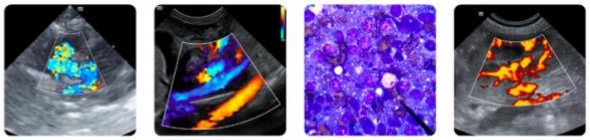


PATIENT

Chance Kennedy

SPECIES

Canine

BREED

Labrador Retriever Mix

SEX

Neutered Male

AGE

11 Years

WEIGHT

12.9 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Kuzimski

HOSPITAL NAME

Animal Emergency Hospital Deland

REFERRING VET

Dr. Kuzimski

INVOICE

12749

DATE

12/19/25

PRESENTING CLINICAL SIGNS

Starting Sunday, patient began to act off. he's been vomiting since Sunday. BW on 16th had no profound changes but radiographs revealed suspected gallstone and possibly something in the stomach. concerningly, he was given an injection of Cerenia on Tuesday but still vomited that night

Abnormal PE/Chem/CBC/UA Results: Abdomen: Tense on palpation. No overt organomegaly appreciated Bloodwork: CBC. owner declined Chemistry owner declined EPOC owner declined Radiographs. N/A Other: CpLi. owner declined

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 2.0 cm) 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 (4.61 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of 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 (4.86 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of 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 0.35 cm at the cranial pole and 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.

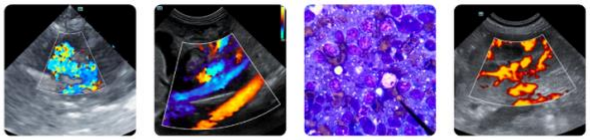
The right adrenal gland is normal in size. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

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. The spleen measured 1.56 cm width.

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.



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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. There is a focal shadowing choleolith visualized amongst the debris measuring 1.33 cm in diameter. The bile duct is not clearly visualized.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of <0.7 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.

Most of the areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal to mild fluid/gas distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis: mucosa layer ratio. The duodenum measured as normal (0.41 cm in wall thickness) and the jejunum measured as normal (0.30 cm) Visualized peristalsis appears appropriate. The proximal duodenum appears mildly fluid distended with mildly reduced progressive motility. No evidence of an obstructive pattern is visualized.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with shadowing fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The left limb of the pancreas is visible/mildly 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.

ULTRASONOGRAPHIC FINDINGS

- Visible/mildly mottled left limb of the pancreas- findings are most consistent with mild pancreatic remodeling +/- chronic pancreatitis.
- Gallbladder choleolith visualized in the gallbladder- this is likely an incidental finding. Recommend continued monitoring.
- Mild fluid distention of the proximal duodenum with nonprogressive motility- findings could be consistent with mild ileus/enteritis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The majority of the GI tract appears relatively normal with no evidence of significant fluid distention or an obstructive pattern. The proximal duodenum appears mildly fluid distended with some nonprogressive motility. Findings are most consistent with focal ileus/enteritis although an unseen foreign material cannot be ruled out.

Correlate today's findings with abdominal radiographs and clinical assessment. Recommend

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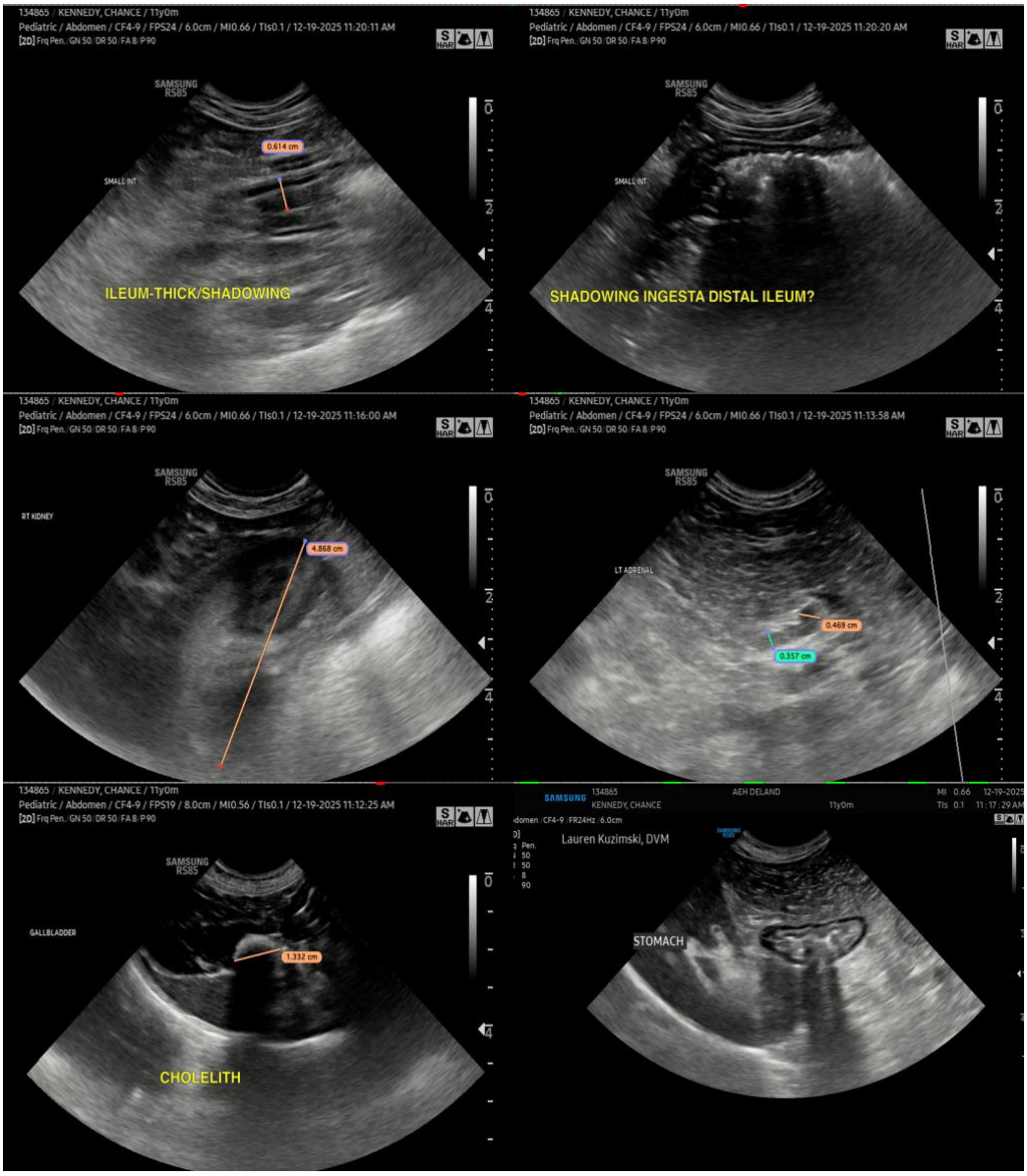
hospitalization with supportive care, IV fluids etc.. with treatment for enteritis +/- pancreatitis. If symptoms are persistent follow up US evaluation could be considered to reassess the lesions observed and to look for the development of new lesions.



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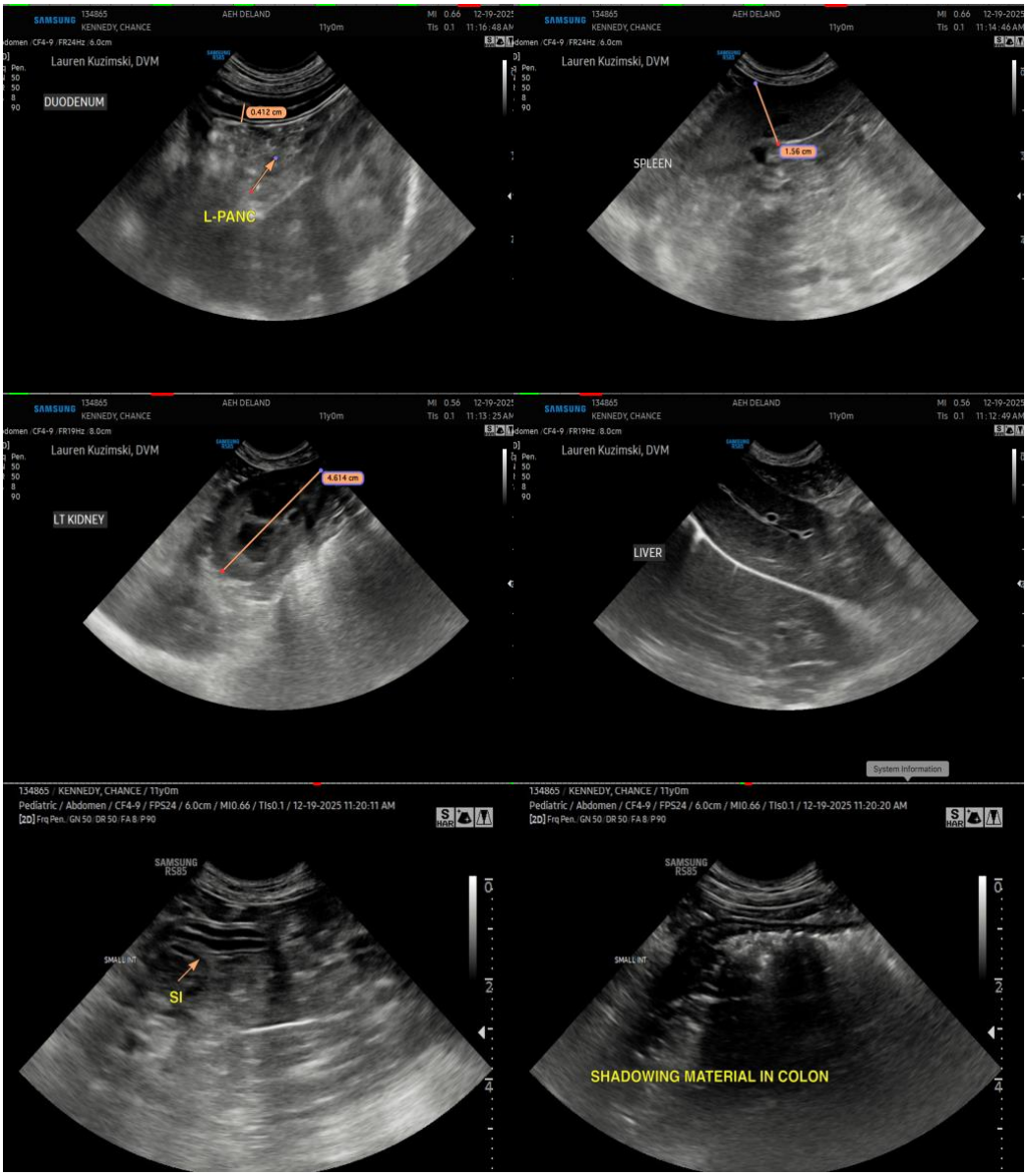

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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