



PATIENT

Coco Guzman Perez

SPECIES

Canine

BREED

West Highland
White Terrier

SEX

Spayed Female

AGE

9 Years

WEIGHT

15.2 Pounds

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Dr. G. Ferrer

HOSPITAL NAME

Paseos Vet Center

REFERRING VET

Dr. Francisco Ortiz
Vidal

INVOICE

42527

DATE

11/3/22

PRESENTING CLINICAL SIGNS

Patient presented for evaluation of vomiting and an abdominal ultrasound was done to further evaluate. Patient has been vomiting with frank blood about 5 times with no history of diet change or intoxication.

Abnormal PE/Chem/CBC/UA Results: radiographs - no evidence of overt dz incidental mild microhepatica CBC - RBC 10.05M/uL ; HCT 63.3% ; HGB 21.2g/dL ; RDW 22% ; Retic 111.6k/uL ; MPV 13.5fL Chem - SDMA 20ug/dL

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 (4.29 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 (4.59 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 0.43 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 relatively normal in size measuring 0.67 cm at the cranial pole, 0.30 cm at the caudal pole, and 2.0 cm in length. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is abnormal in appearance in that there is a hyperechoic nodule in the cranial pole measuring 0.67 cm x 0.96 cm. There is no evidence of vascular invasion visualized.

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 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. There is a moderate amount of non-organized echogenic debris. 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 0.28 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. 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 0.39 cm. Jejunum wall measures 0.36 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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 prominent and mottled compared to the surrounding isoechoic 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, 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.

Other

There is a small hypoechoic structure in the cranial abdomen measuring 0.73 cm in diameter. This could be a benign omental cyst, a hypoechoic lesion in the liver, or could be associated with the pancreas or a lymph node.

ULTRASONOGRAPHIC FINDINGS

- Prominent, mottled pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.
- Mild gallbladder debris – The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting but seems unlikely to be causing a current issue. Recommend continued monitoring.
- Hyperechoic nodule in the cranial pole of the right adrenal gland – Adrenomegaly could be consistent with neoplasia (e.g., adenoma, carcinoma, pheochromocytoma), hyperplasia, inflammation, other.
- Hypoechoic, likely cystic structure in the cranial abdomen – I suspect this is a benign omental cyst, but I cannot rule out a liver, pancreatic, or cystic lymph node. Recommend continued monitoring.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized associated with the gastrointestinal tract to explain the hematemesis reported. The pancreas appears somewhat prominent and mottled. Correlate this with a cPL level and



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recommended treatment for acute pancreatitis and acute gastroenteritis (HGE/acute hemorrhagic diarrhea syndrome). What is concerning is that there has not been any diarrhea reported at this point. Sometimes this lags behind the other symptoms. If vomiting is persistent, consider an upper GI endoscopy to further evaluate the stomach, esophagus, and proximal small intestine.

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Consider the following possible differentials for hematemesis: Gastric ulceration secondary to medications (NSAIDs, etc.), secondary to foreign body ingestion, Addison's disease, GI neoplasia, IBD, coagulopathies, etc.

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There is a hyperechoic nodule visualized in the cranial pole of the right adrenal gland. I suspect this is incidental at this time and not related to the current symptoms, but this could still be a benign lesion, an early neoplastic lesion, a hormone secreting lesion, or a non-active lesion. Consider the following steps once this patient is recovered from its GI signs and feeling significantly better:

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- If signs of cushings are present, consider adrenal function testing. I prefer an ACTH stimulation test combined with an adrenal panel to the University of Tennessee's endocrine lab to look for atypical adrenal hormones as well as cortisol. (other testing can suffice)

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- If adrenal dependent cushings is suspected and supported by adrenal function testing consider medical therapy with lysodren or trilostane or consider surgical removal (recommend referral to a board certified veterinary surgeon and possible pre op CT)

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- Recommend blood pressure evaluation-if hypertensive consider testing catecholamine levels for a possible pheochromocytoma

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- If no symptoms of cushings are present, consider either referral for surgery or continued monitoring with ultrasound (in 3-4 months).

- Many of these nodules can be benign and incidental in nature, unfortunately that is difficult to determine with a single ultrasound.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement.

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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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