



PATIENT

Piper Otto

SPECIES

Canine

BREED

Mini Poodle

SEX

Spayed Female

AGE

12/5/16

WEIGHT

4.34 kg

INTERPRETED BY

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

**IMAGING
PERFORMED BY**

Loetitia Saint-Jacques,
LVT

HOSPITAL NAME

Brighton Greens
Veterinary Hospital

REFERRING VET

Dr. Robin Janeway

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DATE

3/19/26

PRESENTING CLINICAL SIGNS

Sedation was declined, resulting in a tense abdomen and patient movement. PDA sx in 2019. Last echo 6/2025 no significant change. No medications needed. Continued aortic insufficiency and systolic dysfunction.

Abdominal u/s 7/2025 - Mild age related changes visualized associated with both kidneys. Pancreatic changes consistent with mild pancreatic remodeling. Large amount of hyperechoic, non-organized gallbladder debris with a small amount of debris adhered to the gallbladder wall - Consider starting Ursodiol therapy in efforts to prevent organization into a mucocele. Diffusely thickened small intestine with a 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.

On hydrolyzed diet. Episode of pancreatitis 2/23/26. Idiopathic Vestibular (improving) 3/12/2026. Possible IVDD/Possible stifle pain approx 6 months duration. Grade 2/6 systolic murmur. No symptoms. Ataxia and vestibular signs suspected to be idiopathic vestibular. Working diagnosis. Ongoing IBD, aortic insufficiency and systolic dysfunctions.

MEDS- Gabapentin 100mg PO BID, visbiome daily, Methocarbamol 125mg tab PO BID, Ursodiol 62.5mg PO SID, Galliprant 10mg PO SID

Abnormal PE/Chem/CBC/UA Results: 2/16/26 Mild anemia with Hct 35.1%, Bun 34, CHO 347, PL 225 (200 high normal improved from pancreatitis episode at PL= 532)

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is mildly to moderately distended with anechoic urine. The Bladder wall generally has a smooth mucosal surface and is of normal thickness. In the region of the cystourethral junction there is some prominent irregular tissue measuring 0.65 cm x 0.49 cm. This could be prominent due to lack of urine distention in this region, an early focal lesion/mass effect cannot be ruled out.

The left kidney has a normal shape and size (3.05 cm). Overall echogenicity is slightly hyperechoic with mildly reduced 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 (3.53 cm). Overall echogenicity is slightly hyperechoic with mildly reduced 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 0.46 cm at the cranial pole and 0.41 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 0.45 cm at the cranial pole and 0.47 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal



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vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

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Spleen

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The spleen is subjectively normal in size (0.70 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

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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.

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The gall bladder lumen is significantly distended. Some areas of the wall appear mildly thickened with adherent debris. There is a large amount of primarily non-organized echogenic debris. There is no evidence of bile duct dilation.

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Gastrointestinal

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The stomach contains moderate/large fluid and shadowing ingesta. 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. Shadowing ingesta interferes with full evaluation of the stomach and some areas of the cranial abdomen.

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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 0.45 cm. Jejunum wall measures 0.32 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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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.

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Pancreas

The right limb of the pancreas is prominent and mottled 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.

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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.

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ULTRASONOGRAPHIC FINDINGS

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- Prominent, irregular appearing tissue at the cystourethral junction. This is likely artifact due to lack of urine distention, a true mass effect cannot be ruled out,
- Age related changes visualized associated with both kidneys.



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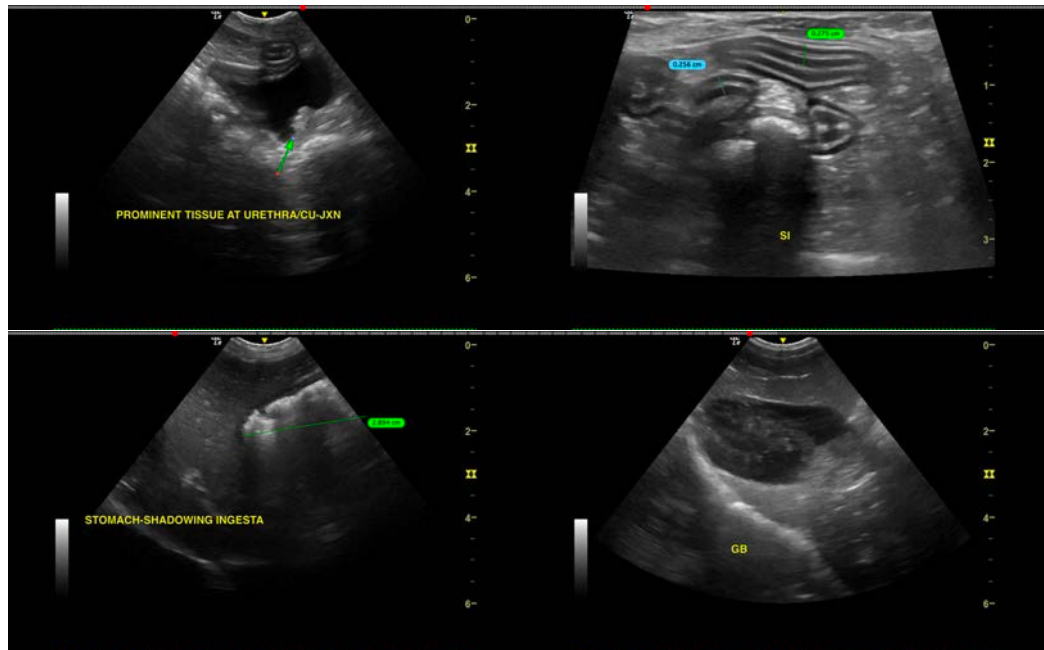
- Significant pancreatic remodeling +/- chronic pancreatitis in the right limb.
- Large gallbladder debris – The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting but seems unlikely to be causing a current issue. Recommend continued monitoring.
- Large fluid/ingesta distended stomach – Correlate with feeding history. If the patient was adequately fasted, this could represent delayed gastric emptying or partial outflow tract obstruction.
- Mildly diffusely thickened small intestine – The mild small intestinal wall changes may be a normal variant in this patient or could be consistent with an inflammatory process (e.g., inflammatory bowel disease).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Many of the changes observed today are stable from the previous exam. This includes changes to the kidneys, gallbladder, and small intestine previously described.

There is some prominent, irregular tissue visualized at the cystourethral junction. I suspect this could be due to lack of urine distention and artifact but consider reevaluation with a full bladder under sedation to reassess.

The right limb of the pancreas appears prominent with some mild hyperechoic reactive mesentery possibly consistent with mild active pancreatitis. Correlate with PLI level and consider empirical treatment for pancreatitis if this is significantly elevated and clinical signs are present.





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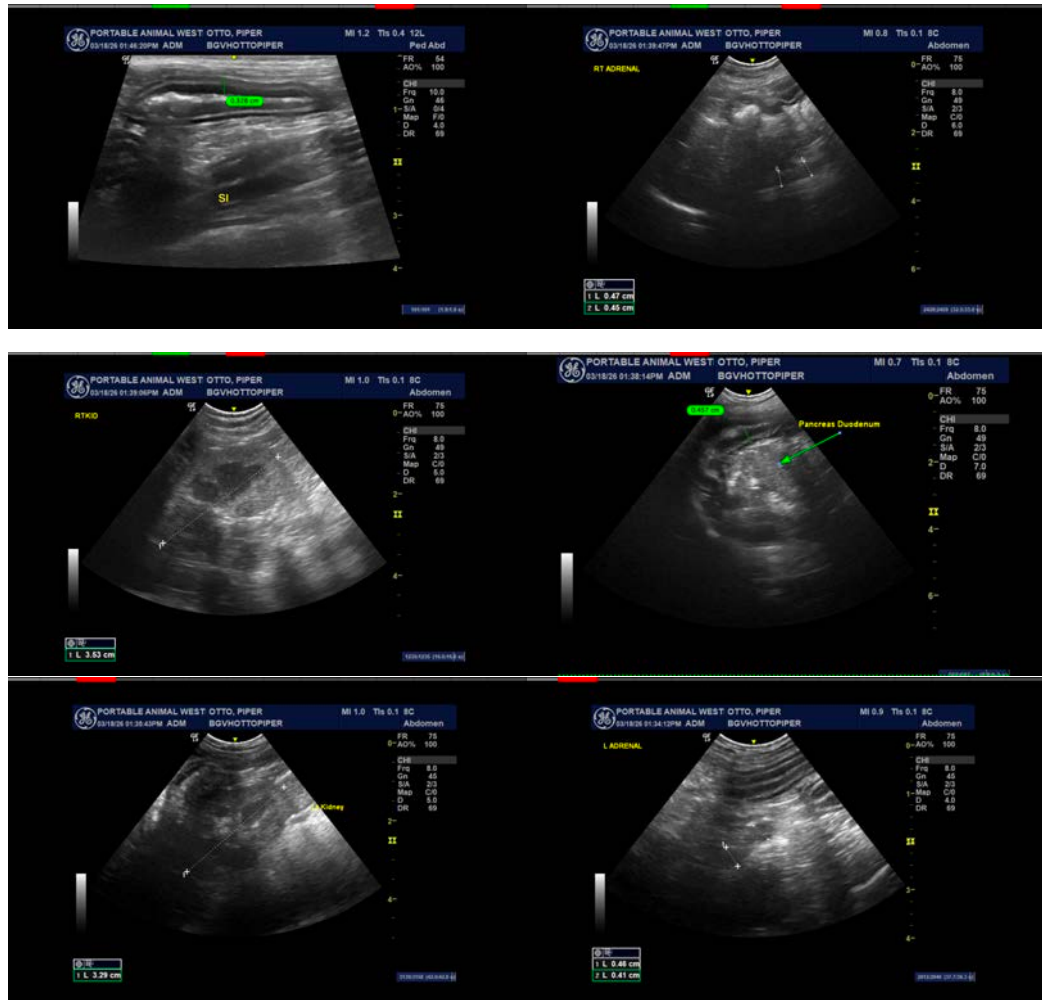
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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