



DATE PRESENTING CLINICAL SIGNS

11/20/25

Patient History: Presented for acute onset: vomiting (3x overnight), retching, episode of collapse ~3am - Subsequently vomited again, defecated in house (soft stool, one portion jelly-like), urinated in house with recent increased frequency/accidents - Recent wide-based gait, ataxia, left-sided head tilt, nystagmus (horizontal/rotary) - Client reports prior dental disease, chronic skin/food sensitivities (on Hill's Science Complete Derm for 2 yrs), possible arthritis - No history of trauma, opportunistic toxin ingestion, or fever noted

PATIENT

Bentley Smith

SPECIES

Canine

BREED

Bichon Frise

SEX

Neutered Male

Current Medications: Provable, Ondansetron, Pimobendan, Meclizine, Amlodipine, Convenia, Cerenia, Entyce.

Labwork Results: Labwork attached. AFAST: Noted gallbladder sludge. No effusion. Urinary bladder wall appears thick. TFAST: No pericardial or pleural effusion. No B lines noted. Three View Thoracic Radiographs: Noted significant cardiac enlargement with dorsal elevation of the trachea and tracheal carina. No overt sign of congestive heart failure, pneumonia, or neoplasia. Otherwise unremarkable geriatric thorax.

Date of Previous IntraPet Ultrasound: No previous.

Sedation: Not required to complete full diagnostic ultrasound.

Stat Report: Not requested.

Imaging Performed by: Rachel Brillhart, RDMS.

AGE

11/18/10

WEIGHT

25.4 lbs

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is minimally distended. The Bladder wall appears slightly thickened and irregular, measuring at 0.58 cm. In the region of the trigone there is an intact foley catheter. The catheter was flushed under video evaluation.

The visualized areas of prostate and surrounding tissue appear normal. Unfortunately, the prostate is not fully visualized likely due to its intrapelvic location. Correlate with rectal exam findings.

The left kidney is normal in size but irregular in shape, measuring 5.0 cm, with mild pyelectasia at 0.22 cm. Numerous small cortical cysts are present, a larger cyst measures 1.03 cm in diameter. Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is scant effusion in the region surrounding the left kidney. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.75 cm) with pyelectasia at 0.22 cm. Numerous pinpoint non-obstructive nephroliths are also noted and an occasional small cortical cyst. Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is mild fluid in the region around the kidney. There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

INTERPRETED BY

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

HOSPITAL NAME

Animal Emergency
Hospital

REFERRING VET

Dr. Perez

Adrenal Glands

The left adrenal gland is large, measuring 0.90 cm at the cranial pole and 1.93 cm at the cauda 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.

INVOICE

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The right adrenal gland is large, measuring 1.13 cm at the cranial pole and 1.29 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. No focal parenchymal abnormalities are visualized.

Liver

The liver is large in size, and normal in echogenicity with smooth peripheral margins. The parenchyma is 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 gall bladder lumen is significantly distended. Some areas of the wall appear mildly thickened with adherent debris. There is a large amount of primarily non-organized echogenic debris. There is no evidence of bile duct dilation.

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. Full evaluation of the stomach is not possible due to interference from the intraluminal shadowing ingesta. Ingested foreign material cannot be ruled out.

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 0.41 cm. Jejunum wall measures 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 visible/mildly mottled in the right limb. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

There is a small amount of free abdominal fluid. No significant lymphadenopathy. The omentum is diffusely hyperechoic.

Other

There is an irregular, somewhat poorly defined hypoechoic lesion in the caudal ventral abdomen measuring 5.14 cm x 2.5 cm.

The right auricle and pericardium were visualized and were unremarkable. No obvious pathology is visualized. If cardiac function evaluation is desired a full echocardiogram is warranted.

PRIMARY FINDINGS

- Mildly thickened/irregular 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.

- Bilateral adrenomegaly – The bilateral adrenomegaly could be consistent with bilateral hyperplasia (e.g., secondary to pituitary-dependent hyperadrenocorticism), bilateral infiltrative neoplasia, inflammatory adrenal disease, other. Correlation with clinical findings is recommended.
- Decreased corticomedullary distinction in both kidneys with small cortical cysts, small non-obstructive mineralizations, mild bilateral pyelectasia, and occasional small cortical cysts – Findings are most consistent with chronic renal disease. Pyelectasia of the kidney(s) could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.
- Large, heterogeneous liver – This has the appearance most consistent with a vacuolar hepatopathy. Other hepatopathies are possible.
- Large, distended gallbladder with a large amount of non-organized echogenic debris – A large amount of debris is evident in the gall bladder with no evidence of a mucocele or associated inflammation at this time. This could represent an early mucocele or cholestasis, with minimal evidence of associated inflammation at this time. Continued monitoring of labwork and ultrasound are warranted for progression of this lesion. Ursodiol therapy could be considered.
- Large, shadowing ingesta visualized within the gastric lumen – Findings are most consistent with a non-fasted patient. If the patient was adequately fasted, then consider such differentials as delayed gastric emptying or partial outflow tract obstruction (none observed).
- Mildly thickened small intestine – Findings could be normal for this individual or consistent with mild inflammation/enteritis.
- Small volume free abdominal fluid.
- Irregular, hypoechoic structure visualized in the caudoventral abdomen – The nature of this is unclear. Current appearance could be consistent with a hematoma (possibly secondary to cystocentesis?). Recommend continued monitoring.

SECONDARY FINDINGS

- Visible right limb of the pancreas, most consistent with pancreatic remodeling.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A definitive cause for the free abdominal fluid is not identified. Recommend sampling for fluid analysis and cytology.

The urinary bladder appears mildly thickened and irregular. Recommend a urinalysis and culture to further evaluate (I believe this is pending).

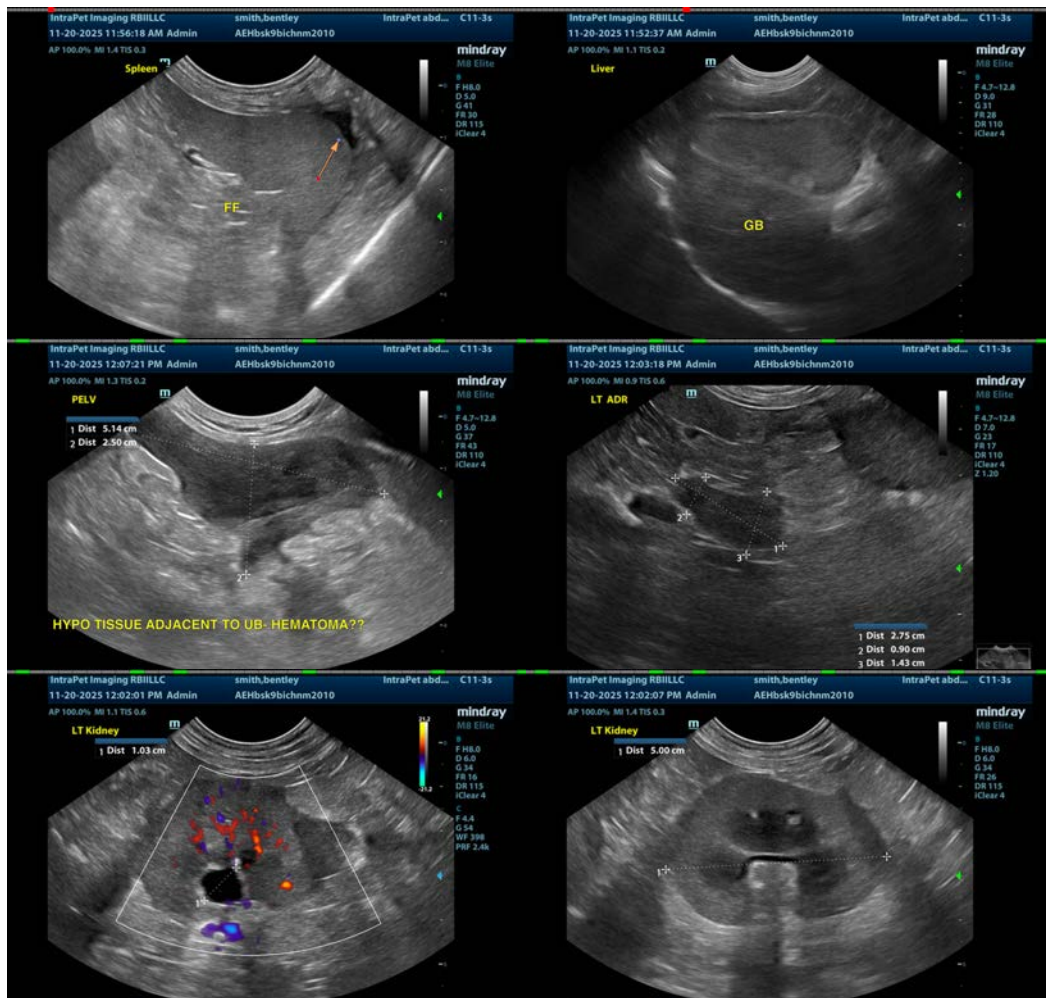
Additionally, both kidneys have changes consistent with chronic renal disease. Correlate these findings with the aforementioned urinalysis, culture, blood pressure (I believe hypertension is present), and urine protein to creatinine ratio.

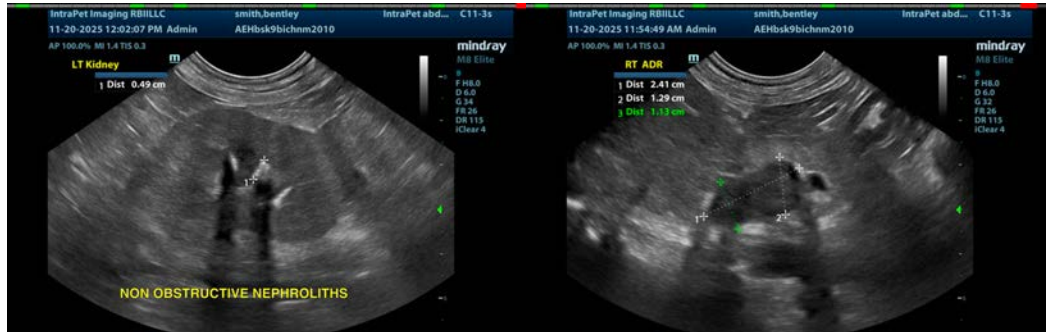
Both adrenals are large, and the liver is large and heterogeneous. These findings could be consistent with pituitary dependent hyperadrenocorticism. When the patient is feeling better, and if symptoms consistent with Cushing's are present, you could consider adrenal function testing.

There is a large amount of non-organized debris visualized in the gallbladder with no evidence of surrounding inflammation. Recommend starting chronic Ursodiol therapy and continued monitoring of the gallbladder for progression to a mucocele.

There is irregular, hypoechoic, amorphous tissue/echogenic fluid visualized in the caudoventral abdomen. At this time this has the appearance most consistent with a hematoma. Consider reevaluation in 2-3 weeks. If it has not improved in appearance at that time, consider a fine needle aspirate.

Recommend consultation with a veterinary neurologist regarding the neurologic symptoms described. If the hypertension reported is persistent, recommend antihypertensive therapy.





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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