



PATIENT

Catalina Garcia

SPECIES

Canine

BREED

Weimaraner

SEX

Spayed Female

AGE

9 Years

WEIGHT

50.8 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Gabriel Ferrer, DVM

HOSPITAL NAME

Pulse: Pet Ultrasound

REFERRING VET

Dr. Richard Gonzalez

INVOICE

24163

DATE

3/12/26

PRESENTING CLINICAL SIGNS

Px presented as a referral for an abdominal ultrasound due to significant weight loss and blood in the stool. Px visited rDVM 2 weeks ago and was prescribed the following Mx: Royal Canin Gastrointestinal diet, and Metronidazole 250mg. Owner is also giving Px home-cooked meals with ingredients such as boiled chicken, sweet potatoes, etc. (no seasoning). Px was inappetent but after starting on the Mx listed above now has an appetite. rDVM also administered a single dose of inj Dexamethasone

Abnormal PE/Chem/CBC/UA Results: Bloodwork attached below for your reference

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 (6.88 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 (7.59 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

A normal left adrenal gland is not clearly visualized. In the region of the left adrenal gland there is a focal mineralized shadowing structure described under "other".

The right adrenal gland is normal in size measuring 0.41 cm at the cranial pole and 0.43 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 (1.66 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 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. There is a moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.



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Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of 0.45 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 appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. Duodenum wall measures 0.56 cm. Jejunum wall measures 0.50 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with non-formed fecal material and gas shadowing distally. The descending colon wall appears thickened with intact wall layering, measuring up to 0.43 cm.

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. There are occasional prominent mesenteric lymph nodes. An example measures 1.57 cm x 4.34 cm. The right iliac lymph node is prominent measuring 1.21 cm x 2.55 cm. The omentum is normal in echogenicity.

Other

There is a hypoechoic structure that appears to be shadowing, most consistent with possible mineralization, noted medial to the left kidney. I cannot associate this structure with bowel, but this could be a concern. Alternately, this could represent a mineralized left adrenal mass lesion. It measures 1.07 cm x 3.02 cm in the sagittal view and 1.47 cm x 2.17 cm in the transverse view.

ULTRASONOGRAPHIC FINDINGS

- Shadowing/possibly mineralized structure visualized near the left kidney – The nature of this lesion is unclear, as visualization is impaired by the shadowing. Findings could be consistent with mineralized adrenal. It could less likely be associated with bowel, etc.
- 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 some areas exhibiting prominent muscularis layer – The small intestinal wall changes are most consistent with an inflammatory process (i.e., inflammatory bowel disease) with a low possibility of emerging lymphoma.
- Thickened descending colon wall with intact wall layering – Findings are most consistent with colitis, although early neoplastic change cannot be definitively ruled out.



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- Prominent mesenteric lymph nodes – Findings could be consistent with highly reactive or early neoplastic lymph nodes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small intestine appears diffusely mildly thickened with intact/prominent wall layering, possibly consistent with an inflammatory type process. Additionally, the descending colon is somewhat thickened, most consistent with colitis. The lab work provided could be supportive of an iron deficiency, and combined with the low albumin levels increases concern for possible ulcerative GI lesion? No such lesion was clearly visualized but could be a concern.

There is a shadowing structure visualized medial to the left kidney. This could represent a left adrenal mass lesion, have an unseen association with bowel or similar. Correlate with abdominal radiographs. A contrast CT scan would be helpful for further assessment.

Initial therapy for a possible primary enteropathy could include the following:

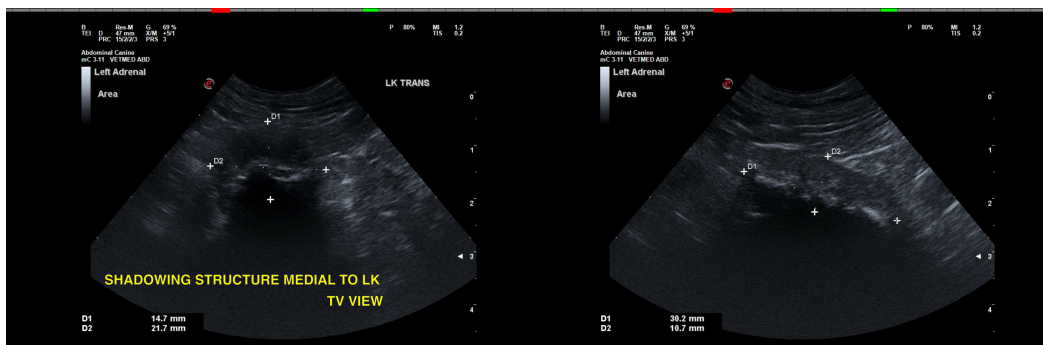
- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend chronic probiotic therapy.

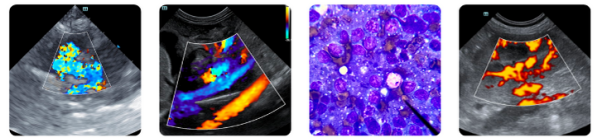
If not already done, consider empirical deworming and screening for GI parasites.

Correlate these findings with urinalysis +/- urine protein to creatinine ratio, looking for proteinuria contributing to hypoalbuminemia reported. Additionally, a liver function test could be considered.

If GI signs are persistent, upper and lower GI endoscopy may be warranted for further evaluation of the colon and proximal GI tract.

Recommend three view thoracic radiographs to evaluate for possible concurrent thoracic disease/involvement (disregard if this has already been done).





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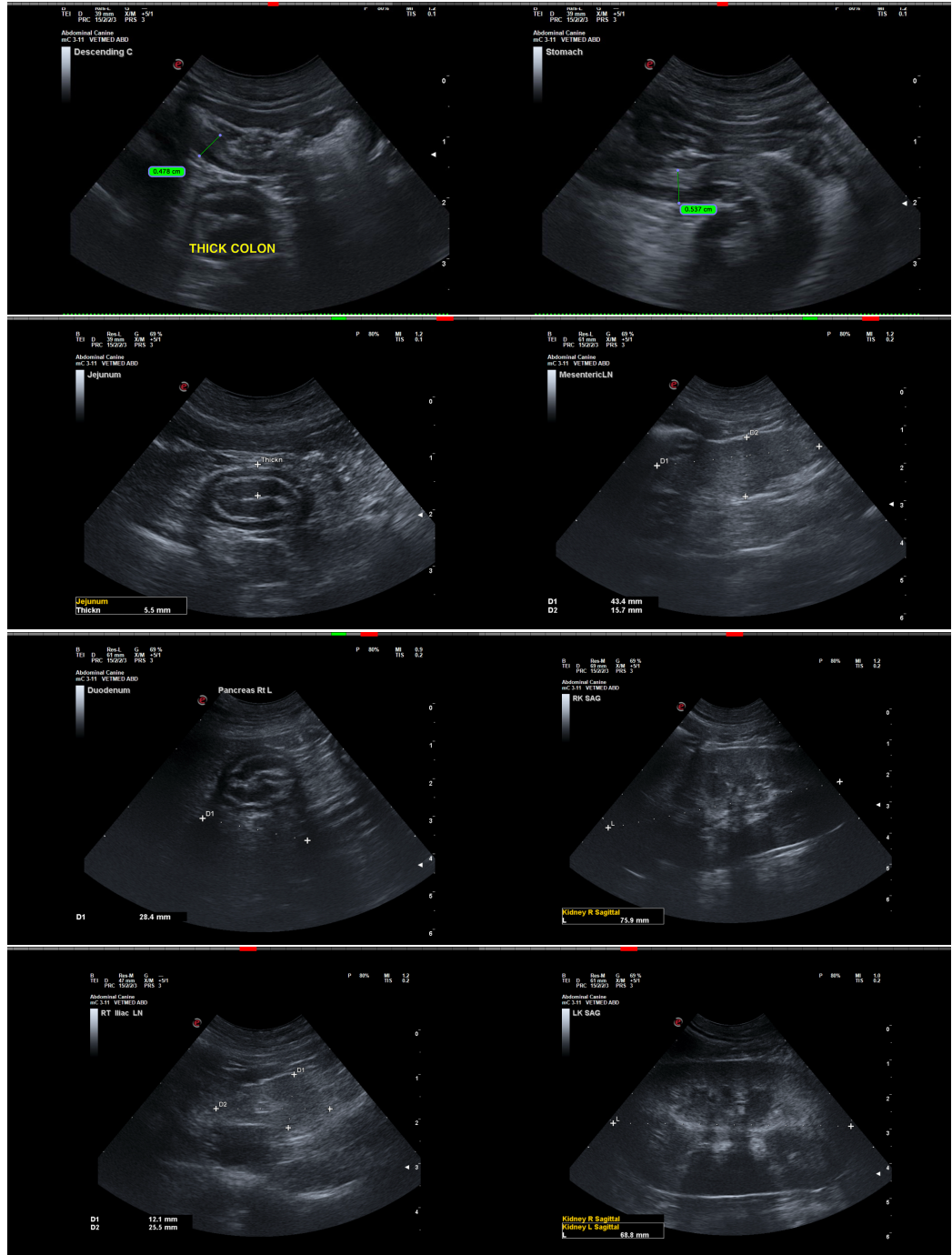
Dr. Richard Gonzalez

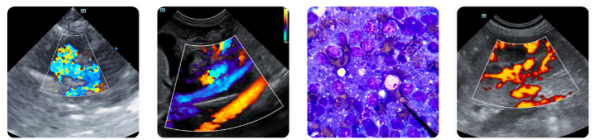
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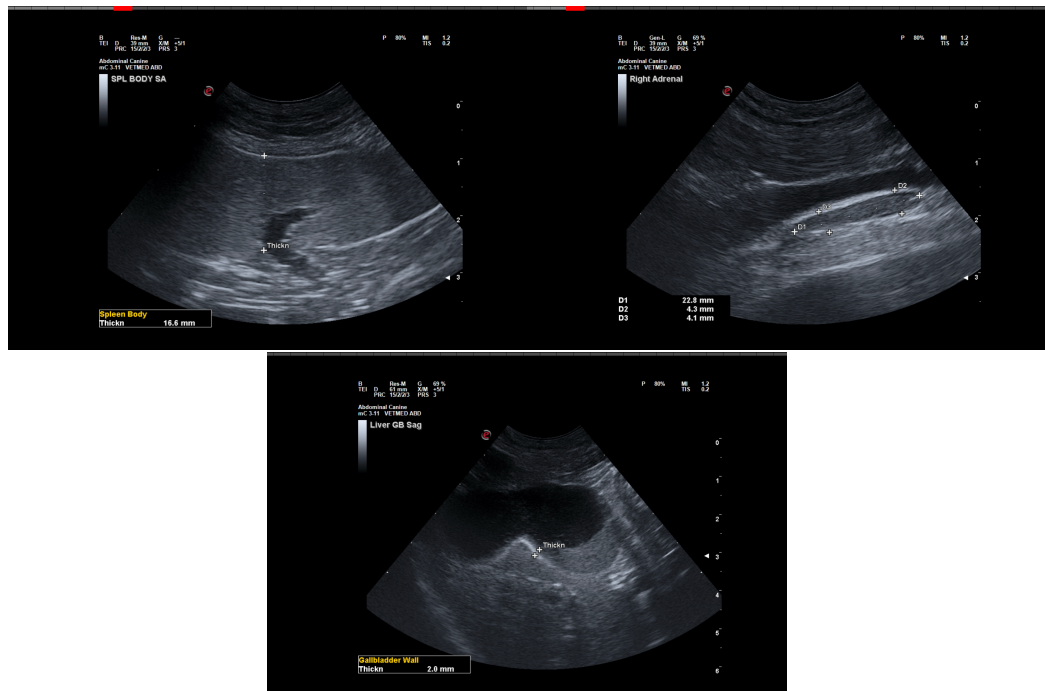
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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