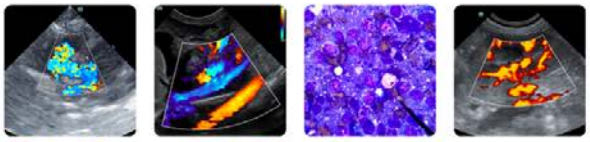

PATIENT

Stella Rickey

SPECIES

Canine

BREED

Dachshund x

SEX

Spayed Female

AGE

16 Years

WEIGHT

10.4 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Megan Cassels-Conway, DVM

HOSPITAL NAME

Central Broward Animal Hospital

REFERRING VET

Megan Cassels-Conway, DVM

INVOICE

71642

DATE

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PRESENTING CLINICAL SIGNS

Intermittent vomiting progressed over past few days to daily. Zofran helps but P will vomit food few hours after eating if not given daily. Currently on I/D low fat diet. No murmur/arrythmias, clear lung sounds. Significant dental disease. KCS of OD. OA hindlimbs. CKD stage 2. Received dexdomitor 200ug/kg and butorphanol 0.2mg/kg IV prior to ultrasound.

Abnormal PE/Chem/CBC/UA Results: 11/6/25: Radiographs 1. Concern for underlying gastrointestinal paralytic ileus that could be associated with gastroenteritis, toxicity, or pancreatitis. 2. Persistent left-sided cardiomegaly consistent with mitral valvular endocardiosis. 3. Persistent bronchial pattern suggesting fibrosis or mild inflammatory/infectious lower airway disease. 4. Persistent redundant dorsal tracheal membrane could represent incidental finding or component of tracheomalacia and dynamic upper airway collapse. 5. Limited assessment of the hind limbs with evidence of left stifle effusion and osteoarthrosis. 11/4/25: CBC: HCT 63% CHEM: ALT 135, Creat 1.8, SDMA 19.3, K 5.6 T4: WNL U/A: 1.016, 1+ protein

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 (3.34 cm) with occasional small cortical cysts and hyperechoic medulla. Overall echogenicity is slightly hyperechoic with poor 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.

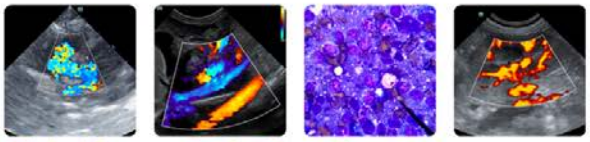
The right kidney has a normal shape and size (3.51 cm) with occasional small cortical cysts and hyperechoic medulla. Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. 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 0.33 cm at the cranial pole and 0.52 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 0.43 cm at the cranial pole and 0.42 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



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The spleen is subjectively normal in size (1.25 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.

Liver

The liver is subjectively borderline large in size, and normal in echogenicity with smooth peripheral margins. The parenchyma is homogenous echotexture. The visible portions of the vasculature and biliary tract appear normal. There is a hypoechoic nodule visualized in the left cranial aspect of the liver measuring 1.12 cm in diameter.

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.

Gastrointestinal

The stomach contains a moderate/large amount of fluid. The gastric wall appears slightly prominent and hyperechoic, measuring at 0.52 cm with intact wall layering. 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 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 0.42 cm. Jejunum wall measures 0.41 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 mildly prominent and slightly hyperechoic in the left 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 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.

ULTRASONOGRAPHIC FINDINGS

- Bilateral renal changes consistent with chronic age related renal disease.
- Hypoechoic nodule in the left cranial aspect of the liver – The significance of this lesion is uncertain. This has the appearance most consistent with a benign lesion, but an early neoplastic lesion cannot be ruled out.
- Moderate 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.

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- Fluid distended stomach with a slightly prominent wall with intact wall layering – Correlate with feeding/drinking history. If the patient was adequately fasted, this could represent delayed gastric emptying or partial outflow tract obstruction (none visualized). The gastric wall changes could be consistent with mild gastritis.

- Mild diffuse small intestinal thickening – The mild small intestinal wall changes may be a normal variant in this patient or could be consistent with an inflammatory process (e.g., inflammatory bowel disease).

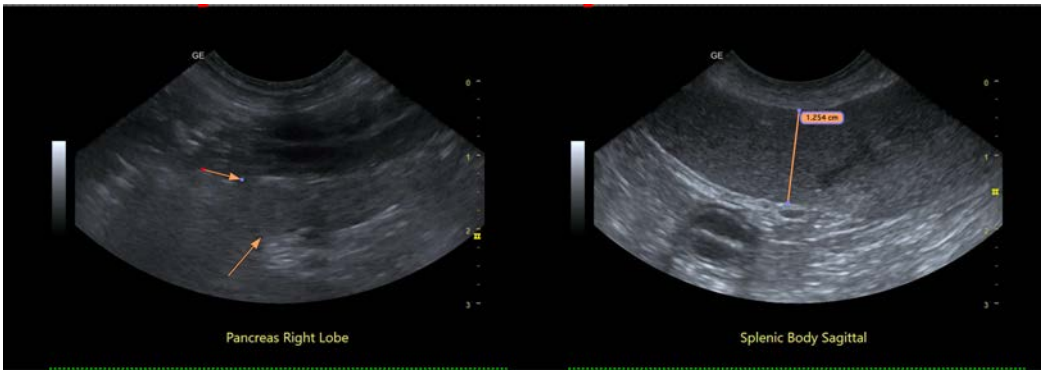
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A definitive lesion responsible for the reported vomiting is not observed. The stomach is significantly fluid distended, and there is very subtle inflammation in the region of the pyloroduodenal junction. No evidence of overt pancreatic inflammation is evident in this region, but there could be mild focal pancreatitis/gastroenteritis. The stomach is significantly fluid distended, indicating some level of likely gastric ileus. Consider a hypoallergenic diet (Royal Canin makes a hydrolyzed protein/ultra low-fat diet). Additionally consider a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate. If PLI elevations are present, consider concurrent treatment for possible mild pancreatitis.

If B12 levels are low, there could be a concurrent enteropathy, and biopsies of the GI tract may be warranted.

There are bilateral renal changes consistent with chronic renal disease. If not already done, recommend a urinalysis, culture, blood pressure, and urine protein to creatinine ratio as a baseline.

There is a hypoechoic nodule visualized in the left cranial aspect of the liver. I suspect this is not in an area that is easy to sample. Consider continued monitoring (recheck ultrasound in 2-3 months). If a safe window for sampling is available, consider a fine needle aspirate.



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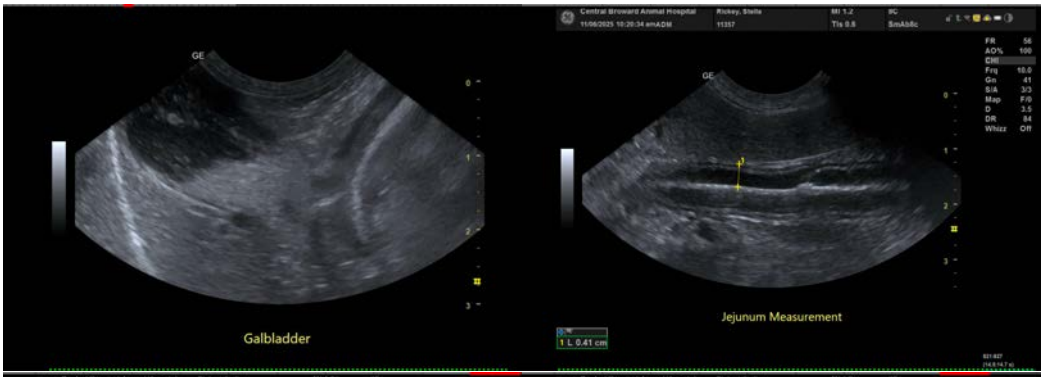

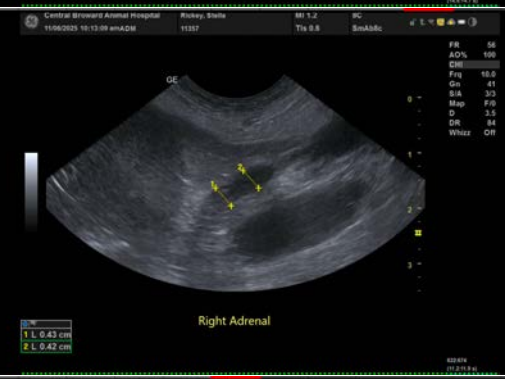

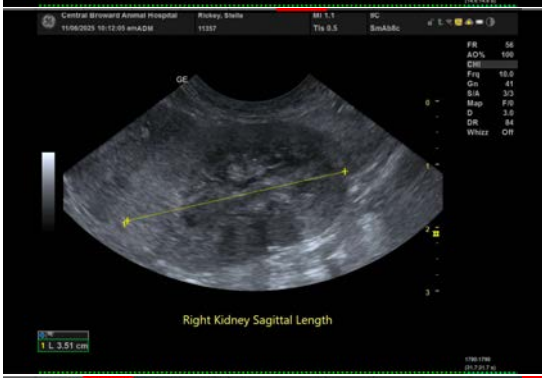

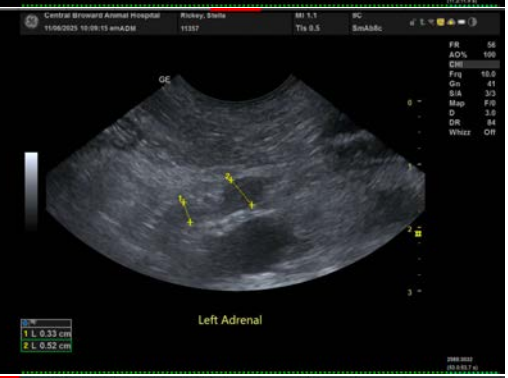

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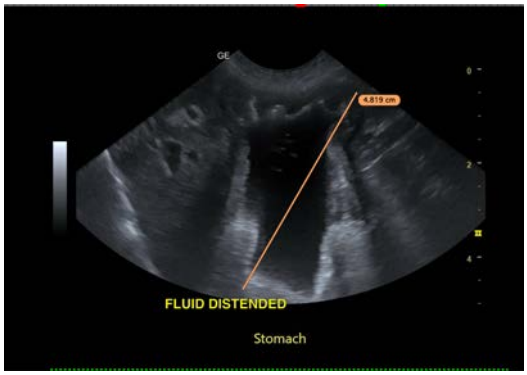

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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