



## PATIENT

Claire Hester

## SPECIES

Canine

## BREED

Mix

## SEX

Spayed Female

## AGE

7 Years

## WEIGHT

54 lbs

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Jessica Milligan, DVM

## HOSPITAL NAME

Dockside Veterinary  
Imaging

## REFERRING VET

Claire Hefner, DVM

## INVOICE

73229

## DATE

2/24/26

## PRESENTING CLINICAL SIGNS

Pet presented for vomiting and treated at urgent care on 2/11. Treatment consisted of Clavacillin, cerenia, and SQFT. Pet presented to rDVM 2/19 with moderate icterus, consistent anorexia and vomiting. Chemistry revealed severely elevated ALT/ALKP/Amylase/Cholesterol and moderately elevated lipase. RDVM ddx includes pancreatitis resulting in marked liver enzyme elevation and potential icterus. O declines referral, administered/prescribed SQFT, cerenia SQ, denamarin, clavamox. Scheduled abd u/s for 2/24/26.

Abnormal PE/Chem/CBC/UA Results: 2-19-26: ALT 2394, ALKP 4853, Glob 4.9, GGT 95, TBil 17.5, Lipa 3636, BUN 5, Cl 106, Hct 56.1, Hgb 20.2

## 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 (6.18 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 (6.18 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 0.51 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 0.55 cm at the cranial pole and 0.54 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 (2.59 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.

### Liver

The liver is normal/borderline small in size with normal echogenicity and smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible

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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.

***Gastrointestinal***

The stomach contains mild fluid. The gastric wall appears mildly thickened, measuring at 0.81 cm with intact wall layering. 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 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 measures 0.47 cm. Jejunum wall measures 0.28 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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 large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with moderate pancreatitis.

***Free Abdomen***

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are occasional prominent hypoechoic cranial abdominal lymph nodes. Examples measure 0.45 cm and 0.47 cm. The omentum is hyperechoic in the right cranial abdomen in the region of the pancreas.

**ULTRASONOGRAPHIC FINDINGS**

- Pancreatic changes most consistent with moderate pancreatitis. Pancreatic neoplasia cannot be definitively ruled out.
- Borderline small, 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 gallbladder debris – 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.
- Mildly thickened gastric wall with intact wall layering – Findings could represent anatomic variation, imaging artifact, or mild gastritis.



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- Mild/moderate cranial abdominal lymphadenopathy – Findings are most consistent with reactive lymph nodes. Early neoplastic change cannot be ruled out.

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

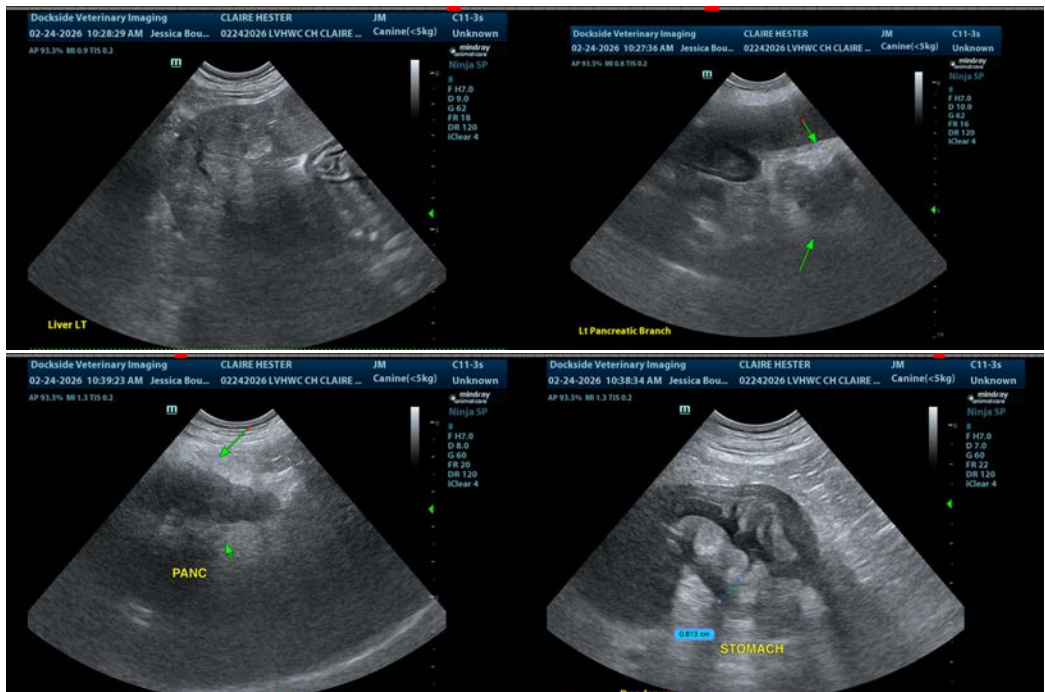
The pancreas, particularly in the region of the body of the pancreas, is hypoechoic and prominent and surrounded by reactive mesentery. Findings are most consistent with moderate pancreatitis, although the severe elevation in liver enzymes is atypical for uncomplicated pancreatitis. This could be secondary to a concurrent hepatopathy, hepatic neoplasia, an infectious process, or a post-hepatic biliary obstruction (none clearly visualized). Recommend aggressive therapy for pancreatitis and acute liver injury (Ursodiol, Denamarin, antibiotics, and supportive care). If possible, consider a fine needle aspirate of the liver (provided coagulation parameters are normal).

The gallbladder has a large amount of debris. Partial biliary obstruction is not clearly visualized but cannot be definitively ruled out.

If symptoms are persistent despite treatment, eventually further evaluation of the liver and pancreas may be warranted. This could involve exploratory with biopsies and visualization of the biliary tract, or a contrast CT scan in hopes of acquiring additional information prior to pursuing more aggressive/invasive procedures.

Additionally, a fine needle aspirate of the pancreas could be considered, or a sample of a cranial abdominal lymph node (if a safe window is available). I suspect this may be challenging.

If Leptospirosis is a clinical concern, you could consider testing and empirical therapy (the reported Clavamox should treat the acute form of this disease).





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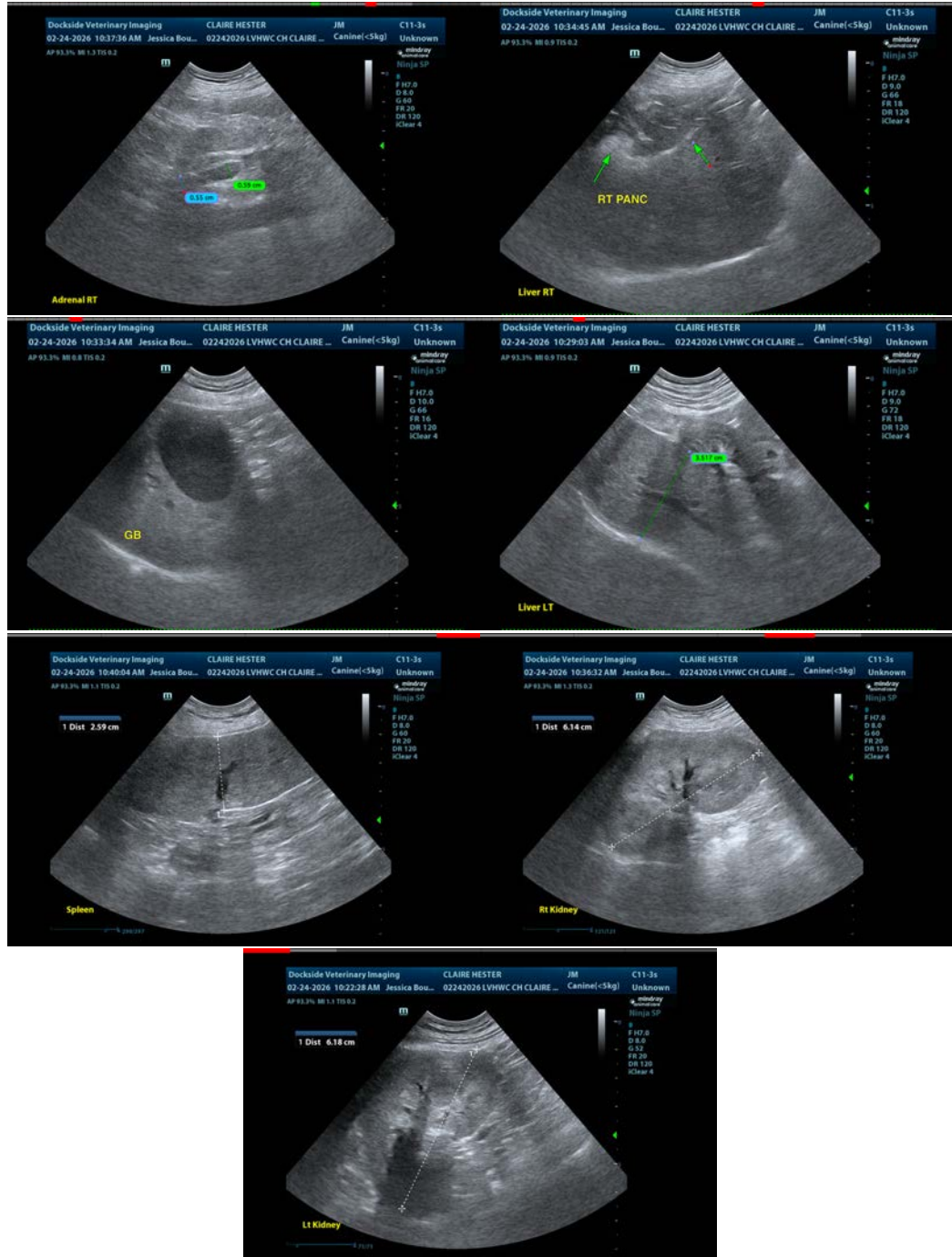
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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