



**PATIENT**

Amelie Guthrie

**SPECIES**

Canine

**BREED**

Toy Poodle

**SEX**

Spayed Female

**AGE**

10 Years

**WEIGHT**

11 lbs

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Kathleen Byrnes

**HOSPITAL NAME**

Monroe Road Animal  
 Hospital

**REFERRING VET**

Dr. Widay

**INVOICE**

71937

**DATE**

11/19/25

**PRESENTING CLINICAL SIGNS**

P presented 11/18/25 for lethargy, vomiting diarrhea. Went to ER clinic, rads taken, treated supportively with fluids and cerenia. Giardia negative bloodwork unremarkable 5 rads attached

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder is moderately distended with anechoic urine. The Bladder wall appears mildly thickened and irregular in the apical wall measuring 0.36 cm. The region of the trigone, ureteral papillae and proximal urethra appear free of any mass lesions or calculi.

The left kidney has a normal shape and size (4.21 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 (4.09 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 0.48 cm at the cranial pole and 0.48 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 0.72 cm at the cranial pole and 0.43 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 (1.2 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 moderate 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. Shadowing ingesta interferes with full evaluation of the stomach and some areas of the cranial abdomen.

Most of 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 0.31 cm. Jejunum wall measures 0.26 cm. Visualized peristalsis appears appropriate. The proximal duodenum appears slightly thickened with some retained fluid. No focal lesions are observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. The colon is significantly distended with non-formed /liquid fecal material. There is no observed focal or generalized colon wall thickening or loss of layering.

**Pancreas**

The pancreas is visible/mildly prominent in both limbs. 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**

- Mildly thickened/irregular apical wall of the urinary bladder – 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.
- Pancreatic changes most consistent with chronic pancreatic remodeling.
- Moderately distended stomach with focal shadowing ingesta – This possibly reflects the treats fed this morning. Retained ingesta or atypical ingested foreign material can't be ruled out.
- Thickened duodenum with retained fluid – Findings are suggestive of mild duodenitis.
- Mildly diffusely 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).

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

No focal lesions are visualized associated with the GI tract to explain the symptoms described. The duodenum appears somewhat fluid distended and thickened, possibly due to focal enteritis. The pancreas in this region does not appear severely inflamed, but mild pancreatitis could be at play. Correlate with a PLI level and consider empirical treatment for pancreatitis.



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There is mild generalized thickening of the small intestine. This could be consistent with an underlying inflammatory type change. Consider the following for further evaluation of a primary enteropathy:

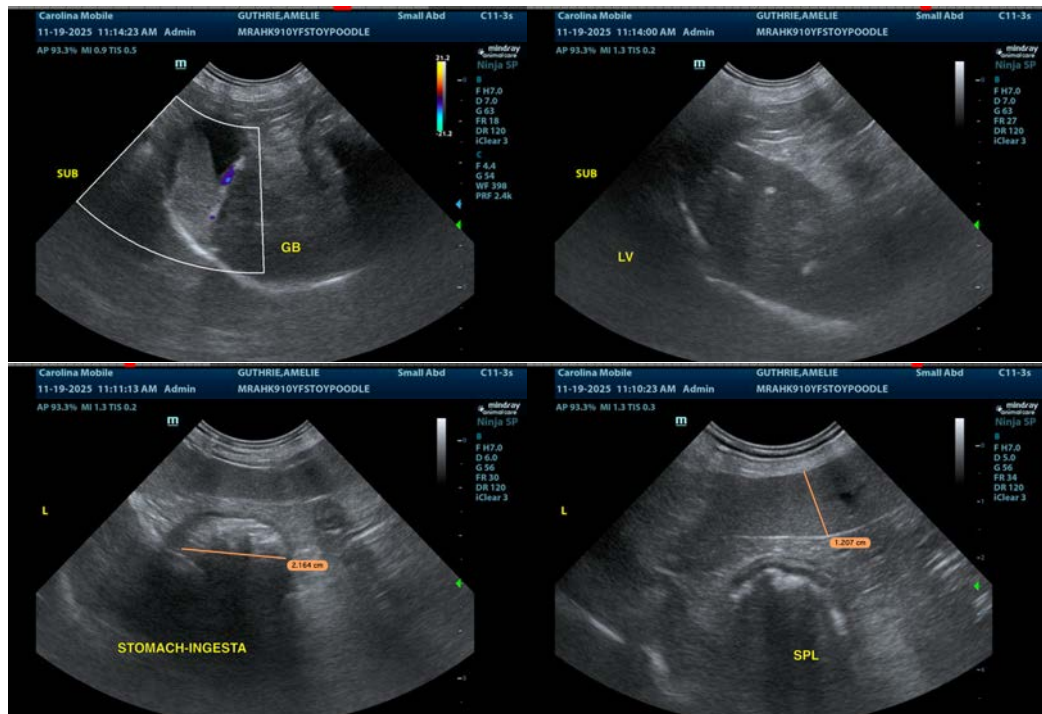
- Recommend a hydrolyzed protein diet.
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend chronic probiotic therapy.

If the diarrhea is acute in nature, consider parasite screening and a panel looking for infectious causes of diarrhea.

If symptoms are persistent despite empirical treatment for non-specific gastroenteritis/pancreatitis, then consider obtaining GI biopsies for further evaluation.

If desired, repeat imaging could be considered in the future, looking for progression of today's lesions or development of new lesions.

Recommend a urinalysis +/- urine culture.





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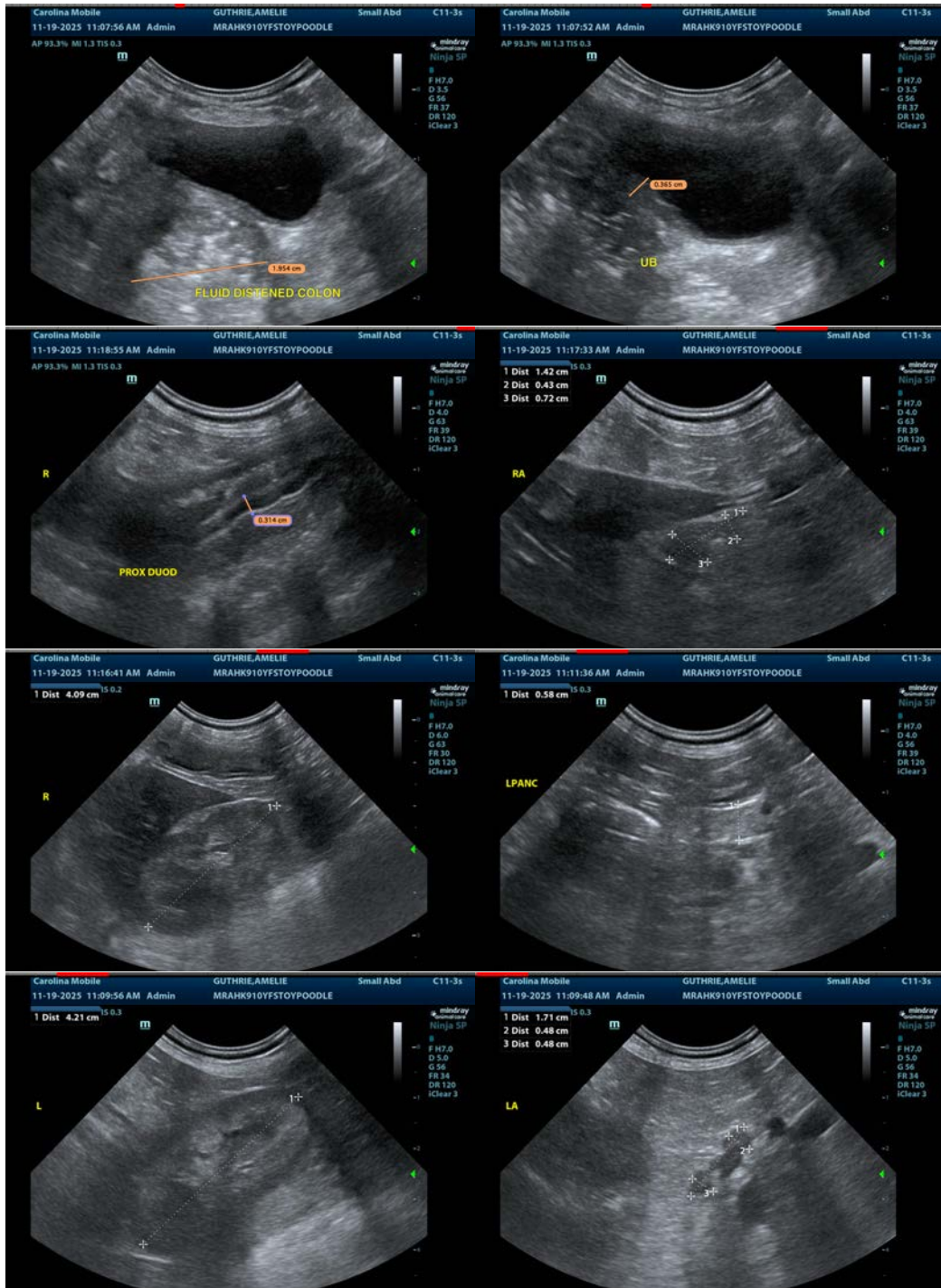
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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](mailto:info@sonopath.com)