



PATIENT

Liza McFarland

SPECIES

Canine

BREED

Boston Terrier

SEX

Spayed Female

AGE

2 Years

WEIGHT

8.63 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

72264

DATE

12/3/25

PRESENTING CLINICAL SIGNS

Started vomiting saturday- gave cerenia and it improved. had new petco treats. diarrhea starting sunday. not much of an appetite, syringe feeding baby food. started to eat chicken/rice last night. came home today to bloody diarrhea. No prior health concerns. admitted for supportive care, iv fluids with KCl, cerenia, buprenorphine, ondansetron, diphenhydramine, denamarin, unasyn, metronidazole. has regurgitated 3 times since admitted. *concern for Hepatopathy r/o anaphylaxis vs. toxin vs. CBD obstruction secondary to duodenal foreign body; less likely infectious (hepatitis, leptospirosis); Hematemesis, hematochezia; AHDS; dietary change (new treats); Electrolyte derangements

Abnormal PE/Chem/CBC/UA Results: *PE: pain 2/4 Mild Pain, cranial abdominal *CBC: LYM 0.29, MONO 2.16, EOS 0.01, *CHEM15: GLU 159, ALT > 1000, ALP 229, GGT 18 *ALT Dilution 1244 *EPOC: PO2 63.4, 90.9, PH 7.353, Na 138, K 2.8, Cl 105, Glu 164 *CPL: WNL *rads: Serosal detail is adequate, the stomach is moderately distended with heterogenous material (food vs. foreign) and dilated at the level of the pylorus. The SI is diffusely dilated and fluid filled but is a single population. Liver, kidneys, spleen, urinary bladder appear WNL *pt/aapt: WNL *epoc 12/3 5 am: electrolytes WNL, hct 37%

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 (4.72 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 (5.21 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 region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.

The right adrenal gland is normal in size measuring 0.49 cm at the cranial pole and 0.68 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 (1.52 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 heterogenous in echotexture with subtle, indistinct focal mottling. 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 a large amount of fluid. 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.

Some 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 0.45 cm. Jejunum wall measures 0.34 cm. Visualized peristalsis appears appropriate. No focal lesions are visualized. Some areas have mild to moderate fluid and gas distention, most consistent with an enteritis type pattern. A partial obstruction or similar cannot be ruled out.

Sections of colon are visualized with non-formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The right limb of the pancreas is prominent and hypoechoic as 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. There is no evidence of a diffuse lymphadenopathy. A prominent mesenteric lymph node is visualized measuring 1.04 cm. The omentum is mildly diffusely hyperechoic.

ULTRASONOGRAPHIC FINDINGS

- Prominent, hypoechoic right limb of the pancreas – Findings are most consistent with pancreatic remodeling. Mild pancreatitis is possible.
- Heterogeneous liver – The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, fibrosis, extramedullary hematopoiesis, toxic hepatopathy (e.g., copper), infiltrative neoplasia (less likely) or other hepatopathy.
- Large fluid distended stomach – Correlate with feeding/drinking history. If the patient was adequately fasted, this likely represents delayed gastric emptying. An outflow tract obstruction is not visualized but cannot be definitively ruled out.
- Enteritis type pattern visualized associated with the small intestine.



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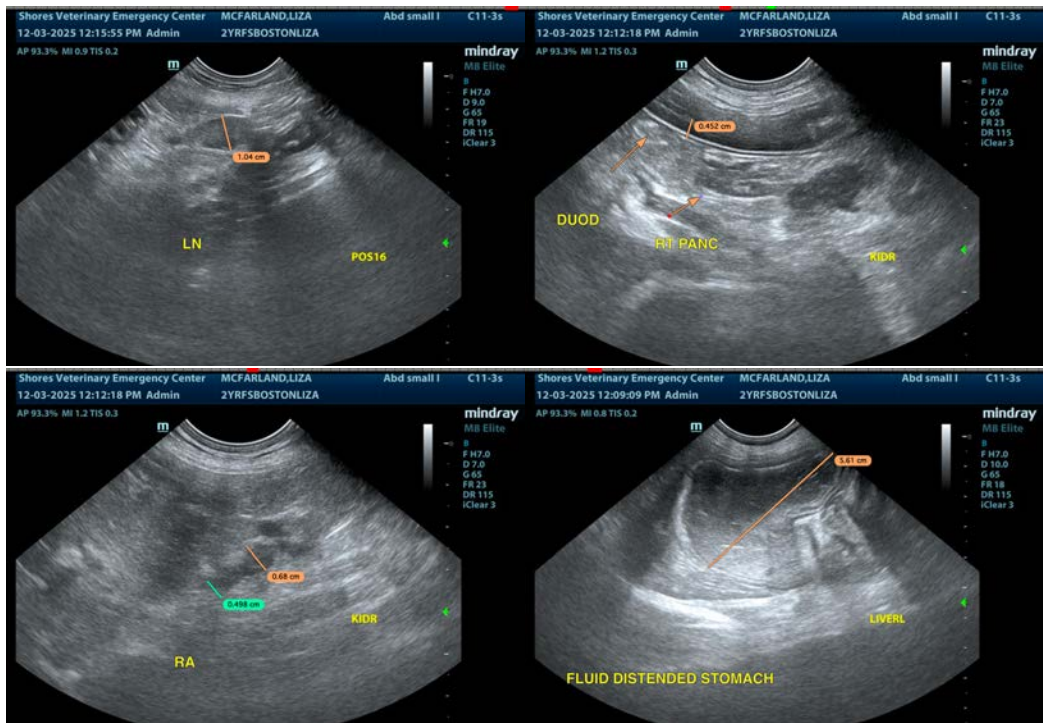
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The liver appears mildly heterogeneous. No focal lesions are visualized to explain the elevation in ALT reported. Recommend treatment for acute liver injury with Ursodiol, Denamarin and antibiotics, as well as supportive care and screening for Leptospirosis.

The stomach is significantly fluid distended. Consider passing a nasogastric tube and decompressing the stomach and starting prokinetic therapy. No evidence of an outflow tract obstruction is visualized but this cannot be definitively ruled out.

The right limb of the pancreas is prominent and hypoechoic, possibly consistent with mild pancreatitis. Recommend concurrent treatment for pancreatitis and gastroenterocolitis.

If symptoms are persistent and liver enzyme elevations do not improve with empirical treatment, surgical biopsies of the liver and evaluation for a focal GI lesion may be warranted. Prior to this, you could consider repeat imaging, looking for the progression of today's lesions or the development of new lesions.





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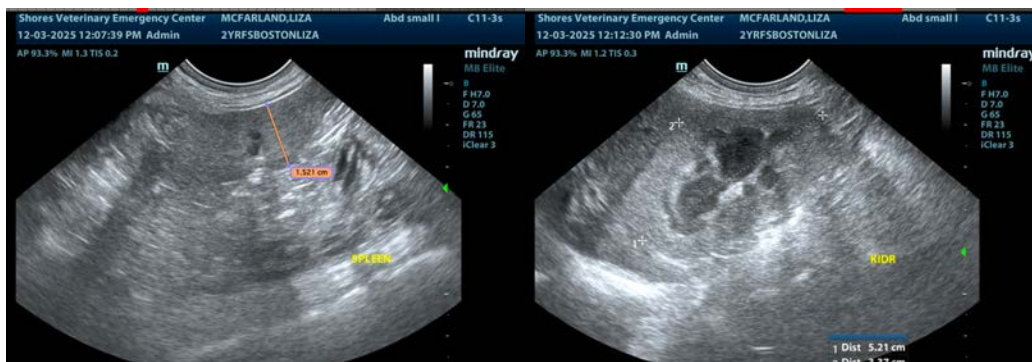
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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