



PATIENT

Oakley Hojski

SPECIES

Canine

BREED

Australian Labradoodle

SEX

Spayed Female

AGE

2 Years

WEIGHT

20.3 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Sarah Barthelemy

HOSPITAL NAME

Britannia Kingsland VC

REFERRING VET

Dr. Hamill

INVOICE

46645

DATE

4/13/23

PRESENTING CLINICAL SIGNS

Recent Hx of decreased appetite. Owner describes she seems tentative when eating/chewing. Had a dental cleaning recently with no abnormalities outside of tartar. Previous history of vomiting and diarrhea in 2021 and was diagnosed with IBD and gluten intolerance. Has previously been screened for Addison's back in 2021.

Abnormal PE/Chem/CBC/UA Results: Mild chronic SDMA elevation at 15. Normal creatinine and well concentrated urine.

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 (5.56 cm) with a thickened hyperechoic medullary rim and a hypoechoic cortex. Adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio noted. There are too numerous to count pinpoint non-obstructive nephroliths throughout the kidney. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (5.47 cm) with a thickened hyperechoic medullary rim and a hypoechoic cortex. Adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio noted. There are too numerous to count pinpoint non-obstructive nephroliths throughout the kidney. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.47 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 0.54 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.

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. 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. 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.

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. Duodenum wall measures 0.49 cm. Jejunum wall measures 0.36, 0.28 cm. Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are prominent/large mesenteric lymph nodes. Example measures 0.95 cm. The left sublumbar lymph node measures 0.42 cm.

ULTRASONOGRAPHIC FINDINGS

- Bilaterally abnormal renal architecture with small non-obstructive nephroliths – Findings are most consistent with underlying chronic renal disease.
- 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.
- Mild mesenteric lymphadenopathy – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized associated with the GI tract to explain the reluctance to eat. The appearance of the kidneys is abnormal. Consider a blood pressure, urinalysis, culture, and a urine protein to creatinine ratio (if not already done). I suspect this is not the cause for the current symptoms.

The reluctance to eat could be due to nausea. You could consider a Cerenia trial to see if this improves the appetite. Alternately, you could have dental pain, jaw pain, etc.

To further evaluate for underlying gastrointestinal disease, consider:

- Consider a novel protein/hydrolyzed protein diet (exclusively at least 4-6 weeks)
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend chronic probiotic therapy.



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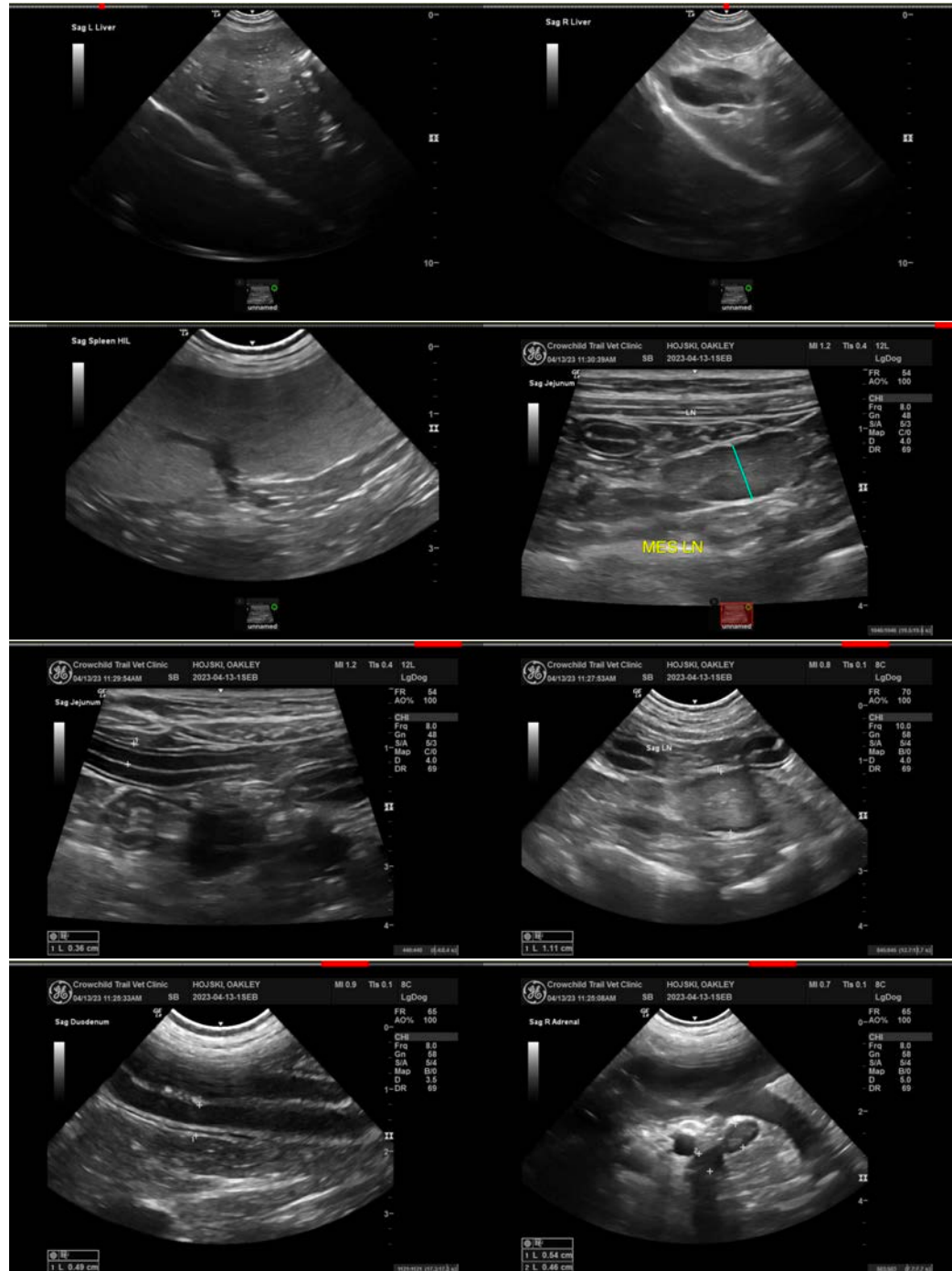
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In a young dog like this, the most common differentials would include food allergy/dietary intolerance, GI parasitism, dysbiosis, dietary indiscretion, less likely underlying neoplasia.





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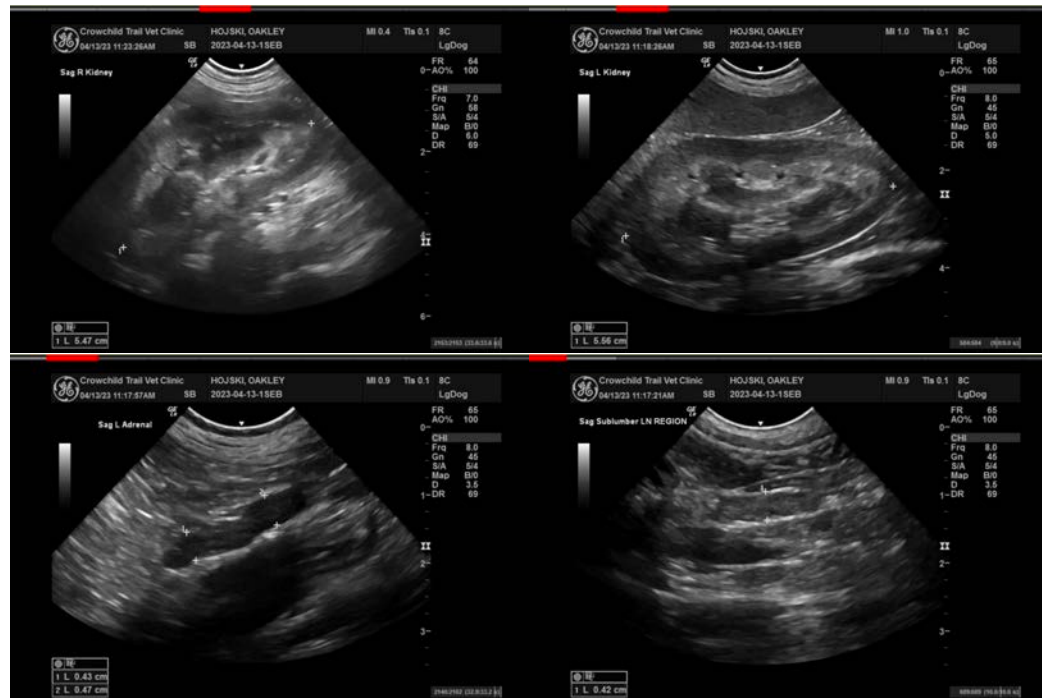
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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