



**PATIENT**

Perla Sofia Aponte

**SPECIES**

Canine

**BREED**

Chihuahua

**SEX**

Female

**AGE**

7 Years

**WEIGHT**

3.5 Pounds

**INTERPRETED BY**

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

**IMAGING  
PERFORMED BY**

Dr. Ferrer

**HOSPITAL NAME**

Paseos Vet Center

**REFERRING VET**

Dr. Marylin Davila

**INVOICE**

35884

**DATE**

2/24/22

**PRESENTING CLINICAL SIGNS**

Presented as a referral for an abdominal ultrasound to evaluate chronic vomiting. Pt has a history of chronic GI signs, chronic vomiting, recovers, and relapses. Multiple visits to the Emergency clinic for stabilization. Last hospitalization from Feb 22-23rd. Vomiting and bloody diarrhea are the most common clinical sign. Treated with famotidine injections, cerenia inj and metronidazole injections. PT recovers well. Currently on Omeprazole, metronidazole and cerenia tabs.  
Abnormal PE/Chem/CBC/UA Results: PE: Was not provided referring Fecal: No parasite seen ( done here by O's request).

**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 (2.92 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 (2.78 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 0.38 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 0.26 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 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. There is a moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.



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***Gastrointestinal***

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The stomach contains a mild 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.

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The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal 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 measured 0.21 cm. Jejunum wall measured 0.17 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

**BREED**

Chihuahua

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. Colon wall measured 0.21 cm.

**SEX**

Female

***Pancreas***

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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***

**WEIGHT**

3.5 Pounds

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. Occasional mesenteric lymph nodes are visible, one measuring 0.36 cm. The omentum is of normal echogenicity.

**ULTRASONOGRAPHIC FINDINGS**

**INTERPRETED BY**

Kathleen Sennello DVM,  
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- Moderate gallbladder sludge – The significance of the aggregated gallbladder sludge is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting.
- Mild gastric distention with fluid – Correlate with feeding history. This could be an indicator of delayed gastric emptying or less likely a gastric outflow tract obstruction.
- Occasional prominent mesenteric lymph nodes – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

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No focal lesions are associated with the GI tract to explain the chronic vomiting and intermittent acute GI signs noted. This is not uncommon, as there are many causes for GI signs that cannot be diagnosed by ultrasound alone. Additionally, I feel these patients with intermittent signs are most challenging to assess, as assessing response to therapy can take much more time. Consider potential metabolic causes for the GI signs reported.

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Consider screening for Addison's disease, and consider a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate to further evaluate the pancreas, look for dysbiosis, etc.

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If metabolic causes appear unlikely, then consider primary GI causes. In an adult dog with intermittent symptoms, the most common differentials would be dietary intolerance/food allergy, dietary indiscretion, stress colitis, less likely GI parasites, flare ups of IBD, and less likely intestinal neoplasia.

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- Consider a novel protein/hydrolyzed protein prescription diet.
- Consider chronic probiotic therapy.



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- Recommend the aforementioned GI panel to screen for exocrine pancreatic insufficiency, dysbiosis, pancreatic disease, etc.
- If intermittent GI signs persist despite dietary changes and the symptoms noted, consider obtaining GI biopsies.

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In some of these cases, I will also equip the owners with “emergency pack” of treatment if they start to see any evidence of an episode starting in an effort to keep them out of the hospital. This will often include anti-nausea medication +/- a short course of Metronidazole, increasing the probiotic dose or adding a prebiotic paste, etc.

**BREED**

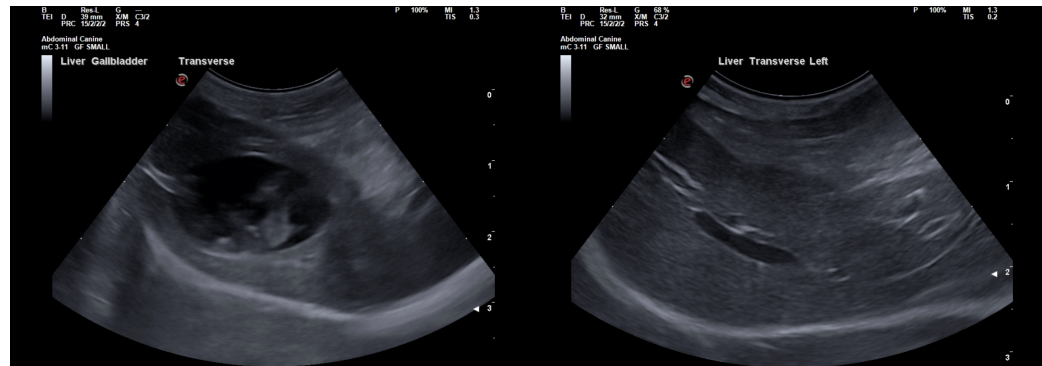
Chihuahua

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Female

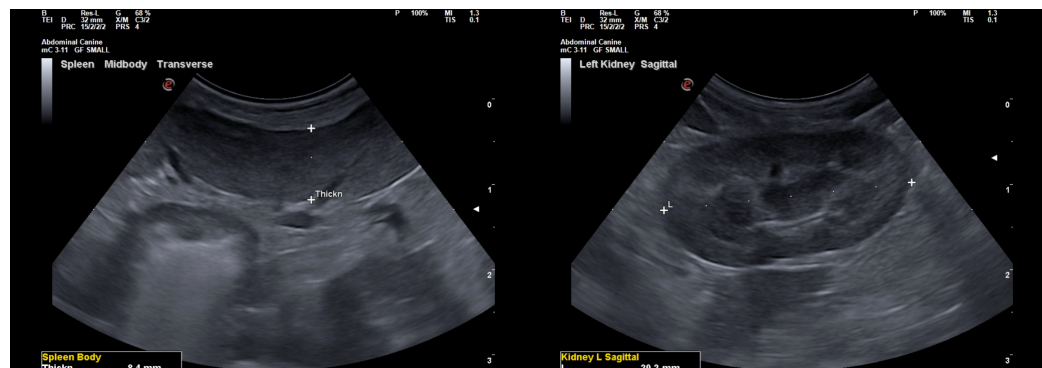
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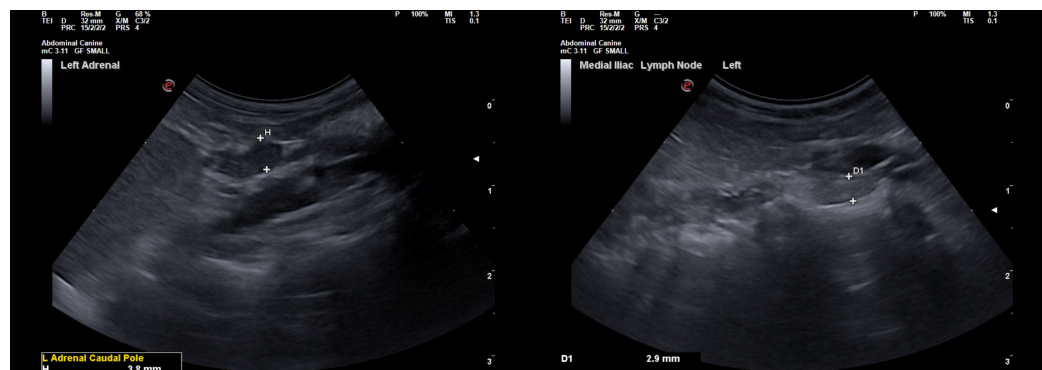
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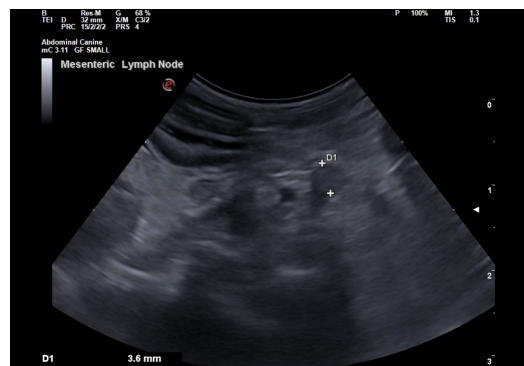
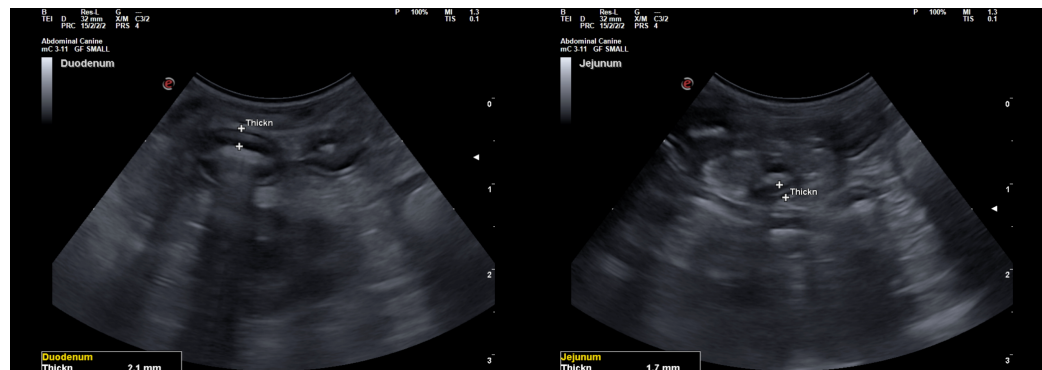
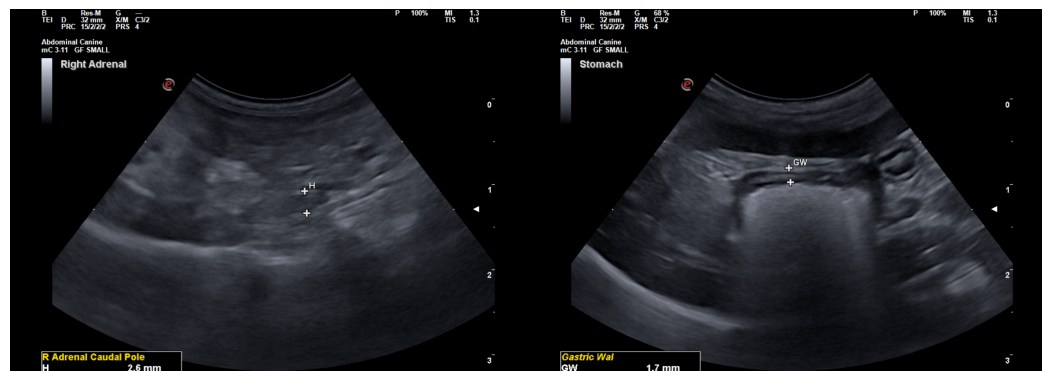
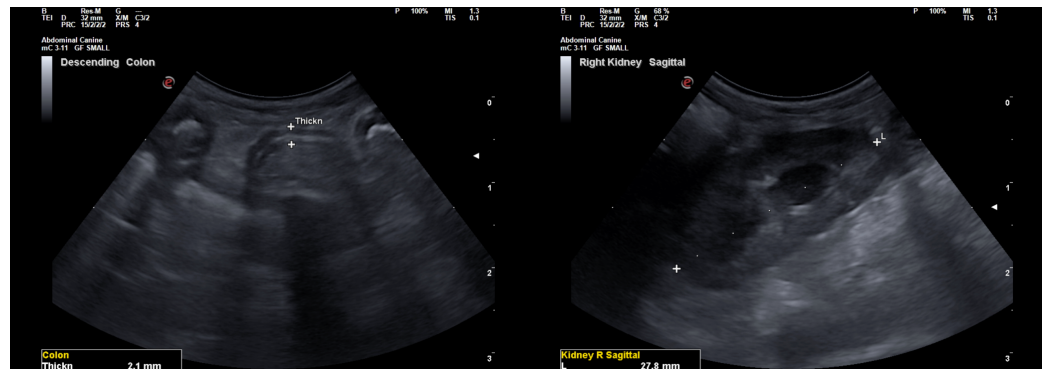
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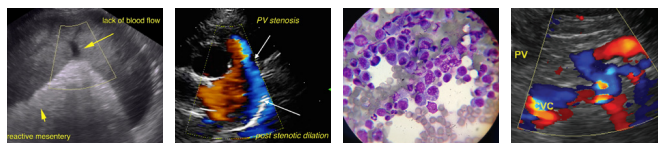
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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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kathleen.sennello@sonopath.com

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