



PATIENT

Spankey Kramer

SPECIES

Canine

BREED

Toy Fox Terrier

SEX

Neutered Male

AGE

4 Years

WEIGHT

3.72 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Melissa Randolph

HOSPITAL NAME

Shores Veterinary
Emergency Center

REFERRING VET

Dr. Logan Law

INVOICE

72526

DATE

12/12/25

PRESENTING CLINICAL SIGNS

*P was hosp here 11/26-11/28 for severe acute hemorrhagic diarrhea syndrome and severe dehydration. After P went home he started vomiting directly after eating and has continued to today. P was seen by the RDVM on 12/11 and was given cerenia inj. P continued to vomit though the cerenia. O has been feeding Hill's ID, ground turkey and hamburger. P has been holding down water well and has no aversion to food with good appetite. *admitted for supportive care, iv fluids, cerenia, pantoprazole. *concern for sever gastroenteritis, gi fb, intussusception, gi parasites, other

Abnormal PE/Chem/CBC/UA Results: *PE: comfortable, BCS 5/9, soft on abdominal palpation *epoc: electrolytes WNL, lactate 3.15 *epoc 12/12 4 am: K+ 5.2 *rads: Stomach empty. Suspicious appearance with possible soft tissue density material in proximal duodenum on multiple views. Scant stool in gas filled descending colon. Remainder of small intestines appear WNL. No other abnormalities.

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 (3.34 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 (3.27 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 0.34 cm at the cranial pole and 0.32 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 0.49 cm at the cranial pole and 0.41 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 (0.90 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 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.

Most of the visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal to mild 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 0.30 cm. Jejunum wall measures 0.25 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 area of 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, 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

- Mild enteritis type pattern visualized associated with the small intestine.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized associated with the GI tract to explain the vomiting that is occurring. The stomach appears empty. There is no visible obstruction evident at the level of the pylorus, although a small, partially obstructive lesion, stricture, small mass effect, etc. cannot be definitively ruled out. You could consider a barium swallow to further interrogate this region. Additionally, if thoracic radiographs have not been done to screen for esophageal disease, etc., this could be considered (is regurgitation an option?). If a baseline cortisol has not been evaluated, this should be considered.

Alternate evaluation to consider could include an upper GI endoscopy. Biopsies of the upper GI tract could be obtained at the same time. Alternately a contrast CT scan could be considered.



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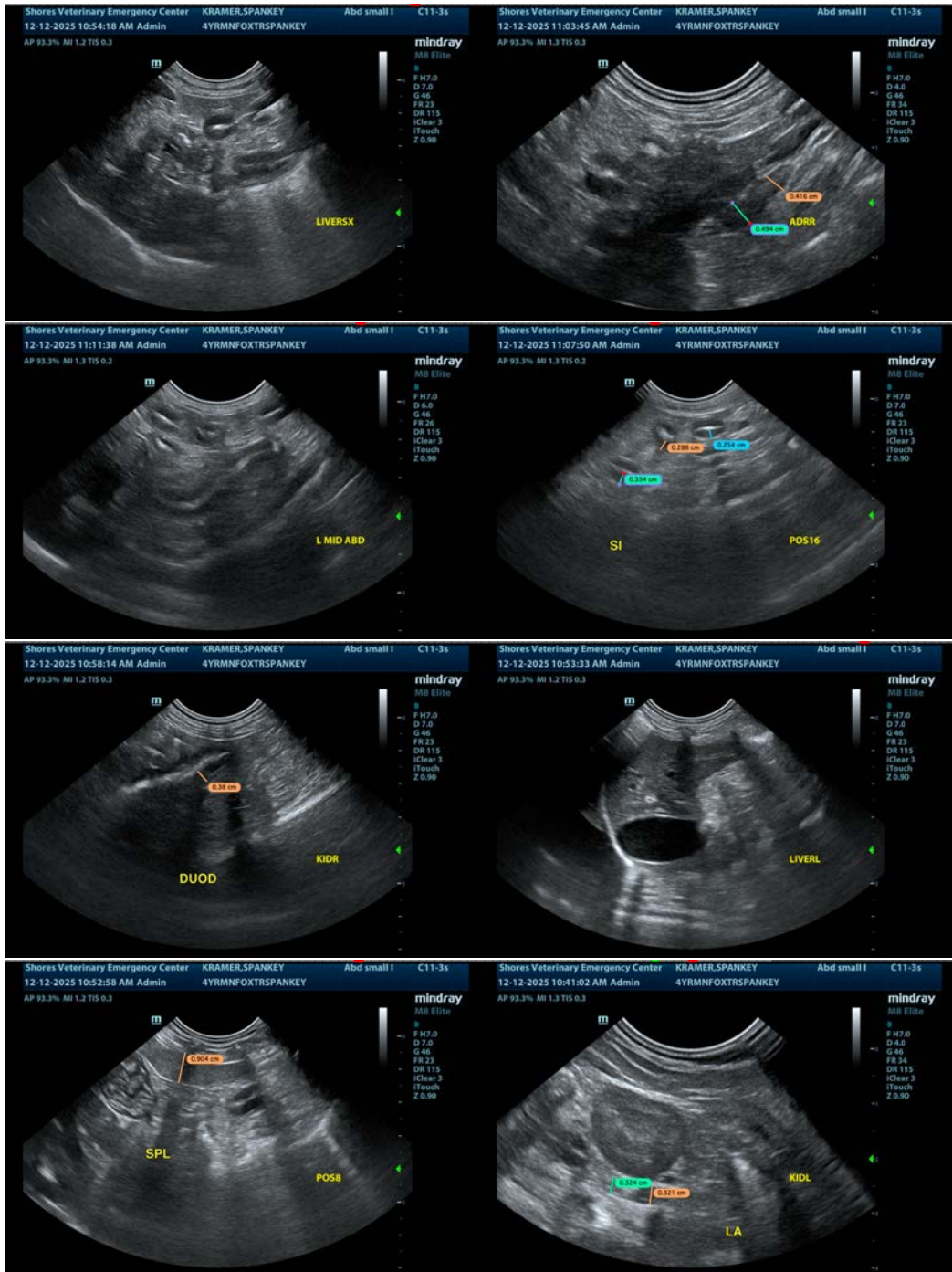
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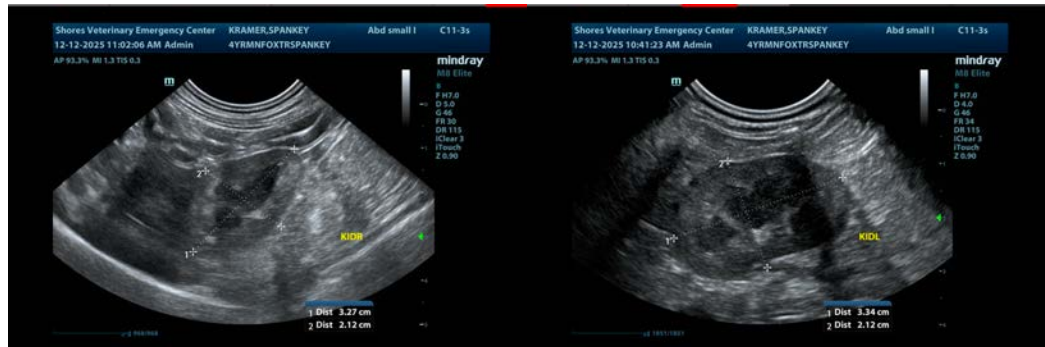
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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