



PATIENT

Timber Pitcher

SPECIES

Canine

BREED

Lab

SEX

Intact Male

AGE

8 Months 1 Week

WEIGHT

27 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Jill Rankin

HOSPITAL NAME

Canyon Meadows Vet
Clinic

REFERRING VET

Dr. Laurina

INVOICE

72121

DATE

11/26/25

PRESENTING CLINICAL SIGNS

The patient presented for recurrent vomiting following a suspected foreign body ingestion approximately one week prior, with diagnostics revealing suspicious findings on abdominal radiographs. A week ago, the patient was evaluated at an emergency clinic for vomiting after reportedly swallowing cork pieces. Vomiting was induced at the emergency clinic, which produced grass, and the patient was managed with supportive care. The vomiting reoccurred on Monday night, and the owner also reported watery stool on Monday. The patient was brought into the clinic on Tuesday, and there have been no further episodes of vomiting since Monday night. The patient was able to eat and keep food down on Tuesday. Upon presentation, the patient's energy level was noted to be good. Blood work, including a random cortisol level, was normal. Abdominal x-rays were taken which revealed a suspicious object in the stomach. The patient had been fasted prior to the radiographs. An ultrasound is being considered to further investigate for a potential partial obstruction. The owner was instructed to withhold food as of 9 PM the night before the planned procedure.

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 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 has a normal shape and size (4.86 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 (4.81 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 0.41 cm at the cranial pole and 0.39 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 0.64 cm at the cranial pole and 0.48 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 (1.8 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 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.

Gastrointestinal

The stomach contains mild fluid/gas/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. There does appear to be some shadowing material visualized within the stomach, but no evidence of an outflow tract obstruction at this time.

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 0.52 cm. Jejunum wall measures 0.34 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 normal and isoechoic to surrounding mesentery. 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. There is a mild/moderate diffuse lymphadenopathy. A lymph node in the left cranial abdomen measures 0.95 cm x 1.91 cm. A jejunal lymph node measures 0.83 cm x 1.94 cm. The omentum is generally of normal echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Mild fluid/gas/ingesta visualized within the gastric lumen – No evidence of an obstruction at this time. A small amount of shadowing material is present.
- Suspect juvenile lymphadenopathy. A neoplastic lymphadenopathy is much less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a small amount of gas, fluid and shadowing ingesta visualized within the stomach. The nature of this material is uncertain. There is fluid visualized within the pylorus, but no evidence of an outflow tract obstruction. Options at this point include continued monitoring with gradual return to normal activity with reevaluation if vomiting reoccurs, or you could consider an upper GI endoscopy to further investigate the nature of the shadowing material.



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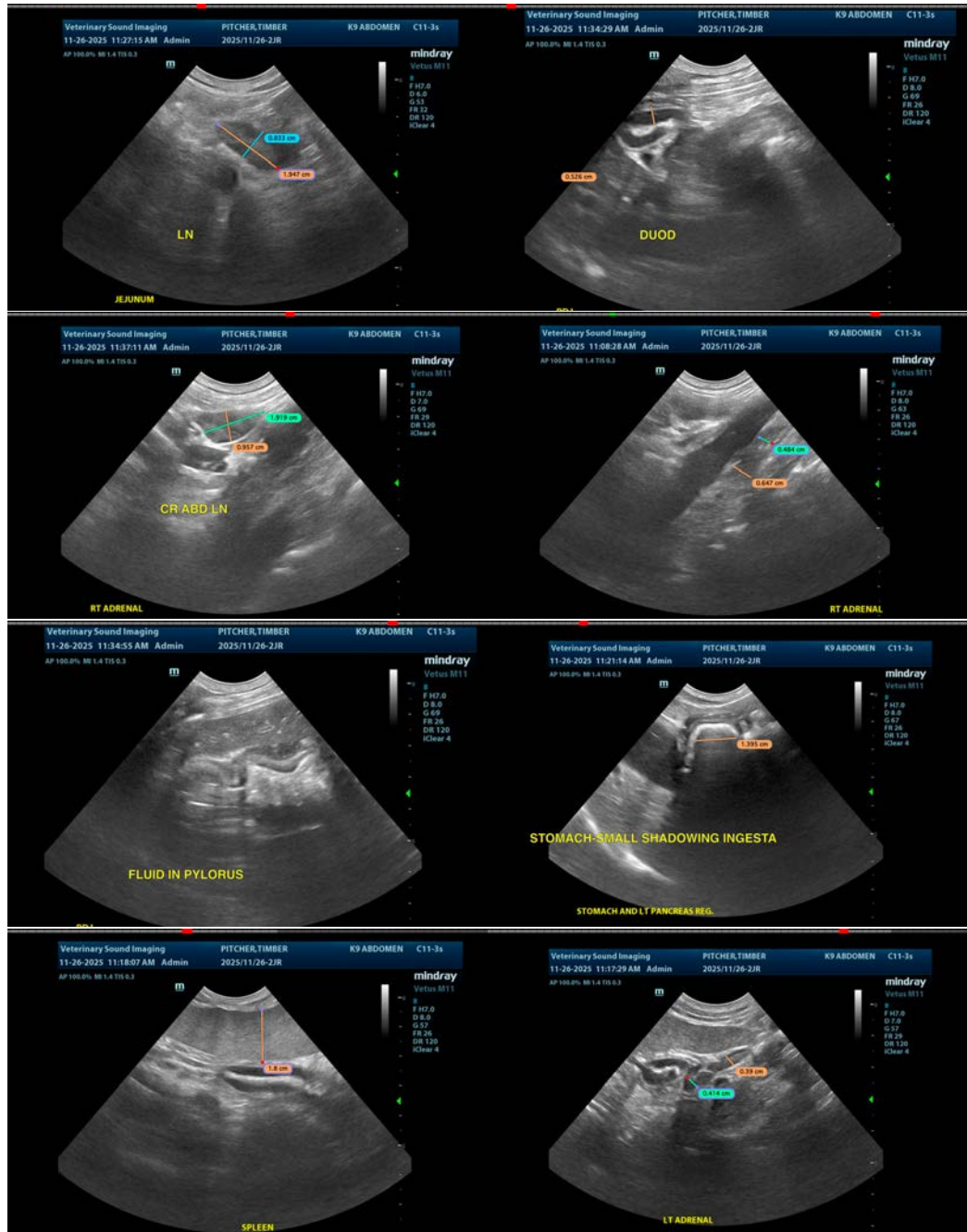
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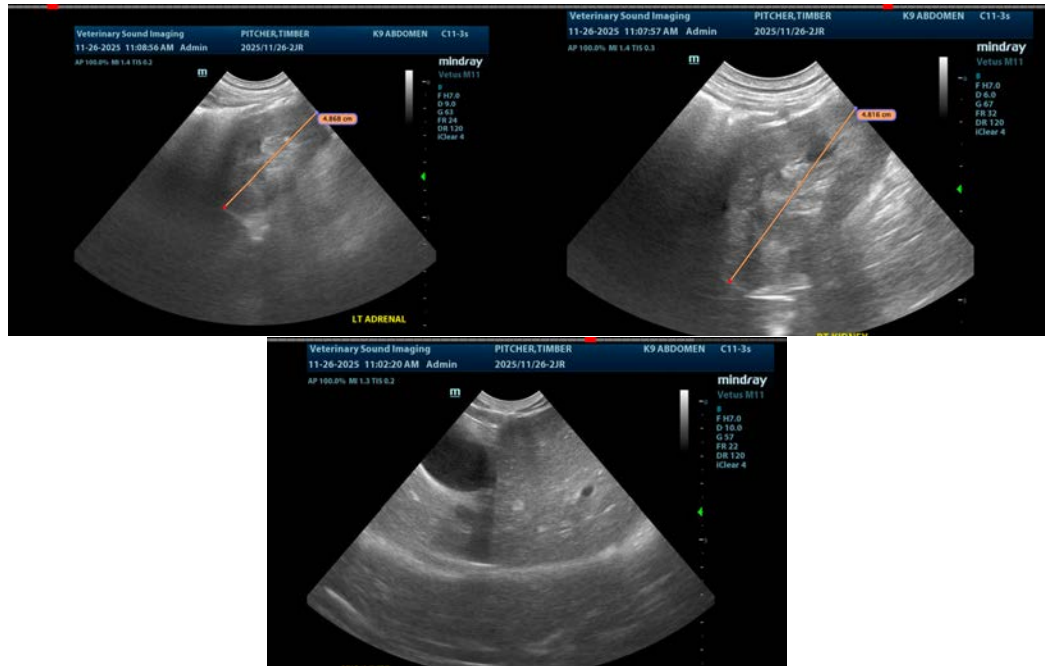
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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