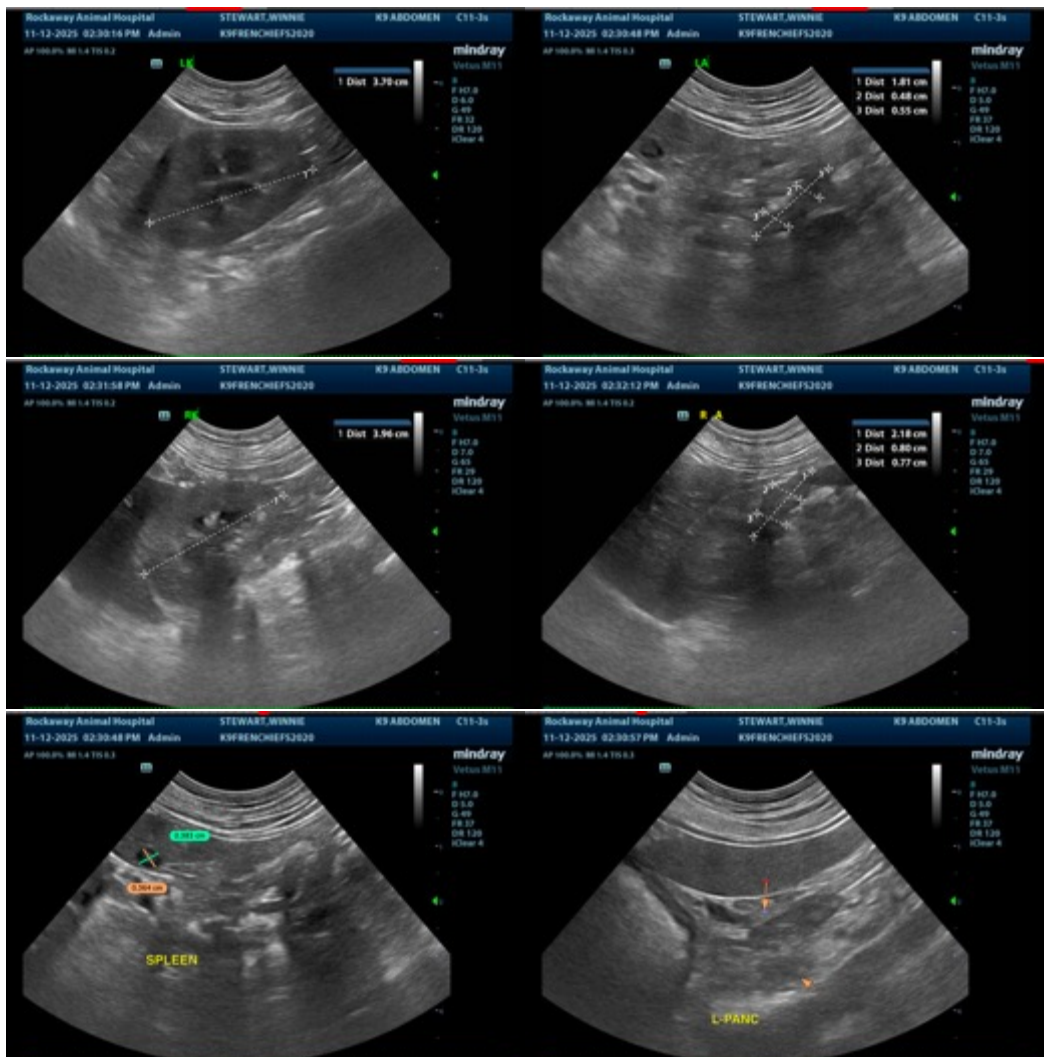
11/12/2025

radiographs and full biochemical evaluation. If this is more chronic in nature, then further workup for a primary enteropathy may be warranted.

In this breed, there is an increased incidence of regurgitation, which can be associated with upper airway issues. Consider three view thoracic radiographs to evaluate the esophagus, and possibly endoscopy for an upper airway exam and to evaluate the esophagus, stomach, proximal GI tract, and obtain biopsies.

There's a small nodule visualized associated with the spleen. Options moving forward would include a fine needle aspirate or continued monitoring with ultrasound.

The pancreas is somewhat prominent. If PLI is elevated then consider concurrent treatment for chronic pancreatitis.





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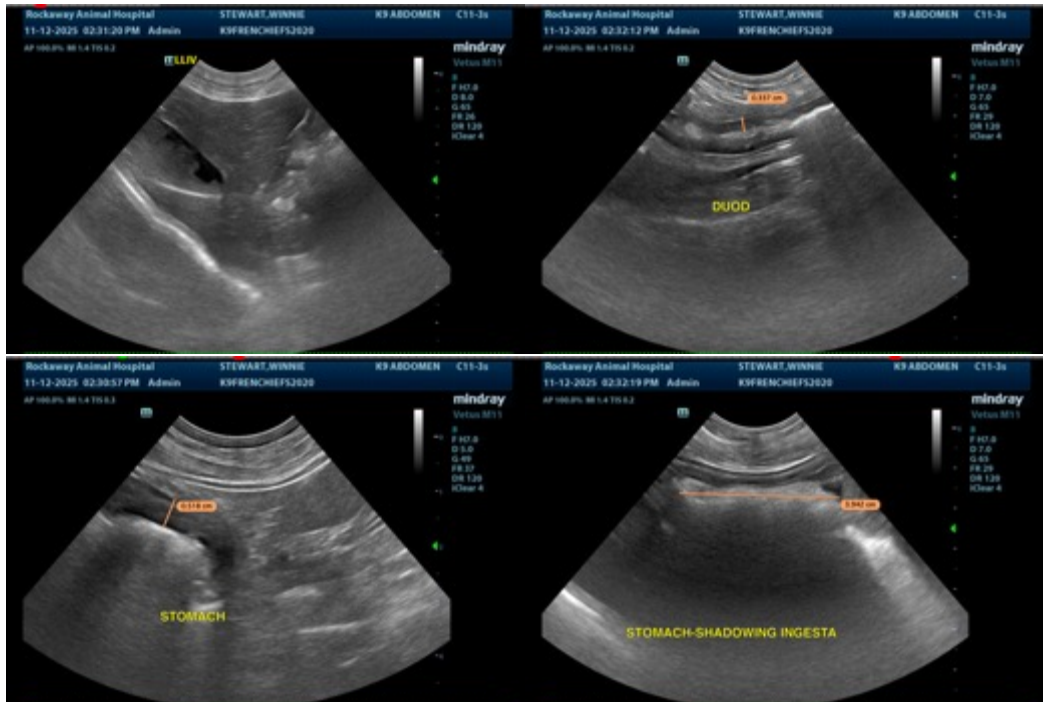
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@sonopath.com

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