



PATIENT

Hermine Moorhouse

SPECIES

Canine

BREED

German Shepherd

SEX

Spayed Female

AGE

9 Years

WEIGHT

30.1 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Iacovides

HOSPITAL NAME

Clearspring Animal
Hospital

REFERRING VET

Dr. Gaw

INVOICE

72743

DATE

2/5/26

PRESENTING CLINICAL SIGNS

Been having watery diarrhea since 2022-23 and history of pancreatitis and liver issue. on Low fat diet and Pankreacare for 1-2 years now and still having BM issue. Recent visit had pancreatitis again and watery stool. sent home metronidazole, cerenia, nsaid and vit B inj. owner called yesterday that still having BM issue. Also day of scan owner reporting dog had sluggish appetite

Current meds: Vit B inj SID for 3 days and every 7 days for 4 days. Omeprazole for 15 days both for trial treatment.

Abnormal PE/Chem/CBC/UA Results: CBC: HCT 0.368 (0.373-0.617) Retic 2.3% Plateletcrit 0.48 (0.14-0.46) CHEM:(minichem, chem 10) TP 37 g/l (52-82) ALB 12 g/l (22-39) GLOB 24 g/l (25-45) ALP <10 u/l SNAcPL Abnormal PE: weight loss

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 (6.69 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 (6.33 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 0.50 cm at the cranial pole and 0.50 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 region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect is visualized.

Spleen

The spleen is subjectively normal in size (2.42 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 subjectively normal in size, and echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. 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. There is a moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of 0.28 cm 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 uniform diameter with minimal fluid distension. Wall thickness is increased. Bowel loops follow a typical curvilinear path. Duodenum wall measures 0.45 cm. Jejunum wall measures 0.44 cm. There is mucosal fogging and occasional speckling noted. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

Sections of colon are visualized with non-formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering. The descending colon wall measures 0.35 cm.

Pancreas

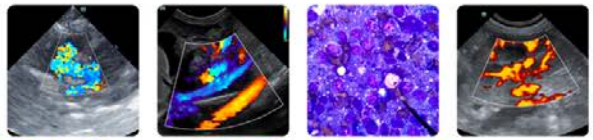
The right limb of the pancreas is prominent and hypoechoic as compared to the surrounding isoechoic mesentery. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

There is a scant amount of free fluid noted. There are occasional prominent jejunal lymph nodes. An example measures 0.55 cm. The omentum is mildly diffusely hyperechoic.

ULTRASONOGRAPHIC FINDINGS

- Pancreatic changes most consistent with chronic pancreatic remodeling and chronic active pancreatitis.
- Mildly 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.
- Moderate gallbladder debris – The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting but seems unlikely to be causing a current issue. Recommend continued monitoring.
- Diffusely thickened small intestine with moderate mucosal fogging and speckling – The bowel wall thickening could be consistent with inflammation, edema, or infiltrative neoplasia. Bright mucosal speckling has been postulated to represent dilated lacteals or focal accumulations of mucus, cellular debris, etc.. in the mucosal crypts.



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- Scant free abdominal fluid and occasional prominent mesenteric lymph nodes – Findings are most consistent with inflammatory type change. An early neoplastic process cannot be ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small intestine appears diffusely thickened with mucosal fogging and occasional speckling. Findings are most consistent with a primary protein losing enteropathy based on the information provided. The most common differentials would be severe IBD +/- lymphangiectasia, less likely underlying neoplasia. Biopsies of the GI tract would be necessary to further evaluate.

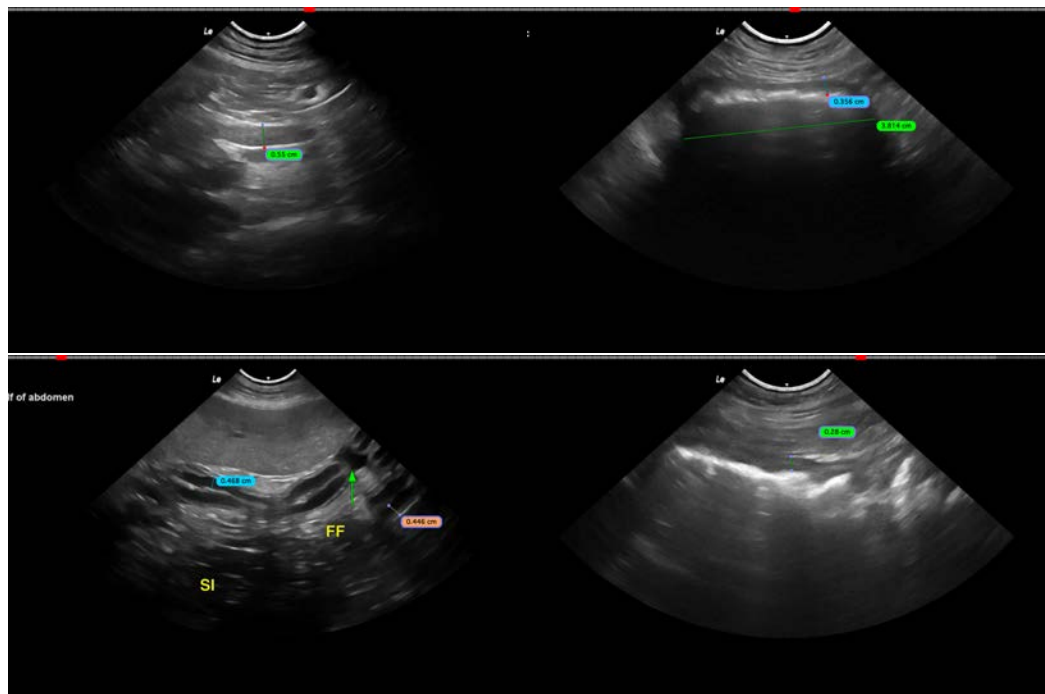
The right limb of the pancreas is prominent and hypoechoic, most consistent with chronic pancreatic remodeling and chronic pancreatitis. Correlate with a PLI level and recommend continued treatment for chronic pancreatitis.

The liver is mildly heterogeneous, and there is some moderate debris visualized associated with the gallbladder. The significance of these changes is uncertain.

Chronic treatment for protein losing enteropathy is challenging, and specific recommendations are beyond the scope of this consultation. I will provide information for a more in depth internal medicine consultation below, if desired:

For an additional charge an internal medicine consult can be utilized through [Sonopath.com](http://sonopath.com). You can select the internal medicine drop down at <http://spa.sonopath.com/>.

One of the world's top internists & SonoPath associate Dr. Remo Lobetti BVSc, MMedVet, PhD, DECVIM can evaluate your case through SonoPath. <https://sonopath.com/resources/sonopath-services/internal-medicine-teleconsultation-services>





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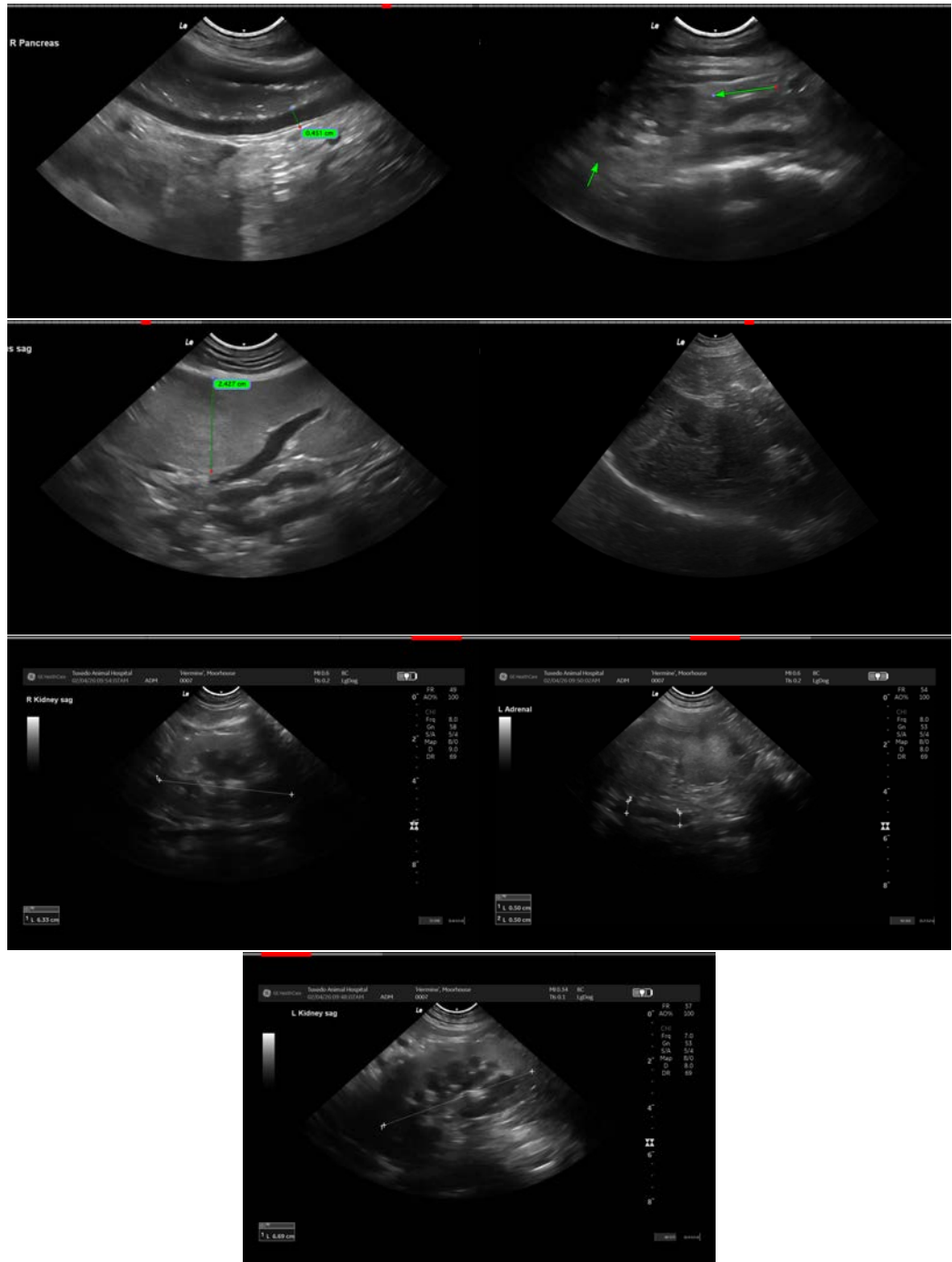
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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