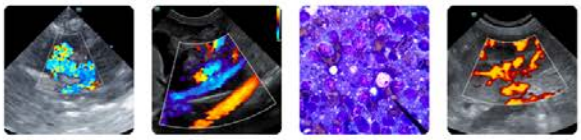


DATE

3/27/26

PATIENT

Skye Marlow

SPECIES

Canine

BREED

Cattle Dog x

SEX

Spayed Female

AGE

12/14/14

WEIGHT

15.2 kg

INTERPRETED BY

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

HOSPITAL NAME

Mason Dixon Animal Emergency Hospital

REFERRING VET

Dr. Parr

INVOICE

74055

PRESENTING CLINICAL SIGNS

Patient History: Acute onset of intermittent pain. R/o lumbar vs. GI/UG. Pt has a history of progressed bilious vomiting that is currently managed with increased feedings.

Current Medications: None listed.
Labwork Results: Labwork not attached, reported as: CBC/Chem unremarkable
Date of Previous IntraPet Ultrasound: No previous.
Sedation: Torbugesic.
Stat Report: Requested.
Imaging Performed by: Stephanie Warga RDCS, RVT.

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 (5.58 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 (5.55 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 0.55 cm at the cranial pole and 0.49 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 0.53 cm at the cranial pole and 0.68 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 (1.64 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. There is a hypoechoic nodule visualized on the left side, visualized intracostally, measuring 2.04 cm x 1.34 cm.

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 0.33 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. On some views of the esophageal inlet, the lumen appears somewhat narrowed, possibly consistent with a prominent/abnormal cardiac sphincter. A focal lesion cannot be definitively ruled out.

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. Jejunum wall measures 0.33 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are occasional prominent mesenteric lymph nodes. A lymph node in the caudal abdomen measures 0.75 cm x 2.47 cm. A mesenteric lymph node measures 0.34 cm in diameter. The omentum is normal in echogenicity.

ULTRASONOGRAPHIC FINDINGS

- Hypoechoic nodule in the left liver – This could represent a benign or early neoplastic lesion. Recommend continued monitoring.
- 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.
- Prominent area at the esophageal inlet/cardiac sphincter – Possible differentials include anatomic variation or thickening in this region.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

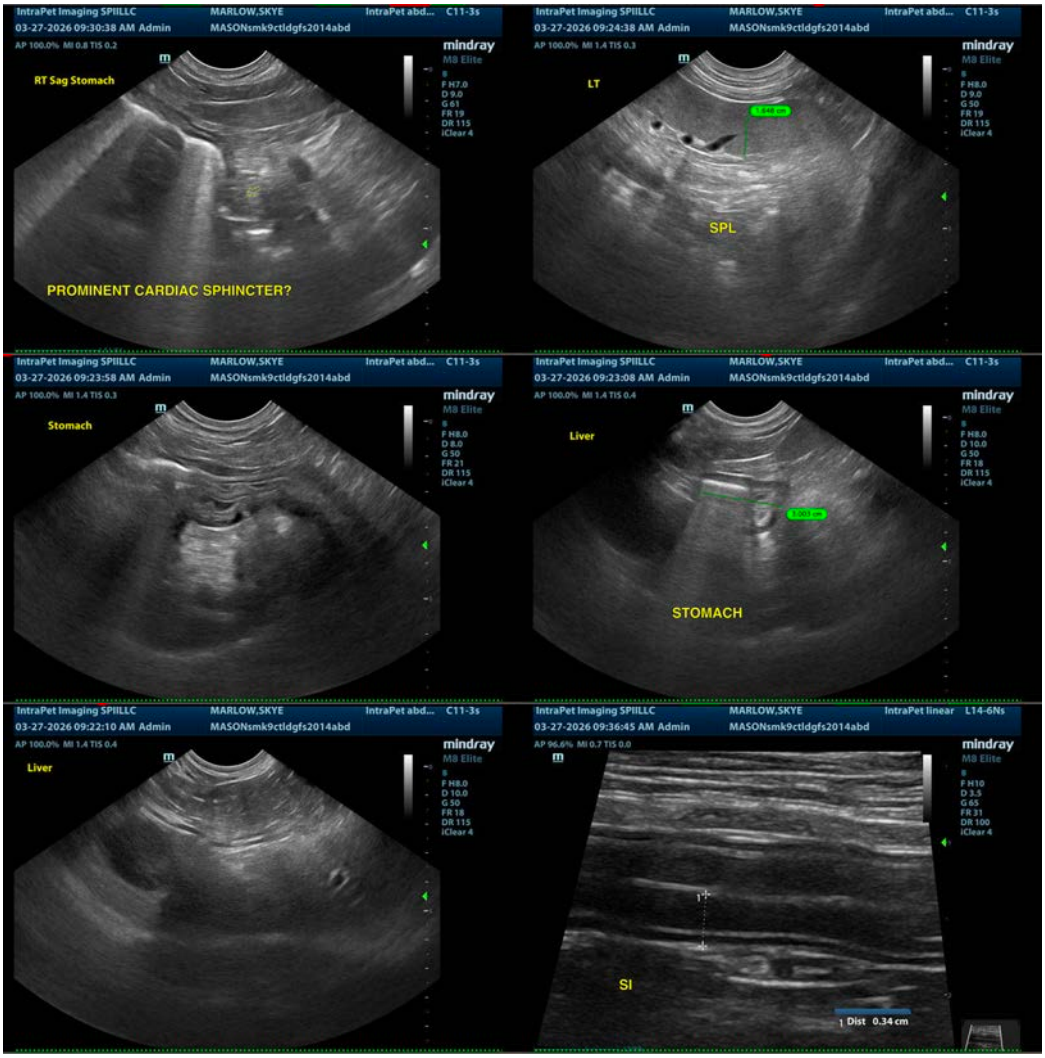
No definitive cause for abdominal pain is noted on today's exam. There is a hypoechoic nodule on the left side of the liver. This could represent a benign or early neoplastic lesion. I suspect based on the location that this would be difficult to sample. Recommend continued monitoring with ultrasound (recheck in 2-3 months). If a window for sampling is available, consider a fine needle aspirate.

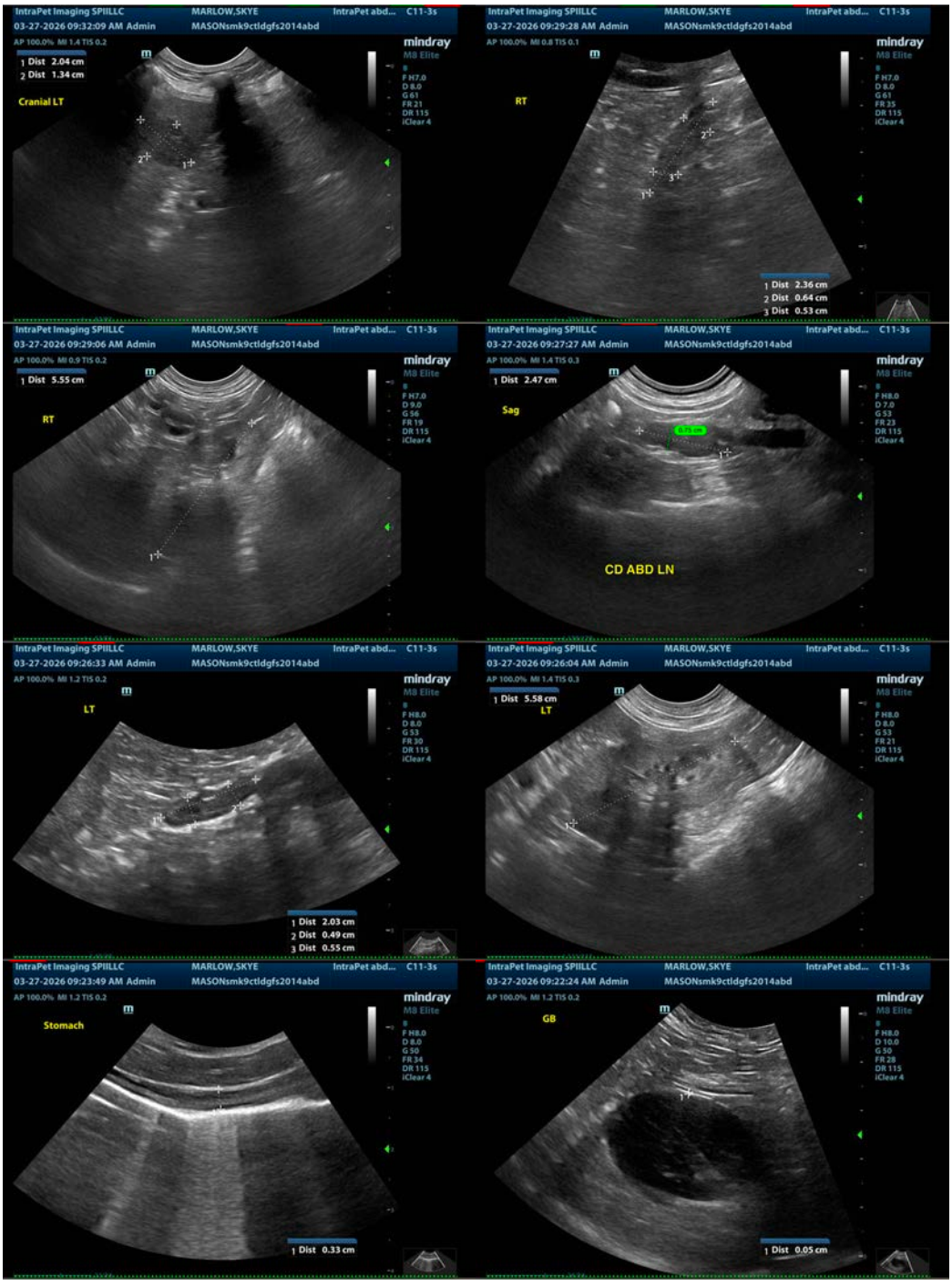
No definitive gastrointestinal lesions are visualized. The stomach is relatively empty. On some views the esophageal inlet appears somewhat prominent. This could be normal for this individual or be consistent with

a thickened sphincter. Typical symptoms to accompany this could be regurgitation, reluctance to eat, possible vomiting, etc. Further evaluation would likely involve upper GI endoscopy and/or a contrast CT scan. Additionally, you could consider continued monitoring and reevaluation of this area with the hepatic nodule in the future.

Correlate these findings with your clinical assessment. In general, it would be unusual for a patient to eat well in the face of gastrointestinal pain (not sure if this pet does?), whereas with back pain this is sometimes the case. This can sometimes be clue as to the source of the discomfort.

Additionally, you could consider referral to a neurologist for further assessment.

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M8 Elite
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2 Dist 1.34 cm
Cranial LT
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RT
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2 Dist 0.64 cm
3 Dist 0.53 cm
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RT
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LT
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1 Dist 5.58 cm
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Stomach
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GB
1 Dist 0.05 cm

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