



**PATIENT PRESENTING CLINICAL SIGNS**

Bailey Moore

**SPECIES**

Canine

**BREED**

German Shepherd

**SEX**

Spayed Female

**AGE**

11 Years

**WEIGHT**

70 Pounds

**INTERPRETED BY**

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

**IMAGING PERFORMED BY**

Sara Hansen

**HOSPITAL NAME**

Echo Hollow VH

**REFERRING VET**

Dr. Kenna

**INVOICE**

46063

**DATE**

3/21/23

Visit on 2/17/23 \* O presented P; States P was gasping for air, excessive panting and licking at the air, slight swelling around the muzzle. \* Doctor's Assessment: overweight, increased ALP, possible bee sting - although muzzle no longer swollen. \* Doctor's Plan: Recom denamurin, recheck panel A in 3 to 4 weeks, ok to give benadryl 50mg every 12 hours for 2 to 3 days Visit on 2/18/23 \* P presented for T4 thyroid recheck. Per Dr. Gildersleeve, WNL. P seemed to be doing better at this time. Visit on 3/18/23 \* P presented for Panel A as per Dr. Kenna. Please see lab findings below. Per Dr. Kenna, if pet was not improving, recommend recheck +/- abdominal ultrasound.

Abnormal PE/Chem/CBC/UA Results: 2/17/23- Per Dr. Kenna RADS performed- WNL ALP = 258 H 1.5 x T4 = too lipemic, recom 12 hour fast and re-do T4 2/18/23- Per Dr. Gildersleeve CTO: relayed wnl T4 results. P seems to be doing better per owner. TG: 02-21-23 at 9:20p: 3/18/23- Per Dr. Kenna ALP = 303 (2x increase) BUN = 17 WNL Creat = 1.4 H normal Spoke with O - picky eater, drinks normal amt of water. Dog has been more lethargic. O hasn't given Gabapentin yet. recom starting Gabapentin - if no help then recom recheck +/- abd ultrasound. MK: 03-18-23 at 3:01p: Current Medications Gabapentin 300mg capsule, Denamarin Adv. Chews- Large Dog Radiographic Findings Radiographs were WNL per Dr. Kenna.

**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 was not fully imaged, partially viewed adjacent to left adrenal-no abnormalities noted.

The right kidney has a normal shape and size (7.32 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 0.67 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 0.85 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, 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.



**PATIENT** *Liver*

Bailey Moore

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 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***

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The stomach contains a moderate amount of fluid/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. No masses or focal lesions were observed.

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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 (between 0.3-0.5cm in wall thickness) and the jejunum measured as normal (between 0.2-0.47cm.)

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Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. 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.

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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**

**REFERRING VET**

Dr. Kenna

- 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.
- Moderate fluid/ingesta within the gastric lumen – Correlate with feeding history. Findings could be consistent with a non-fasted patient, delayed gastric emptying, or a partial outflow tract obstruction (none observed).

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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

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No significant focal lesions were visualized associated with the liver or gallbladder to explain the elevation in ALP reported. The ALP can be a non-specific liver enzyme, which can become elevated due to a primary hepatopathy, but also can rise due to other factors such as medications, systemic



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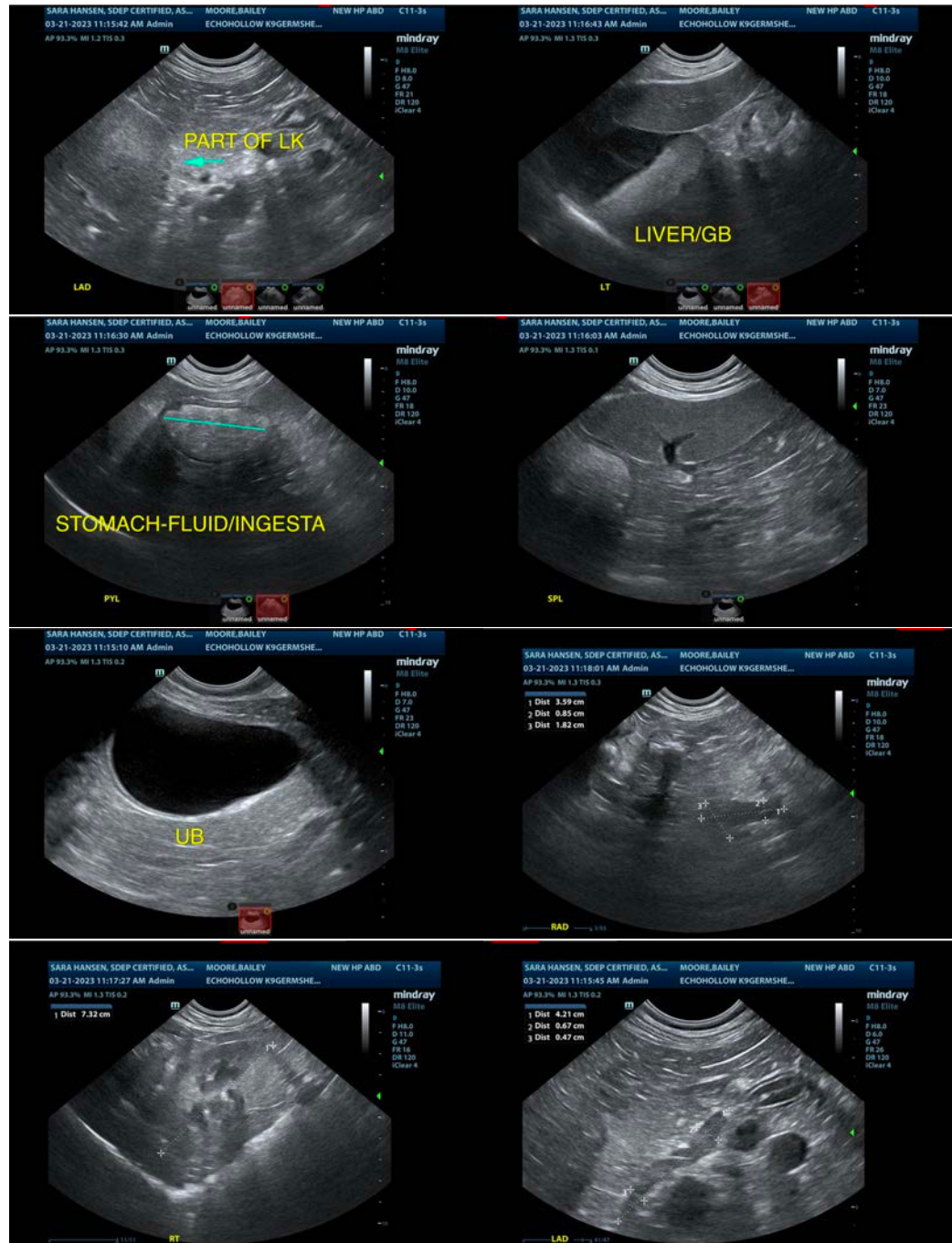
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inflammation, etc. Consider a liver function test, and if it is abnormal or the ALP continues to rise, consider obtaining a fine needle aspirate (provided coagulation parameters are normal).

No changes are visualized associated with the kidneys. Recommend correlating the BUN and creatinine with a urine specific gravity. If early renal issues are a concern, then recommend a urinalysis, culture, urine protein to creatinine ratio, blood pressure, +/- Leptospirosis screening.





**PATIENT**

Bailey Moore

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.

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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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kathleen.sennello@sonopath.com

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