PATIENT

Lilo Wyatt

SPECIES

Canine

BREED

French Bulldog

SEX

Spayed Female

AGE

12 Years

WEIGHT

18 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Pamela Harrigan, RDCS, Certified Vet Sonographer

HOSPITAL NAME

Chase Veterinary Clinic

REFERRING VET

Halli Lipinski, DVM

INVOICE

72857

DATE

12/30/25

PRESENTING CLINICAL SIGNS

Diffuse alopecia and cachexia on exam. Diarrhea x 6 months. Currently being fed I/D and getting probiotics with no improvement. 4 lb weight loss. SDMA 18, alb 2.5, UDG 1.006, pH 5.5, T4 0.9

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with urine. The Bladder wall appears mildly diffusely thickened and irregular, measuring at 0.50 cm. The region of the trigone, ureteral papillae and proximal urethra appear free of any mass lesions or calculi.

The left kidney has a normal shape and size (3.88 cm) with occasional small, non-obstructive cortical nephroliths and mild pyelectasia at 0.16 cm. Overall echogenicity is slightly hyperechoic with mildly reduced 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 infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (4.47 cm) with occasional small, non-obstructive cortical nephroliths and mild pyelectasia at 0.22 cm. Overall echogenicity is slightly hyperechoic with mildly reduced 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 infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is large and somewhat irregular, measuring 1.23 cm at the cranial pole and 0.88 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is abnormal in that it is enlarged at both poles (particularly the cranial pole) with no evidence of vascular invasion visualized.

The right adrenal gland is large, measuring 0.64 cm at the cranial pole and 0.89 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.

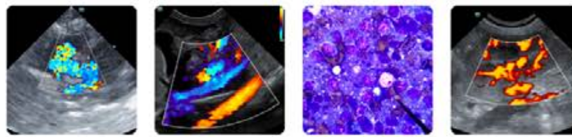
Spleen

The spleen is subjectively normal in size, 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 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 significantly distended. Some areas of the wall appear mildly thickened with adherent debris. There is a large amount of primarily non-organized echogenic debris. There is no evidence of bile duct dilation.



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Gastrointestinal

The stomach contains a large amount of fluid/shadowing ingesta. It measures at a normal thickness of 0.32 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.

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 0.51 cm. Jejunum wall measures 0.48 cm. There is mild mucosal speckling visualized associated with the duodenum. Visualized peristalsis appears appropriate.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with non-formed fecal material and gas shadowing distally. The proximal ascending colon appears thickened with mildly reduced detail of wall layering, measuring up to 0.70 cm in thickness. Distally the colon wall appears normal with intact wall 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. There is no evidence of a significant lymphadenopathy. Mesenteric lymph nodes are visualized measuring 0.44 cm. A prominent lymph node near the ileocecal junction is visualized measuring 0.62 cm. The omentum is mildly diffusely hyperechoic.

PRIMARY FINDINGS

- Bilateral adrenomegaly with an enlarged cranial pole of the left adrenal gland- Findings could be consistent with bilateral hyperplasia or less likely a mass effect at the cranial pole of the left adrenal.

- Age related changes visualized associated with both kidneys as well as mild bilateral pyelectasia and non-obstructive nephroliths – Pyelectasia of the kidney(s)could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.

- 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, non-organized debris visualized within the gallbladder – A large amount of debris is evident in the gall bladder with no evidence of a mucocele or associated inflammation at this time. This could represent an early mucocele or cholestasis, with minimal evidence of associated inflammation at this time. Continued monitoring of labwork and ultrasound are warranted for progression of this lesion. Ursodiol therapy could be considered.

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- Fluid and shadowing ingesta distended stomach – Correlate with the feeding history. If the patient was adequately fasted, this could represent delayed gastric emptying.

- Mild diffuse thickening of the small intestine with mild mucosal speckling – The diffuse splenic changes are non-specific and could be consistent with lymphoid hyperplasia, extramedullary hematopoiesis, infiltrative neoplasia, inflammation, other. Cytology or histopathology would be necessary to get a definitive diagnosis.

- Thickened proximal ascending colon with mildly reduced detail of wall layering – Findings are most consistent with severe inflammatory or early infiltrative disease.

SECONDARY FINDINGS

- Mildly irregular/thick urinary bladder wall – The bladder mucosal changes could be consistent with cystitis or artifactual due to lack of adequate luminal distension. Bladder neoplasia cannot be ruled out but is considered unlikely in this patient.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The proximal ascending colon just distal to the ileocecal junction appears thickened and prominent with slightly reduced detail of wall layering. Findings are concerning for early infiltrative disease (round cell neoplasia, other), although severe inflammation in this area is also possible. If a safe window for sampling is available, consider a fine needle aspirate of the colon wall in this region.

The small intestine appears mildly thickened with some areas exhibiting mild mucosal speckling. These changes could be consistent with inflammatory type change (IBD, etc.) +/- lymphangiectasia. An early neoplastic process cannot be ruled out. Consider an ultra low-fat prescription hydrolyzed diet (Royal Canin) and consider a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate, looking for additional evidence of underlying small intestinal disease. It is likely that biopsies of the GI tract would be necessary to further evaluate.

Both adrenals are large and somewhat irregular in shape. This could be consistent with bilateral hyperplasia, infiltrative neoplasia, or even an early mass effect in the cranial pole of the left adrenal. If symptoms consistent with Cushing's disease are present, consider adrenal function testing, keeping in mind that false positives can occur with concurrent illness. Additionally recommend continued monitoring with ultrasound, looking for progression of the adrenal enlargement. Fine needle aspirate of the left adrenal could be considered provided there is no evidence of hypertension, which could be consistent with a pheochromocytoma.

Consider initiating chronic Ursodiol therapy and continued monitoring of the gallbladder.

Consider a urinalysis, urine protein to creatinine ratio, and a urine culture to assess the bladder changes reported.

Based on the hypoalbuminemia reported, a primary protein losing enteropathy is suspected. Biopsies of the GI tract may ultimately be necessary, although there is concern for possible underlying round cell neoplasia, given the thickened proximal colon noted.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement (disregard if this has already been done).

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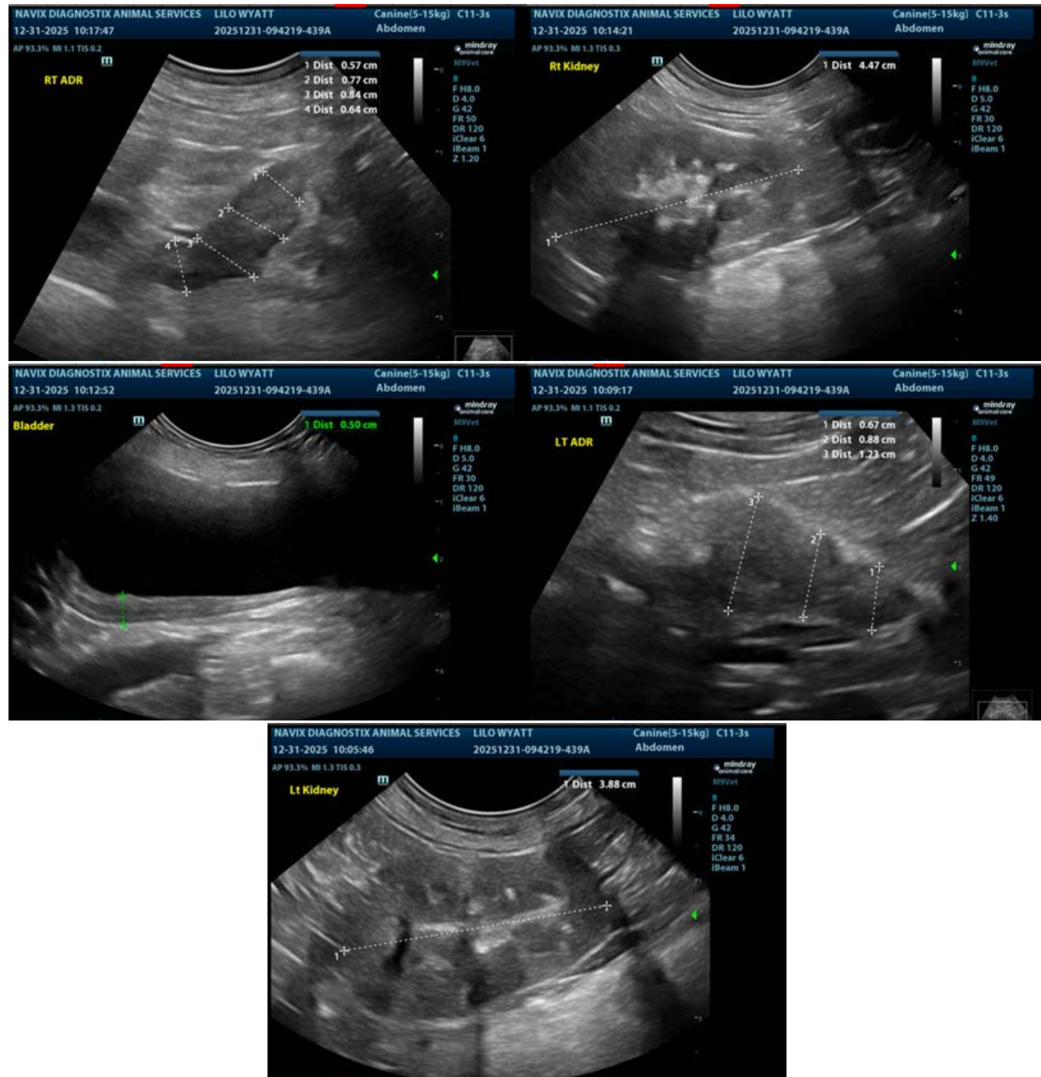

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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