PATIENT

Ethel Delong

SPECIES

Canine

BREED

Dachshund

SEX

FS

AGE

4 years

WEIGHT

12 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

MountainView Animal Hospital

REFERRING VET

Dr. Ashlie Brown

INVOICE

10811

DATE

11/21/2025

PRESENTING CLINICAL SIGNS

Patient has a history of pancreatitis and gastroenteritis. Her most recent cPL test was normal. She was seen about a year ago and was having monthly episodes of vomiting and lethargy. She was on a hydrolyzed diet and was transitioned to a low fat diet. She was doing well and being managed with Ondansetron, Omeprazole, Marshmallow Root and SP Pancreatrophin. Recently she had another bad bout which involved anorexia and vomiting of bile. Her most recent blood work was normal.

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 (3.83 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.

The right kidney has a normal shape and size (4.32 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 0.3 cm at the cranial pole and 0.46 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 0.37 cm at the cranial pole and 0.34 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 (1.72 cm) 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. 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 minimal luminal contents. It measures at a normal thickness of 0.29 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. The region of the esophageal inlet is visualized. The distal esophagus/cardia subjectively appears mildly thickened measuring at 0.8 cm. Clear visualization in this area is challenging.

Most of 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 (0.43 cm in wall thickness) and the jejunum measured as normal (0.24 cm.) Visualized peristalsis appears appropriate. Theres a section of small intestine which appears mildly/moderately fluid distended, and the wall appears more prominent/thickened with reduced detailed wall layering measuring at 0.28 cm.

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 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

Evaluation of the peritoneal cavity revealed scant free fluid. There was no lymphadenopathy. 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

- Mild pancreatic changes consistent with chronic pancreatic remodeling.
- Enteritis type changes visualized associated with the small intestine including a segmental fluid distension and mild wall thickening. An early neoplastic lesion cannot be ruled out.
- Questionable mildly thickened esophageal inlet. Differentials include imaging artifact, inflammation, less likely neoplastic change.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There's some mild thickening of the small intestine and a segmental area which appears mildly fluid distended. Findings are suggestive of an enteritis type pattern although early neoplastic change or a partial obstruction cannot be definitively ruled out. Recommend treatment for gastroenteritis. You could consider a combination of ultra low-fat/hydrolyzed protein prescription diet (royal canin makes this.) Additionally, you could consider a GI panel to Texas A&M for a PLI/TLI, cobalamin, and folate looking for evidence of underlying small intestinal disease and/or pancreatic inflammation.

The esophageal inlet appears somewhat prominent on imaging with question thickening. This would be concerning if there are symptoms consistent with regurgitation, etc. If symptoms are persistent consider upper GI endoscopy, both to evaluate the cardiac region of the stomach/distal esophagus,

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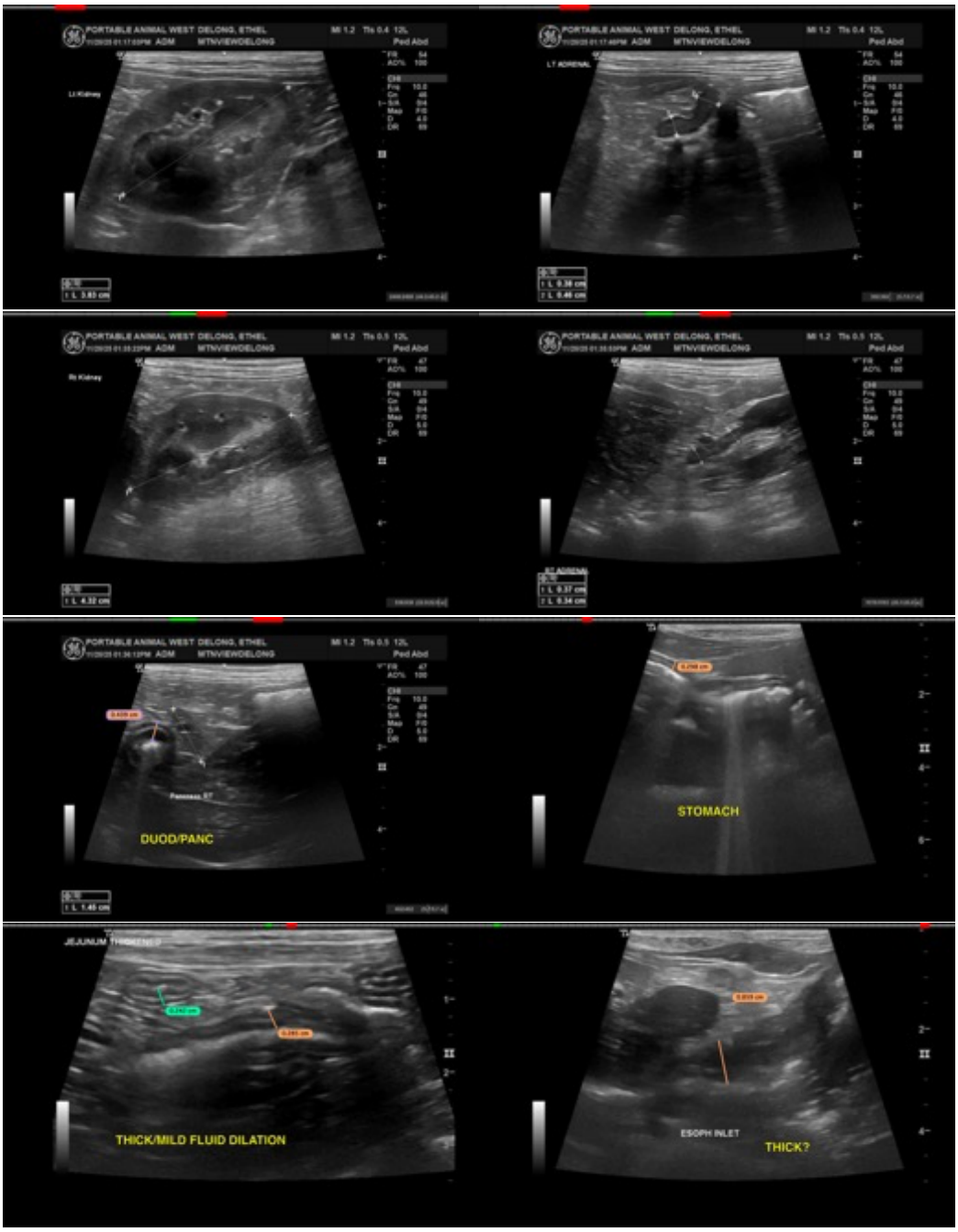
and the proximal GI tract, and to obtain biopsies for cytologic evaluation.



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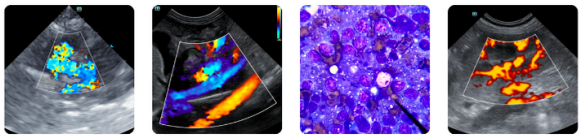

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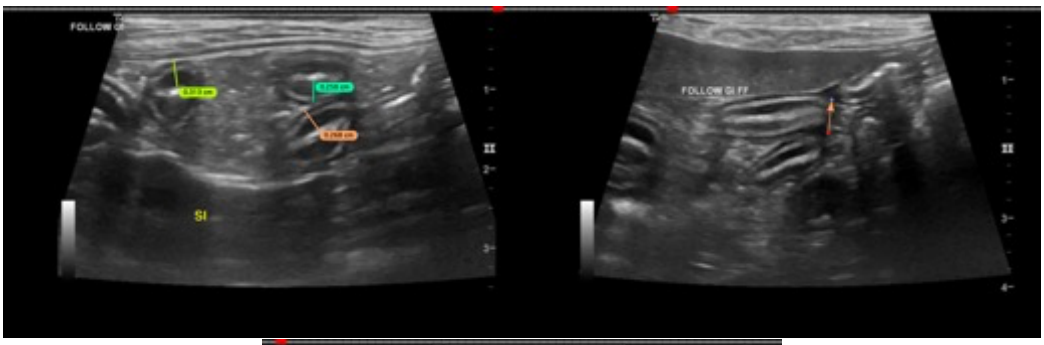

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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