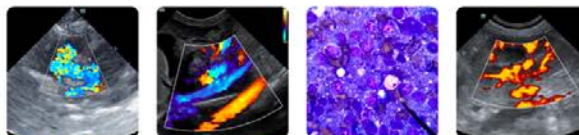



**PATIENT**

Sydney Rathman

**SPECIES**

Canine

**BREED**

Spaniel x

**SEX**

Spayed Female

**AGE**

5 Years

**WEIGHT**

28 kg

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Renee Trionfetti, VMD

**HOSPITAL NAME**

Blue Pearl Wyomissing

**REFERRING VET**

Heatherlynn McFarlane, DVM

**INVOICE**

72129

**DATE**

11/26/25

## PRESENTING CLINICAL SIGNS

AUS to further evaluate abdominal pain, acute onset of illness. Presented to the ER with an acute onset of vomiting, lethargy, and loss of appetite. Work-up confirmed Addisonian crisis. Tense and splinting repeatably during cranial abdominal palpation. Initial Doppler BP 60 mmHg, HR on ECG 58-65 w/ tall T-wave. Responded to initial stabilization, HR improved to 140, NSR. Hosp mgmt: DexSP, IVF, and supportive care

Abnormal PE/Chem/CBC/UA Results: Presenting BW 11/24/25 CBC: WBC 14.2K, Neut 9.14K, Lymph 3.57K, Mono 0.49K, HCT 58%, PLT 251K Chem: TP 7.1, Alb 3.8, Glob 3.3, Creat 4.8 (H), BUN 77 (H), ALT 216 (H), ALP 31, GGT 0, TBil 0.4, Chol 150, Na 136 (L), K 9.3 (H), Cl 100, Ca 11.7, Phos 11.1 ACTH: Pre Cortisol: <0.2, Post Cortisol: 0.2 Today's BW 11/26/25 EPOC: pH 7.397, PCO2 28.4, HCO3 17.5, Creat 1.01, BUN 14, Na 139 (L), K 4.7, Cl 113, iCa 1.27

## 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 (6.07 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 (6.75 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 “flat” measuring 0.33 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 “flat” measuring 0.59 cm at the cranial pole and 0.40 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 (1.95 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.

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## *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 gallbladder wall appears thickened, measuring at 0.49 cm. Luminal contents are mild and likely incidental at this time. The cystic and common bile ducts are normal/not visible.

## *Gastrointestinal*

The stomach contains minimal luminal contents. 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. No masses or focal lesions were observed.

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. Duodenum wall measures 0.29 cm. Jejunum wall measures 0.12 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

Sections of colon are visualized with non-formed fecal material and gas shadowing distally. The descending colon wall appears mildly thickened, measuring at 0.33 cm with intact wall layering.

## *Pancreas*

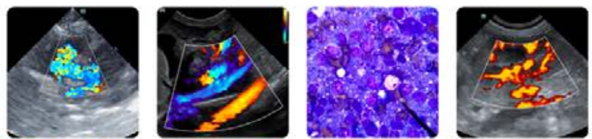
The pancreas is large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with moderate pancreatitis.

## *Free Abdomen*

There is a moderate amount of free abdominal fluid. No significant lymphadenopathy noted. A medial iliac lymph node is prominent measuring 0.78 cm. A lymph node near the spleen measures 1.0 cmx 0.84 cm. The omentum is mildly diffusely hyperechoic.

## ULTRASONOGRAPHIC FINDINGS

- Borderline “flat” adrenal glands – Findings are most consistent with Addison’s diagnosed.
- Prominent, hypoechoic, mottled pancreas with surrounding peripancreatic inflammation – Findings are most consistent with moderate pancreatitis in both limbs.
- Thickened gallbladder wall – Findings are most consistent with gallbladder wall edema.
- Prominent/thickened descending colon wall with intact wall layering – Findings are most consistent with wall edema or inflammation.
- Moderate volume free abdominal fluid.





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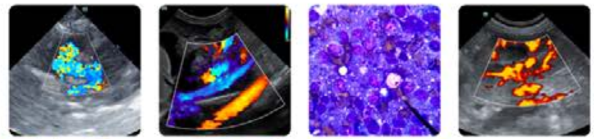
## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Both limbs of the pancreas are very prominent and hypoechoic, suggestive of pancreatitis possibly secondary to hypertension. Additionally, there is evidence of gallbladder wall edema and thickening of the colon wall possibly secondary to shock/hypotension. A source for the free abdominal fluid is uncertain. This could be secondary to pancreatitis. Consider fluid analysis and cytology and continued monitoring and support for the Addisonian crisis and pancreatitis.





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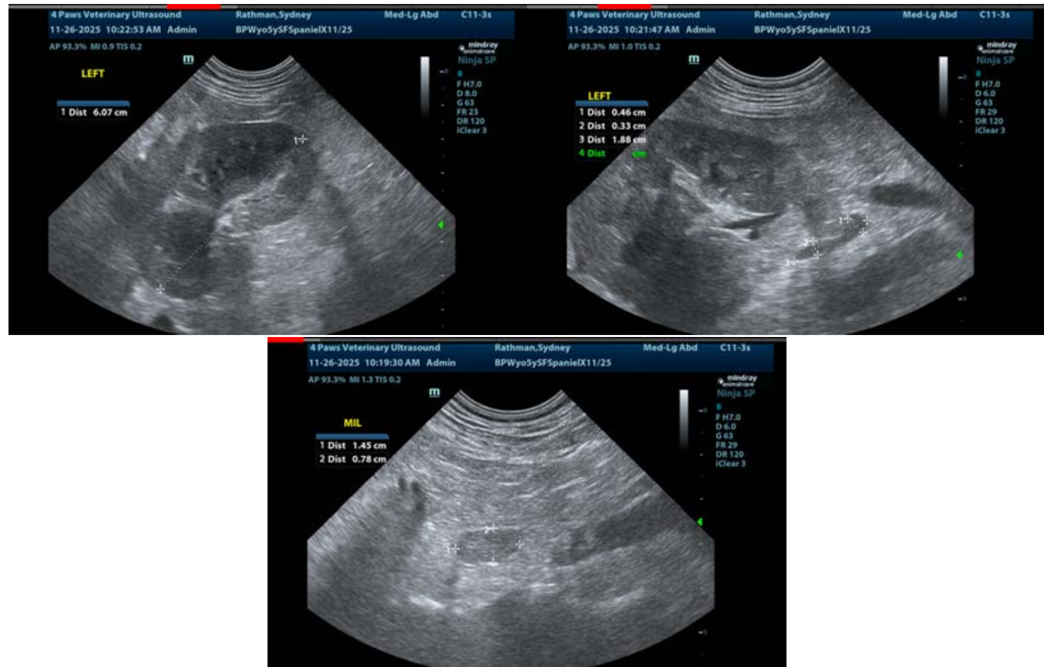


**The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.**

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