PATIENT

Suku Bertrand

SPECIES

Canine

BREED

Cattle Dog Mix

SEX

FS

AGE

9 years

WEIGHT

23.35 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

Roundhill Animal Hospital

REFERRING VET

Dr. Carl Kelly

INVOICE

11366

DATE

2/24/2026

PRESENTING CLINICAL SIGNS

- Presented on 2-19-26 for complete anorexia for 24 hours. Liquid diarrhea for past 10 days. Emesis X24 hours. Low calcium, elevated kidney values although improving since IV fluids in hospital this day (attached labs). Has a MCT under the front leg that was removed/grew back.
- Current RXs
- -Sucralfate 1g bid
- -Peptobismal 15-20cc sid-bid
- -Yunnan Baiyao 100mg 2 caps bid
- -25mg prednisolone sid
- -Calcitrol 0.4mg bid
- -Phosbind 500mg into food daily

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 (5.75 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. Occasional pinpoint cortical mineralizations noted. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (5.63 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. Pinpoint non-obstructive mineralizations noted. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.55 cm at the cranial pole and 0.57 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 0.55cm 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

Surgically absent.

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.

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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 is moderately dilated with fluid and irregular shadowing material. 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.. Shadowing ingesta interferes with full evaluation of the stomach in some views. Some of the shadowing material is hard shadowing possibly consistent with ingested foreign material, medication etc.. Some of this is seen within the pylorus but there is not evidence of an outflow tract obstruction at the time of the study.

Some of the visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal to moderate 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. The duodenum measured as normal (0.29 cm in wall thickness) and the jejunum measured as normal (0.25 cm.) There are some sections of small intestine which appear moderately fluid distended with non-progressive motility, most consistent with focal ileus/enteritis. Although an unseen partial obstruction cannot be ruled out.

Sections of colon are visualized and are distended 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 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 pancreatitis in the right limb.

Free Abdomen

Evaluation of the peritoneal cavity revealed a small amount of free abdominal fluid. There is no lymphadenopathy noted. The omentum is hyperechoic around the pancreas.

PRIMARY FINDINGS

- Mild age-related change visualized associated with both kidneys.
- Pancreatic changes most consistent with mild pancreatitis.
- Moderate segmental fluid distension of the small bowel and stomach with areas of non progressive motility-findings are suggestive of ileus but an unseen obstruction cannot be ruled out.
- Fluid and gas distended colon. Findings are most consistent with the diarrhea reported.
- Free abdominal fluid. Recommend fluid analysis and cytology.

SECONDARY FINDINGS

- Surgically absent spleen.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Imaging performed by
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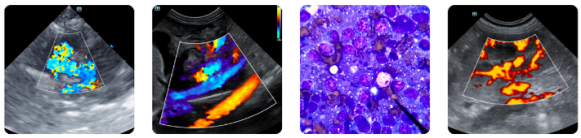
530-786-8340



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There's a moderate amount of fluid and shadowing ingesta/hard shadowing ingesta visualized within the stomach and some sections of small intestine. Some of the more distal sections of the small bowel appear mildly distended with non-progressive motility, possibly consistent with focal ileus. In some areas this borders on an obstructive pattern. An unseen focal obstruction cannot be ruled out. The colon appears significantly fluid distended, consistent with the diarrhea reported.

Findings are suggestive of severe diffuse gastroenteritis and colitis with ileus but supportive care and close monitoring is recommended if the fluid distension is persistent an obstruction could be present. Consider recheck ultrasound in 12-24 hours.

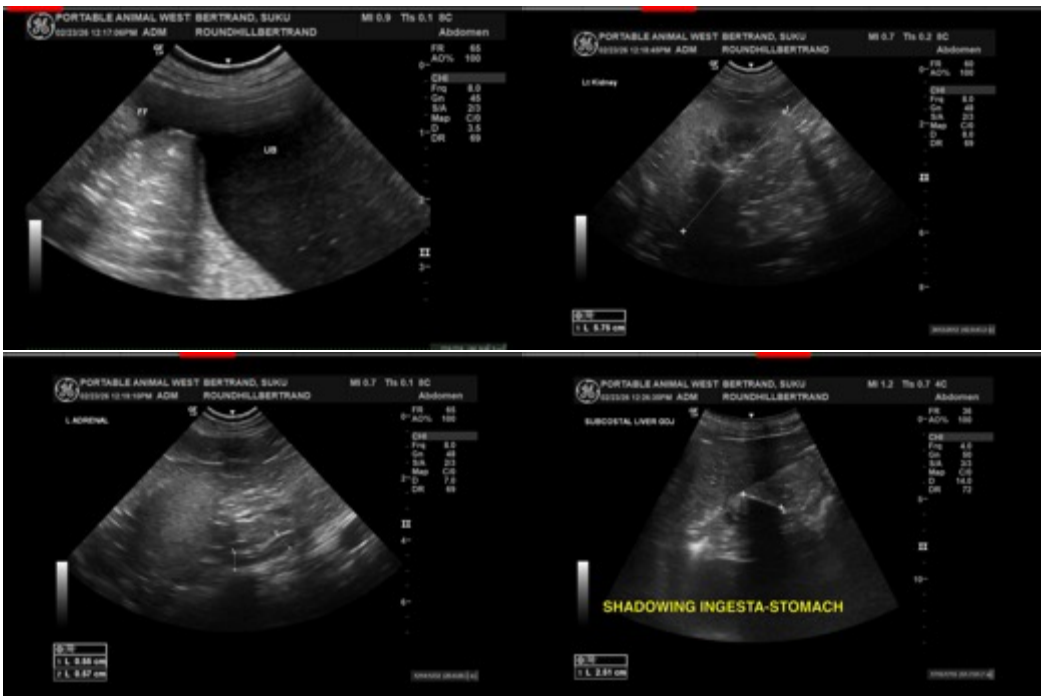
No gross gastric wall abnormalities/ulcerations are visualized. This does not rule out the possibility of small lesions/ulcerations. (ultrasound can be insensitive for superficial ulcerations) and steroid therapy can mask inflammation/thickening.

The right limb of the pancreas is hypoechoic and prominent with surrounding reactive mesentery most consistent with pancreatitis. Recommend empirical treatment for acute gastroenteritis/pancreatitis, and close continued monitoring. If symptoms are persistent, consider repeat evaluation (radiographs +/- ultrasound.)

Recommend sampling of the free abdominal fluid for cytologic evaluation in the unlikely event of early septic peritonitis, or neoplastic effusion.

A cause for the anemia is not definitively visualized. There is evidence of server gastrointestinal pathology but no focal lesions are observed. Recommend transfusion, anti-ulcer therapy and close monitoring. A pathologist review to look for evidence of hemolysis, spherocytes etc.. could be helpful.

If further evaluation is desired upper GI endoscopy could be considered to evaluate the upper GI tract. If a persistent obstructive pattern is present ultimately surgical explore with biospies may need to be considered.



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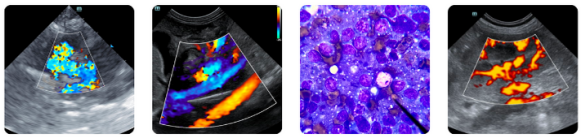

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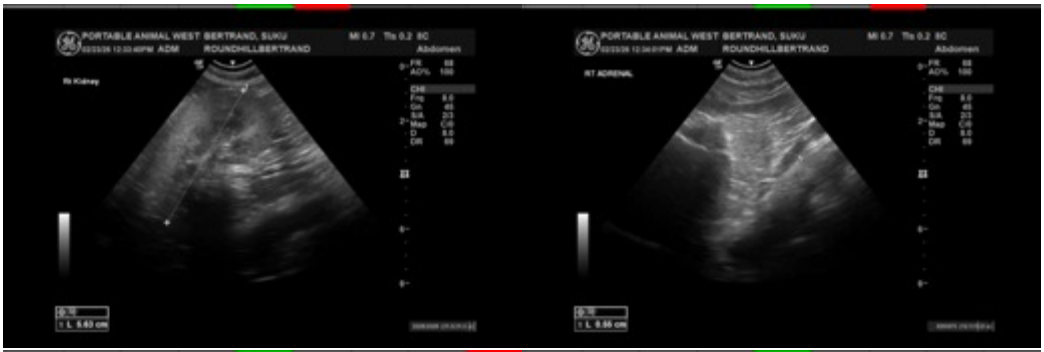

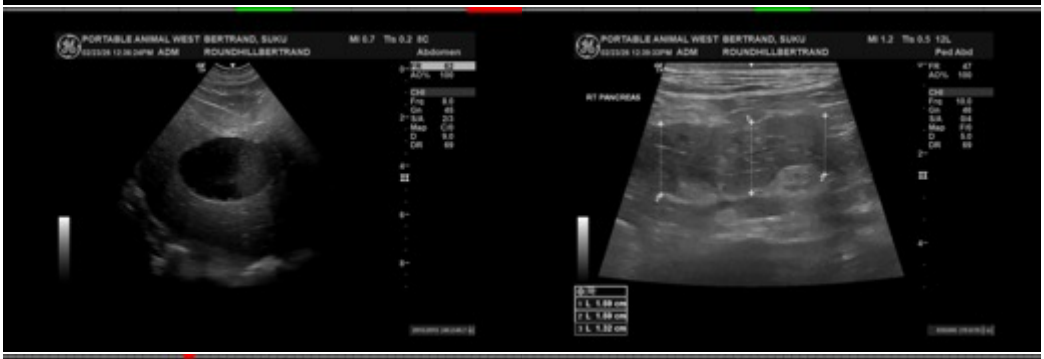

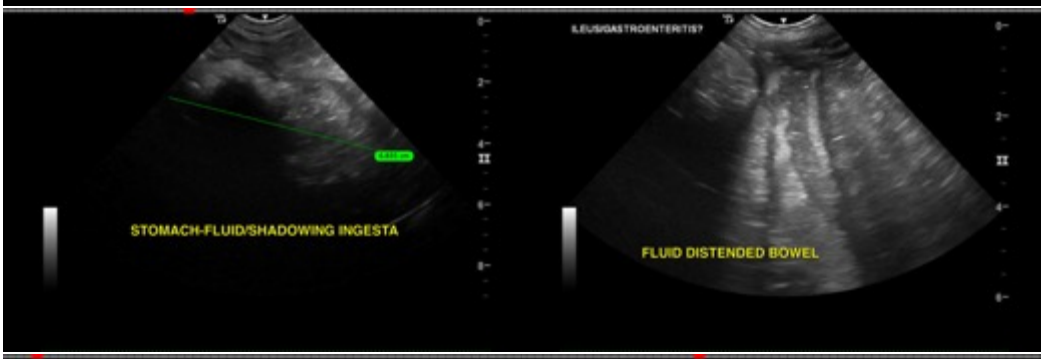

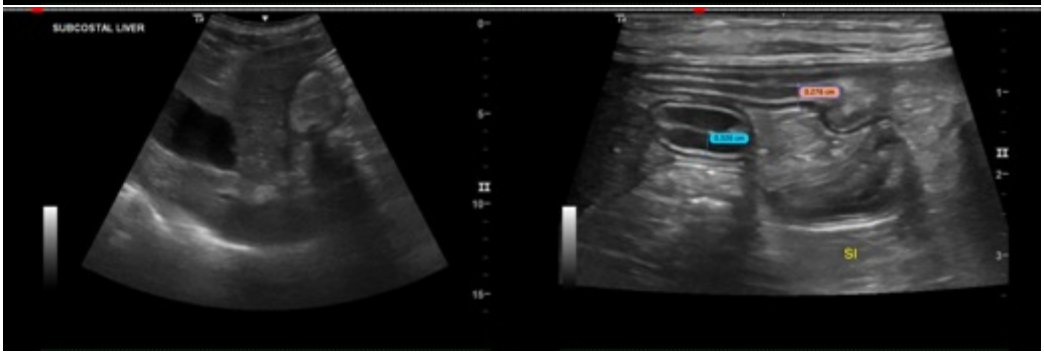

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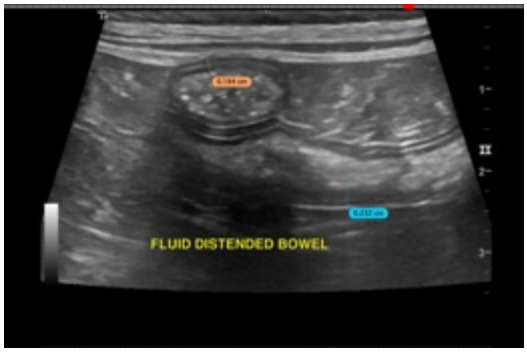

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

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