



PATIENT

Trainer Hill

SPECIES

Canine

BREED

American Bulldog x

SEX

Spayed Female

AGE

5 Years

WEIGHT

36.7 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Kelly Reschny

HOSPITAL NAME

Chippawa Animal
 Hospital

REFERRING VET

Dr. Van Leeuwen

INVOICE

72704

DATE

2/4/26

PRESENTING CLINICAL SIGNS

Gastrotomy performed at NVEC 1/14/2026 to remove foreign material (fabric) from the stomach. Patient still "off" to this day, whining after meals and all night, unsettled, not wanting to play/walk as per usual. Occasional on/off vomiting but eats well when food is offered. BAR on exam, vitals WNL, mild guarding/tensing for abdominal palpation

Current Medications: Gabapentin, Sulcrate

Abnormal PE/Chem/CBC/UA Results: 1/16/2026 - ALT 297 (10-125) - MCHC 380 (320-379) - Reticulocytosis 114.9 (10-110) - Monocytosis 1.13 (0.16-1.12)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly to moderately distended with anechoic urine. The caudal aspect of the urinary bladder appears within normal limits. The cranial/apical region appears somewhat thickened, measuring at 0.51 cm with a smooth mucosal surface. The 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 (7.87 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 (6.94 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 0.57 cm at the cranial pole and 0.59 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 "plump" measuring 2.74 cm at the cranial pole and 1.34 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 (2.36 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.



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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. 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. Duodenum wall measures 0.53 cm. Jejunum wall measures 0.33 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 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, 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.

The body wall appears focally thickened and hypoechoic in the cranioventral abdomen, most consistent with surgical incision.

ULTRASONOGRAPHIC FINDINGS

- Mildly thickened apical wall of the urinary bladder – 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.
- Hypoechoic, thickened body wall incision – Findings are likely consistent with a normal surgical incision/mildly inflamed surgical incision.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

An obvious cause for the vomiting and ADR is not clearly identified. There is no evidence of a diffuse obstructive pattern, and the stomach is empty. Small non-obstructive foreign material cannot be definitively ruled out but is not strongly suspected.



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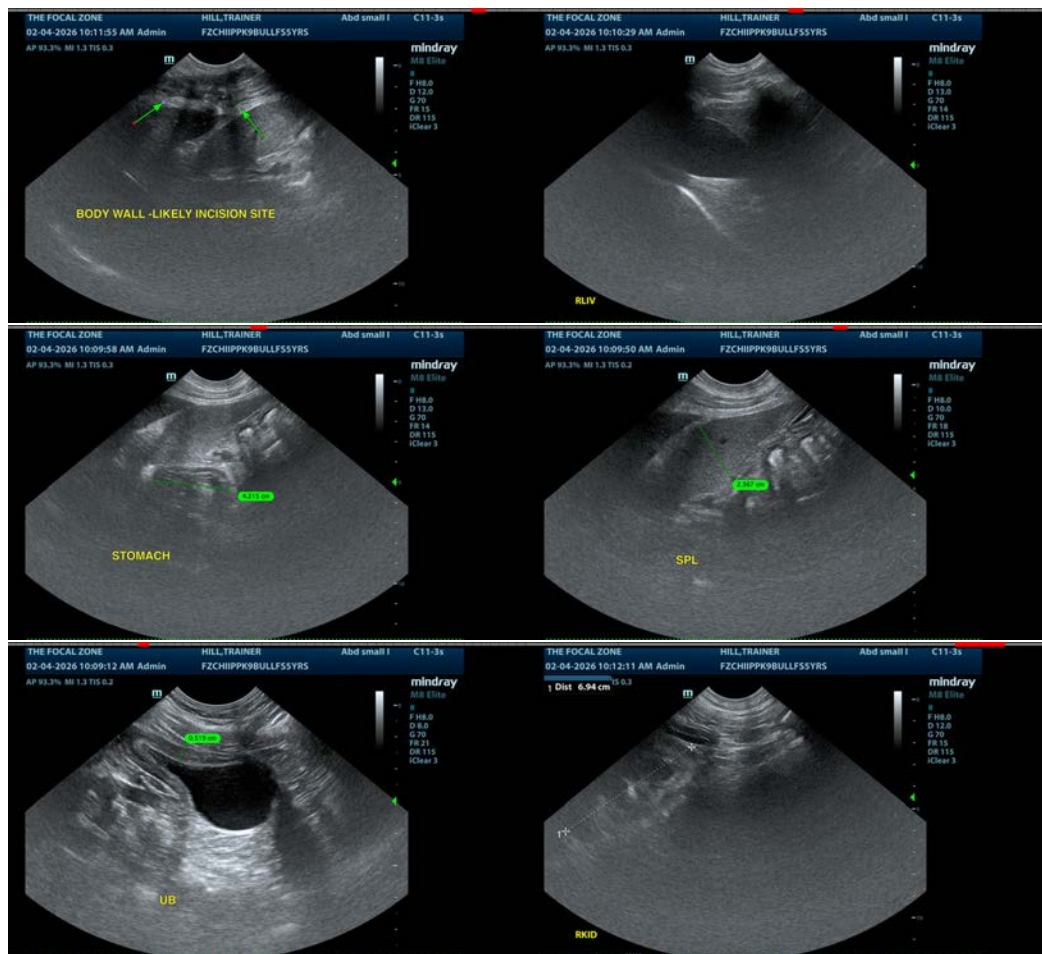
DATE

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The incision is somewhat prominent but likely normal for a healing incision. Correlate with visual inspection and palpation.

Correlate findings with abdominal radiographs. If symptoms are persistent, upper GI endoscopy could be considered, looking for any focal proximal lesions, and biopsy could be obtained. Additionally, you could consider a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate, looking for subclinical pancreatitis, evidence of dysbiosis after antibiotic use, etc. Additionally, repeat imaging could be considered in the future, looking for possible development of a new lesion or progression of a current lesion.

A baseline cortisol could be considered to screen for Addison's.





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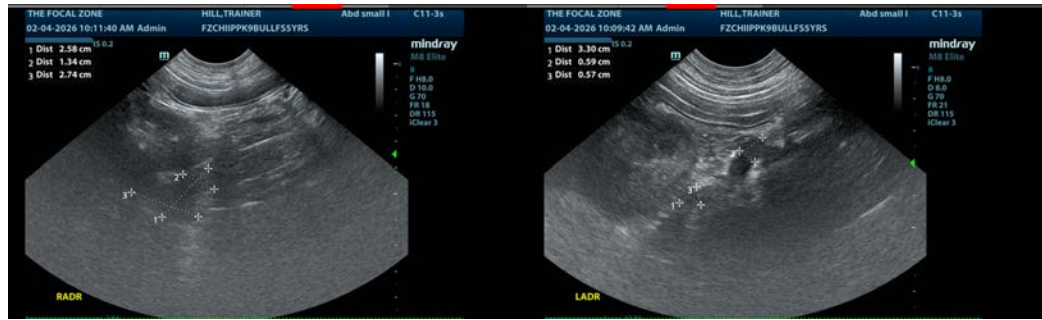
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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