

**PATIENT**

Sierra Royce

**SPECIES**

Canine

**BREED**

Chihuahua Mix

**SEX**

FS

**AGE**

7 years

**WEIGHT**

20 lbs

**INTERPRETED BY**

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

**IMAGING  
PERFORMED BY**

Loetitia Saint-Jacques,  
LVT

**HOSPITAL NAME**

South Reno Veterinary  
Hospital

**REFERRING VET**

Dr. Schmitt

**INVOICE**

10853

**DATE**

12/3/2025

**PRESENTING CLINICAL SIGNS**

P has had a hard time pooping. Drinking a lot water and her stool is watery. O reports that P belly has been getting bigger/ feels bloated over the last few months. O reports that the belly feels hollow and sometimes feels very hard. Assessment: Distended abdomen. Finicky eater behavior versus disease process.

Abnormal PE/Chem/CBC/UA Results: LABs attached.

**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 (4.82 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 (5.17 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 0.71 cm at the cranial pole and 0.56 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.

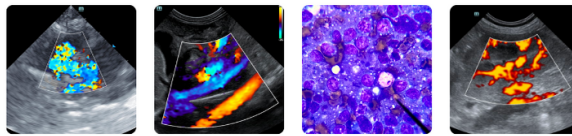
The right adrenal gland is normal in size measuring 0.5 cm at the cranial pole and 0.66 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

**Spleen**

The spleen is subjectively normal in size and shape. The splenic capsule is smooth with no visible irregularities. The blood flow through the hilus and splenic parenchyma appears normal. There is a slightly irregular, hypoechoic lesion visualized near the hilus measuring 0.39 cm x 0.88 cm. There is a small, hyperechoic lesion visualized in the parenchyma measuring 0.2 cm in diameter near the head of the spleen.

**Liver**

The liver is borderline large in size, and rounded margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. There are poorly defined hypoechoic nodules visualized within the parenchyma. A



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hyperechoic nodule in the mid cranial liver measures 1.08 cm x 0.74 cm. An example of an ill-defined hypoechoic nodule measures 1.91 cm.

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 is moderately dilated with fluid and irregular shadowing material most consistent with normal ingesta and gas. 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 layering is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum (0.39 cm), jejunum (0.3 cm) and ileum have a uniform diameter with minimal fluid distension. There is mild mucosal speckling visualized associated with the duodenum and jejunum. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. Visualized peristalsis appears appropriate. Fluid and gas distension is suggestive of a non-fasted patient or generalized ileus.

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 in the right limb. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

**Free Abdomen**

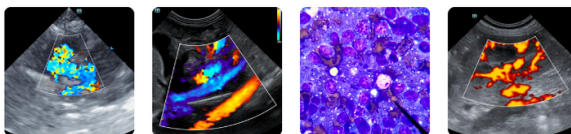
Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

**Other**

The right auricle and pericardium were visualized and were unremarkable. No obvious pathology is visualized. If cardiac function evaluation is desired a full echocardiogram is warranted.

**PRIMARY FINDINGS**

- Small, hypoechoic lesion visualized near the hilus of the spleen. There is a non-cavitated, hypoechoic splenic nodule visualized. Differentials include lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.
- Large, heterogenous liver with ill-defined hypoechoic nodules and a hyperechoic nodule in the mid cranial aspect of the 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. The nodules observed trend toward a more



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benign process, but underlying neoplasia cannot be ruled out. The hyperechoic lesion has the appearance most consistent with a benign lesion. Recommend continued monitoring.

- Large fluid and ingesta distended stomach, and mild fluid and gas distension of the small intestine. Findings are most consistent with a non-fasted patient. If the patient was adequately fasted, consider such differentials as delayed gastric emptying, less likely a partial obstruction, etc.
- Mild mucosal speckling visualized associated with the small intestine. Bright mucosal speckling has been postulated to represent dilated lacteals or focal accumulations of mucus, cellular debris, etc.. in the mucosal crypts.

**SECODNARY FINDINGS**

- Pancreatic changes most consistent with mild pancreatic remodeling in the right limb.
- 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.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The liver is borderline large and somewhat mottled with ill-defined hypoechoic nodules. These generally have the appearance most consistent with benign lesions. A primary hepatopathy is suspected. A vacuolar hepatopathy would be most likely. Recommend pre- and post-prandial bile acids to assess liver function and a fine needle aspirate of the liver (provided coagulation parameters are normal.)

Both adrenals are normal in size, but they are towards the upper end of normal. If classic signs for Cushing's are present, consider adrenal function testing (an ACTH stimulation test would be recommended in this patient with concurrent medical issues.)

There's a small hypoechoic nodule visualized associated with the spleen. Recommend continued monitoring with ultrasound (re-check in 3 to 4 months.) A fine needle aspirate could be considered but the lesion is close to the great vessels at the hilus.

Diarrhea is reported and there is some mucosal speckling noted on today's exam. If a primary enteropathy is suspected, consider the following:

- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend chronic probiotic therapy.
- If not already done, recommend parasite screening and deworming.
- Consider screening for infectious causes of diarrhea (if clinically appropriate.)

If diarrhea is persistent despite making these changes, biopsies of the GI tract may eventually be warranted.

Imaging performed by



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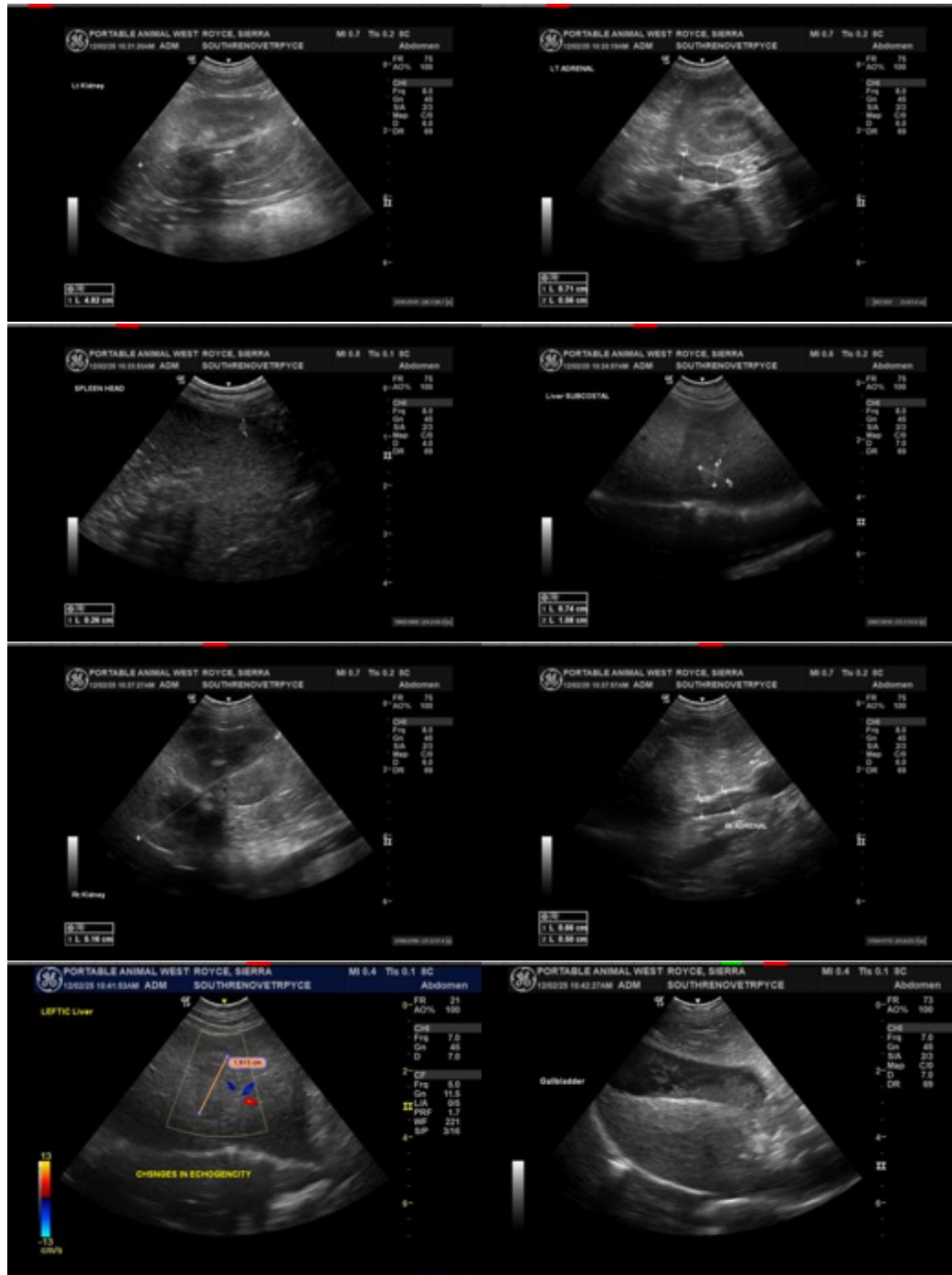
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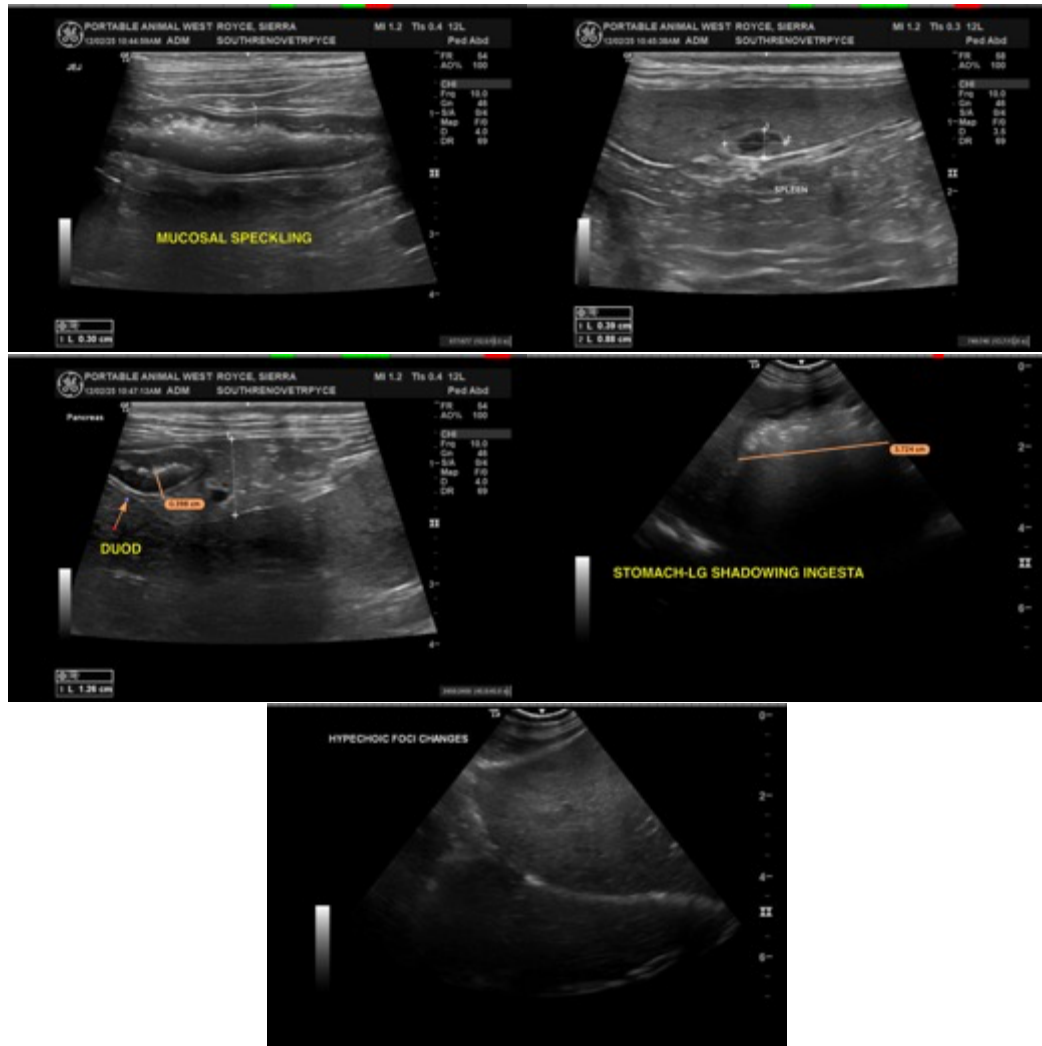
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@sonopath.com