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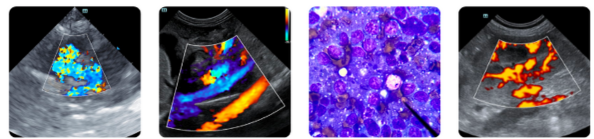


Clinical Sonography & Telecytology

Educational Teleconsultation Services™

PATIENT

Kirby Gieda

SPECIES

Canine

BREED

Shih Tzu Mix

SEX

MN

AGE

8 years

WEIGHT

8.3 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Melissa Randolph

HOSPITAL NAME

Shores Veterinary Emergency Center

REFERRING VET

Dr. Logan Law

INVOICE

11355

DATE

2/25/2026

PRESENTING CLINICAL SIGNS

- Approximately one year history of off and on gastritis, acid reflux/regurgitation. P has had ongoing soft, thin stools. Had been on famotidine 10 mg Q 12-24 hours. Was seen at rdvm in January multiple times. 2/17 was vomiting with hematemesis and diarrhea/hematochezia. P also was hyporexia to anorexia. was seen at Rossmoyne ER. rx'd entyce, ondansetron, emeprev, sucralfate, and metronidazole. Still on ondansetron Q 8 hours and sucralfate Q 8 hours. Fed i/d low fat stew and i/d low fat dry, cooked chicken, and Dr. Marty's freeze dried diet.
- concern for gastroeneritis, primary gi disease, gi parasites, pancreatitis, other

Abnormal PE/Chem/CBC/UA Results: 1/21 rdvm: CpLi normal abdomen rads: gas present in stomach and small intestine chem: unremarkable cbc: wbc 1.93 H, neu 14.21 H, eos 3.39 H 1/28: fecal negative

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 visualized areas of prostate and surrounding tissue appear normal. Unfortunately, the prostate is not fully visualized likely due to its intrapelvic location. Correlate with rectal exam findings.

The left kidney has a normal shape and size (4.04 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 (3.73 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

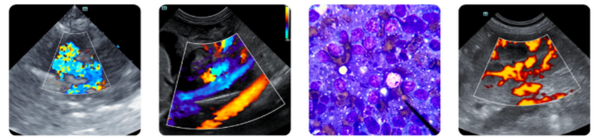
The region of left adrenal (Cranial to left renal artery) is unremarkable but the adrenal is not distinctly visualized. No evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.43 cm at the caudal pole (cranial pole is not clearly visualized). 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 (1.36 cm) and the echotexture is homogenous. The splenic capsule is smooth with no visible irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver



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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. Luminal contents are mild and likely incidental at this time. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. 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.

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. The duodenum measured as normal (0.45 cm in wall thickness) and the jejunum measured as normal (0.36 cm.) Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction is visualized. There is questionable thickening of the proximal ascending colon, measuring at 0.31 cm. 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 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, 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.

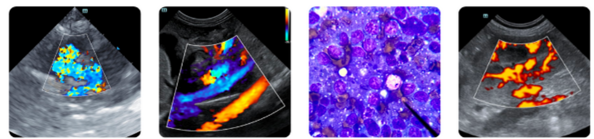
ULTRASONOGRAPHIC FINDINGS

- Questionable thickening of the proximal ascending colon. Findings could be consistent with imaging artifact, colitis, or early neoplastic change.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes observed on today's scan were relatively mild. The stomach was difficult to completely visualize but no evidence of significant pathology is noted. Similarly, the small intestine appears normal with some areas having mild to moderate gas distension. The ileocecal junction is visualized with gas in the proximal ascending colon. On some views the wall appears somewhat thickened in this region, which could be consistent with colitis or less likely early neoplastic change.

Recommend Three View thoracic radiographs to evaluate the esophagus for evidence of dilation, obstruction, etc., based on the regurgitation reported. Additionally, consider the following:



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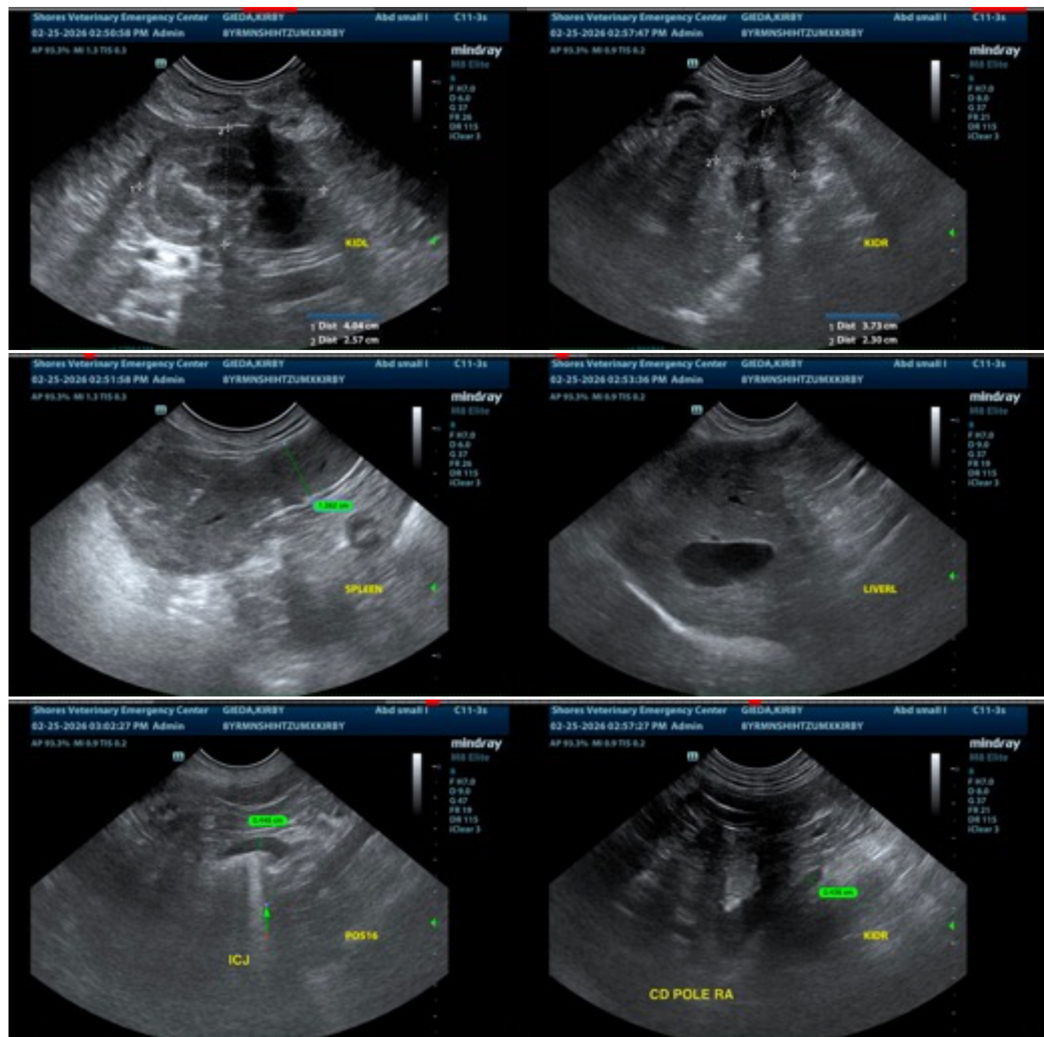
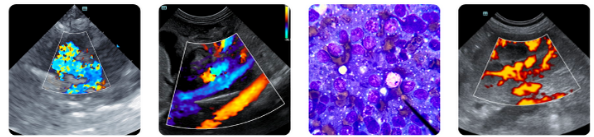
- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend parasite screening and empirical deworming.
- Consider a screening panel for infectious causes of diarrhea.
- Recommend a baseline cortisol to screen for Addison's
- Recommend chronic probiotic therapy.

If symptoms are persistent despite empirical treatment for gastroenterocolitis and the above recommendations, then ultimately, further evaluation such as upper and lower GI endoscopy may be warranted to obtain biopsies of the GI tract. Additionally, you could consider repeat imaging in the future, looking for the progression of the changes observed on today's scan.





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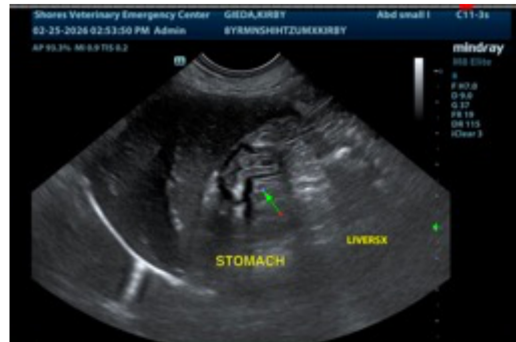

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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