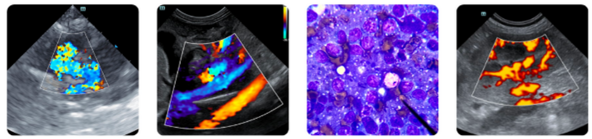


PATIENT

Thunder Pederson

SPECIES

Canine

BREED

Pomsky

SEX

MN

AGE

9 months

WEIGHT

9.8 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Matthew Guenther

HOSPITAL NAME

Hidden Tails Mobile Veterinary Ultrasound

REFERRING VET

Dr. Scotter

INVOICE

11615

DATE

4/1/2026

PRESENTING CLINICAL SIGNS

Chronic vomiting 5-6mths. Vomit always bile, sometimes red tinged. Vomits occur late afternoon or middle of night. No improvement noted with diet change (various pet store) or deworming. Improves on maropitant but vomiting returns once discontinued.

Abnormal PE/Chem/CBC/UA Results: PE normal. CBC - mild anemia Chem - mild increase SDMA and phosphorous.

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 prostate is normal in size (1.2 cm) and shape for this neutered male dog. The parenchyma is homogenous and the external margins are smooth. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (4.85 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. Occasional pinpoint cortical mineralizations noted. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.77 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. Occasional pinpoint cortical mineralizations noted. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

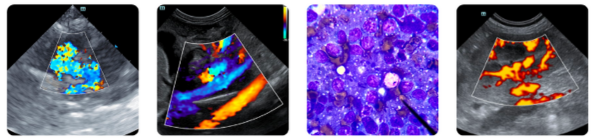
The left adrenal gland is normal in size measuring 0.33 cm at the cranial pole and 0.45 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.57 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 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 (1.4 cm) and the echotexture is homogenous. The splenic capsule is smooth with no visible irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

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.

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and likely incidental at this time. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of 0.62 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. Subjectively, the gastric wall appears slightly prominent/thickened with a prominent muscularis layer.

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 (0.33 cm in wall thickness) and the jejunum measured as normal (0.29 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 visible/mildly mottled in the left limb. 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, 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.

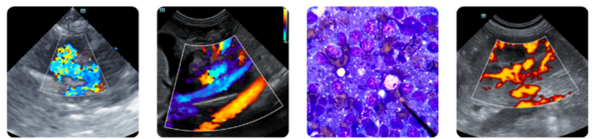
ULTRASONOGRAPHIC FINDINGS

- Visible left limb of the pancreas. Findings could be consistent with mild remodeling/resolving pancreatitis.
- Prominent gastric wall with a prominent muscularis layer. Findings could be consistent with gastritis.
- Occasional pinpoint mineralizations visualized associated with both kidneys.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No definitive lesions are visualized to explain the chronic vomiting reported. Subjectively, the gastric wall appears slightly prominent with a prominent muscular layer, although the stomach is empty. Findings could be consistent with mild gastritis. Consider the following:

- Consider a novel hydrolyzed protein prescription diet in the case of possible dietary sensitivity.



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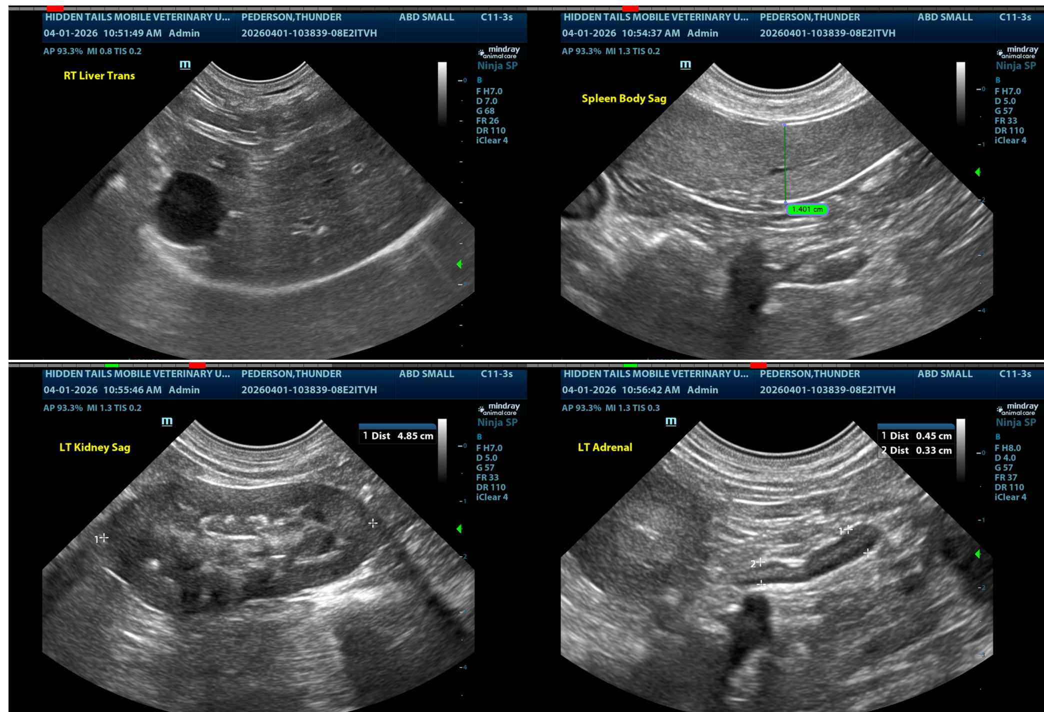
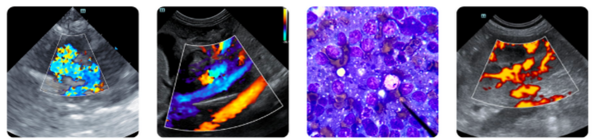
- If not already done, recommend empirical deworming and parasite screening.
- Recommend a baseline cortisol to screen for atypical Addison's.
- Consider an evening snack in the cause of possible bilious vomiting syndrome.
- Consider pre- and post-prandial bile acids to screen for liver dysfunction/a liver shunt.
- Recommend evaluation of urine concentrating ability looking for any evidence of early renal dysfunction.

If symptoms are persistent, despite taking these measures, ultimately upper GI endoscopy may be warranted to further evaluate the proximal GI tract and obtain biopsies. Additionally, consider thoracic radiographs to evaluate esophagus.





Clinical Sonography & Telecytology

Educational Teleconsultation Services™

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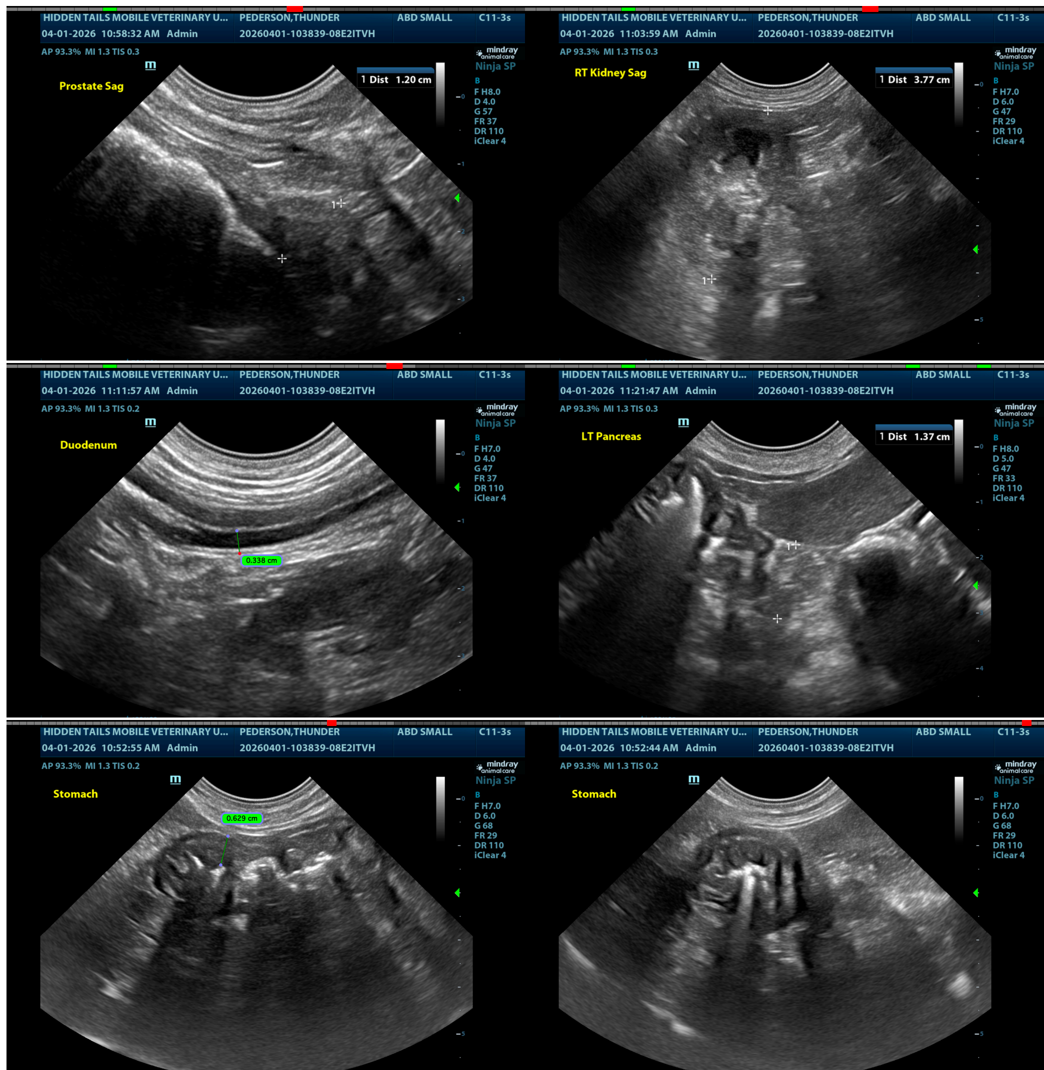

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@sonopath.com