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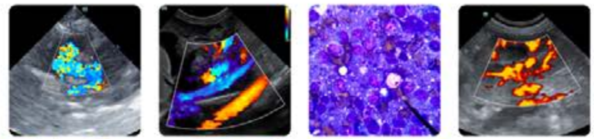


Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT
Zoey Laird

SPECIES
Canine

BREED
Terrier x

SEX
Spayed Female

AGE
14 Years 6 Months

WEIGHT
8.9

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

IMAGING PERFORMED BY
Mariusz Chmielinski

HOSPITAL NAME
Apex Veterinary Services

REFERRING VET
Alpine 24/7 ER

INVOICE
74065

DATE
3/26/26

PRESENTING CLINICAL SIGNS

Acute GI signs × ~6–7 days. Watery diarrhea (frequent, overnight q90 min). Vomiting (yellow bile → clear/yellow oily). Inappetence, lethargy/weakness. Drinking water. Relevant hx: Stage II CKD, Prior pancreatitis (~5 yrs ago)

Abnormal PE/Chem/CBC/UA Results: QAR, ~6% dehydrated, Vitals stable, Abdomen soft, non-painful. LABWORK SUMMARY Mild leukocytosis with neutrophilia/monocytosis Mild increase in BUN (likely dehydration), creatinine WNL Marked increase in ALP Electrolytes WNL Amylase/lipase WNL

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall appears mildly thickened with a slightly irregular surface, measuring at 0.46 cm. The region of the trigone, ureteral papillae and proximal urethra appear free of any mass lesions or calculi.

The left kidney has a normal shape and size (5.11 cm) with numerous small cortical cysts, and pyelectasia at 0.30 cm. Overall echogenicity is slightly hyperechoic with poor 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 nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (5.59 cm) with numerous small cortical cysts and mild pyelectasia at 0.14 cm. Overall echogenicity is slightly hyperechoic with poor 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 nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is large and slightly heterogeneous, measuring 1.76 cm at the cranial pole and 1.77 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 large, measuring 0.84 cm at the cranial pole and 0.89 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.

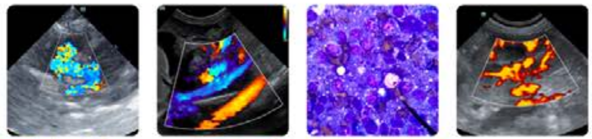
Spleen

The spleen is subjectively normal in size (1.82 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 large in size, and normal in echogenicity with rounded 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.

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. The gastric wall is slightly prominent/thick with intact wall layering, measuring at 0.50 cm. 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 to mild fluid and gas distension. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. Duodenum wall measures 0.34 cm. 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. The descending colon wall is slightly prominent with intact wall layering measuring at 0.30 cm.

Pancreas

The pancreas is prominent, hypoechoic and mottled in both limbs (right > left). 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 hypoechoic mesenteric lymph nodes. Examples measure 0.75 cm and 0.64 cm. The omentum is normal in echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Mildly thickened/irregular urinary bladder wall – 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.

- Very large, mottled left adrenal and a large right adrenal – Findings could be consistent with bilateral hyperplasia or even a left adrenal mass lesion.

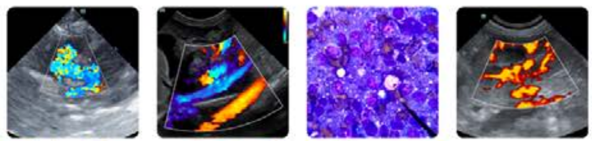
- Age related changes visualized associated with both kidneys as well as bilateral mild pyelectasia – Findings are most consistent with chronic progressive age related renal disease. Pyelectasia of the kidney(s)could be consistent with pyelonephritis, chronic renal disease, secondary to PU/PD or fluid therapy (if applicable), other.

- Pancreatic changes most consistent with chronic pancreatic remodeling. Mild pancreatitis cannot be ruled out.

- Large, heterogeneous liver – Findings are suggestive of a vacuolar hepatopathy. Other hepatopathies are possible.

- 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.

- Mildly thickened gastric wall with intact wall layering – Findings are most consistent with gastritis. Neoplastic change is thought less likely.



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- Enteritis type pattern visualized associated with the small intestine.
- Thickened descending colon wall with intact wall layering – Findings are most consistent with mild colitis.
- Likely reactive mesenteric lymphadenopathy.

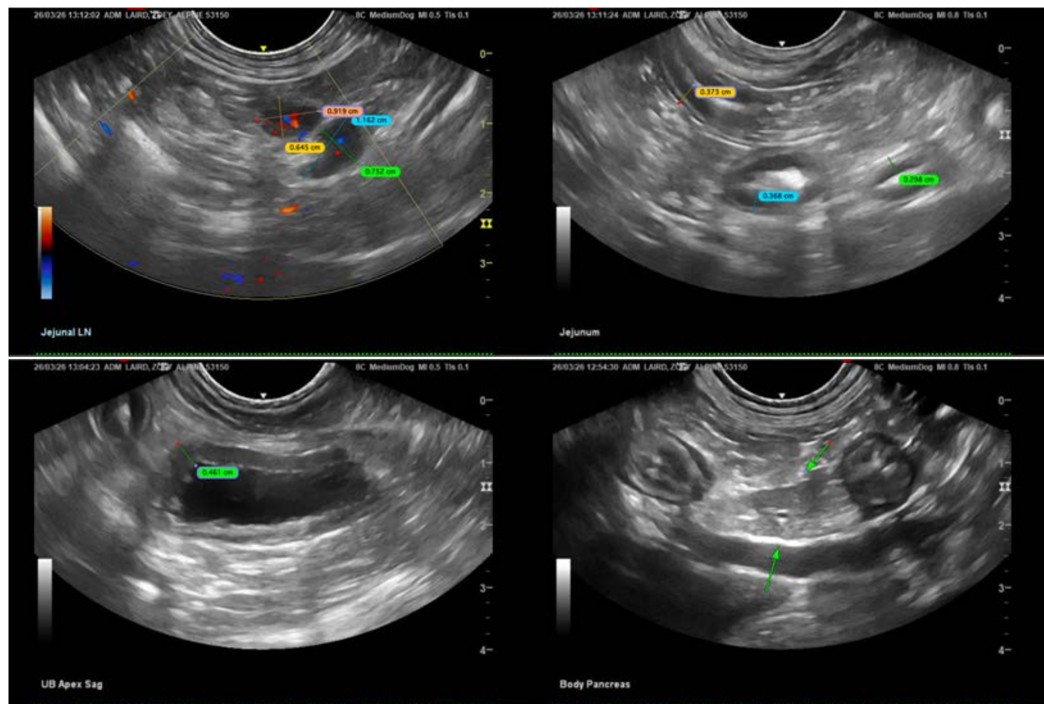
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

There is a general impression of mild inflammation visualized associated with the stomach, small intestine and colon, possibly consistent with non-specific gastroenterocolitis. Recommend aggressive treatment +/- treatment for concurrent pancreatitis depending on measurement of a PLI level.

Both adrenals are large. The left adrenal in particular is very large. This could represent bilateral hyperplasia or even a left-sided mass lesion. If the patient has symptoms consistent with Cushing's disease, you could consider adrenal function testing once the patient has completely resolved from this episode of GI upset. Additionally consider a blood pressure evaluation. If hypertension is present, consider measuring catecholamine levels, looking for possible pheochromocytoma. Recommend continued monitoring of the adrenals, looking for progressive growth over time.

The liver changes are likely consistent with a vacuolar hepatopathy. If a more significant hepatopathy is suspected, consider a fine needle aspirate and liver function testing.

If GI signs are persistent, you could consider repeat imaging in the future, looking for the progression of today's lesions. Ultimately, biopsies of the GI tract might be necessary if symptoms become more chronic in nature.



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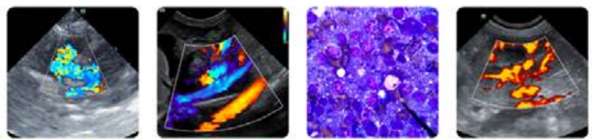

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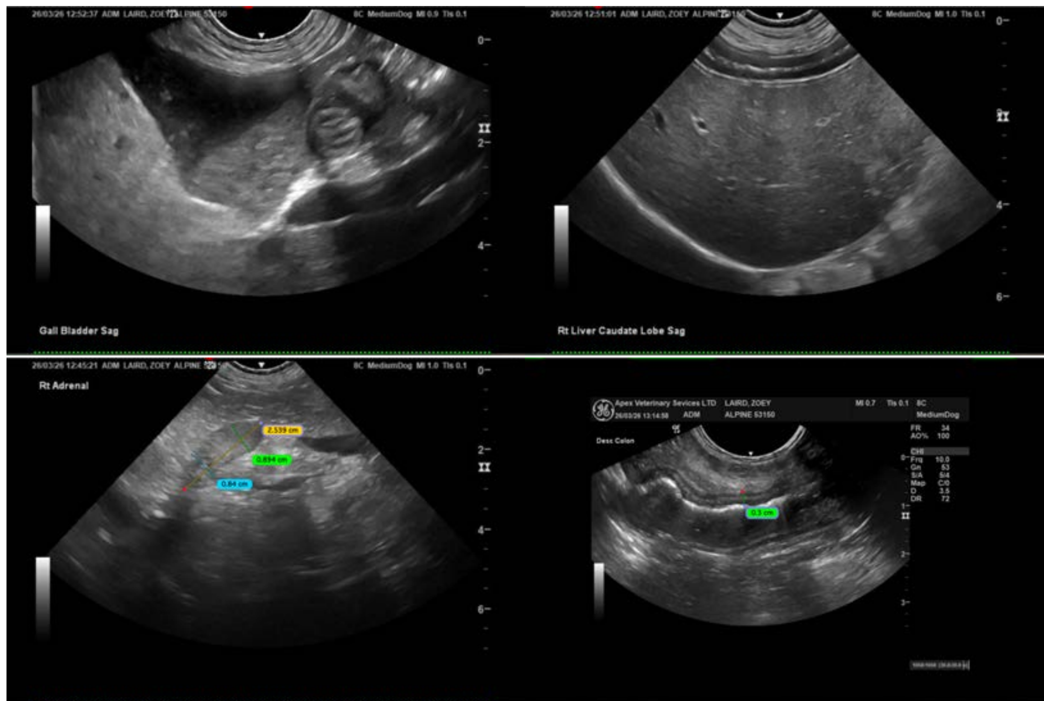

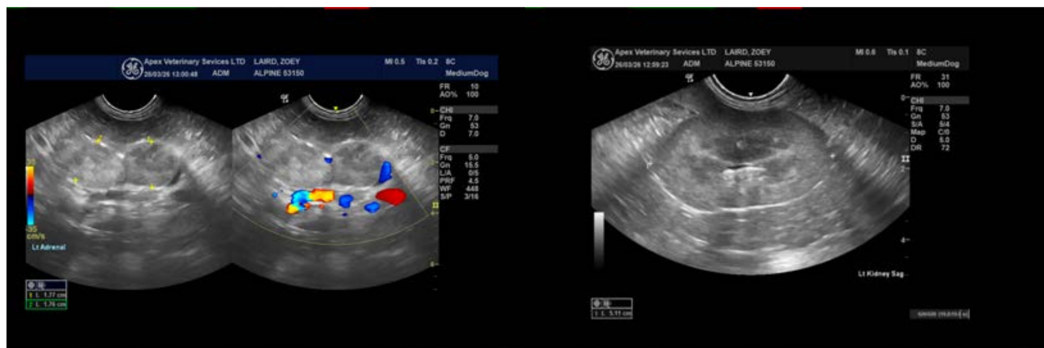

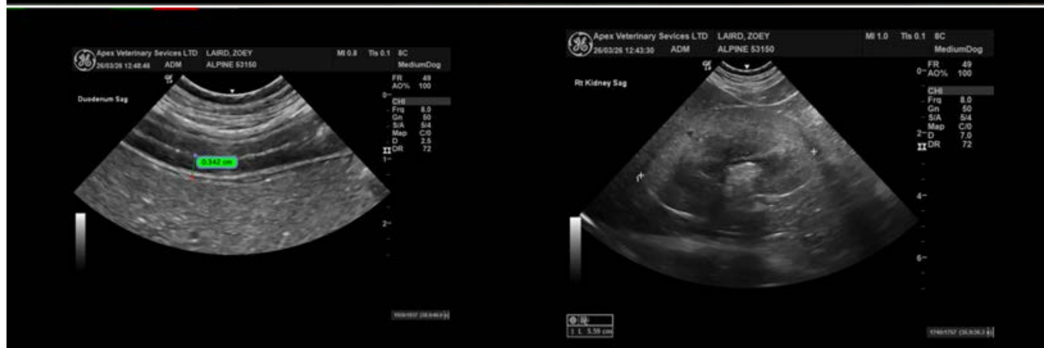

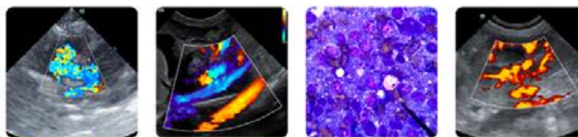

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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