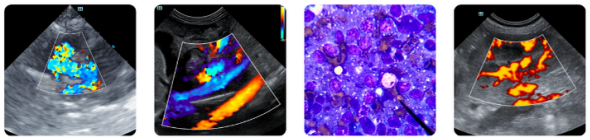


PATIENT

River Wallace Bennett

SPECIES

Canine

BREED

Old English Sheepdog

SEX

MN

AGE

7

WEIGHT

84

INTERPRETED BY

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

IMAGING PERFORMED BY

John Reese

HOSPITAL NAME

Willow Run Veterinary Clinic

REFERRING VET

Dr. Kaeli Witmer

INVOICE

11845

DATE

4/30/2026

PRESENTING CLINICAL SIGNS

Persistent diarrhea/vomiting/decreased appetite for 14 days. Minimal response to metronidazole, Cerenia, and low-fat I/D diet. 13# weight loss over 9 months.

Abnormal PE/Chem/CBC/UA Results: Pancreatic lipase 1112 (4/18/26) and then 162 (4/30/26) CBC, chem 18 w/ lytes, baseline cortisol wnl Fecal negative Gas in colon on abdominal radiographs.

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 visualized areas of prostate and surrounding tissue appear normal. Unfortunately, the prostate is not fully visualized likely due to its intrapelvic location. Correlate with rectal exam findings.

The left kidney has a normal shape and size (7.34 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 (6.46 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 0.33 cm at the cranial pole and 0.74 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.

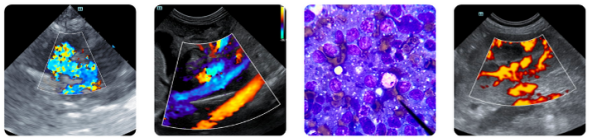
The right adrenal gland is normal in size measuring 0.6 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size (1.92 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

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.

Gastrointestinal

The stomach contains mild/moderate fluid. 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. The duodenum measured as normal (0.43 cm in wall thickness) and the jejunum measured as normal (0.36 cm.) Visualized peristalsis appears appropriate. There are occasional areas of small intestine exhibiting mild corrugation.

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 area of 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, 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

- 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 fluid distension of the stomach. Correlate with the feeding/drinking history. If the patient was adequately fasted this could represent mild gastric ileus.
- Areas of mild corrugation in the small intestine, possibly consistent with focal enteritis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Changes observed on today's scan are relatively mild. No focal lesions responsible for the significant symptoms described are observed. There is some mild fluid visualized within the stomach which is subjectively most consistent with delayed gastric emptying. No evidence of an obstruction is noted, but a small focal lesion cannot be ruled out. Consider the possibility of an esophageal lesion or regurgitation? Recommend three view thoracic radiographs to further evaluate.

No significant pancreatic inflammation is noted on today's exam. This does not rule out the possibility of a small focal area of inflammation but generalized abdominal inflammation is not evident.

There are some areas of small intestine with very mild corrugation, possibly consistent with a mild enteritis type pattern. It would typically be unusual for enteritis to persist chronically.

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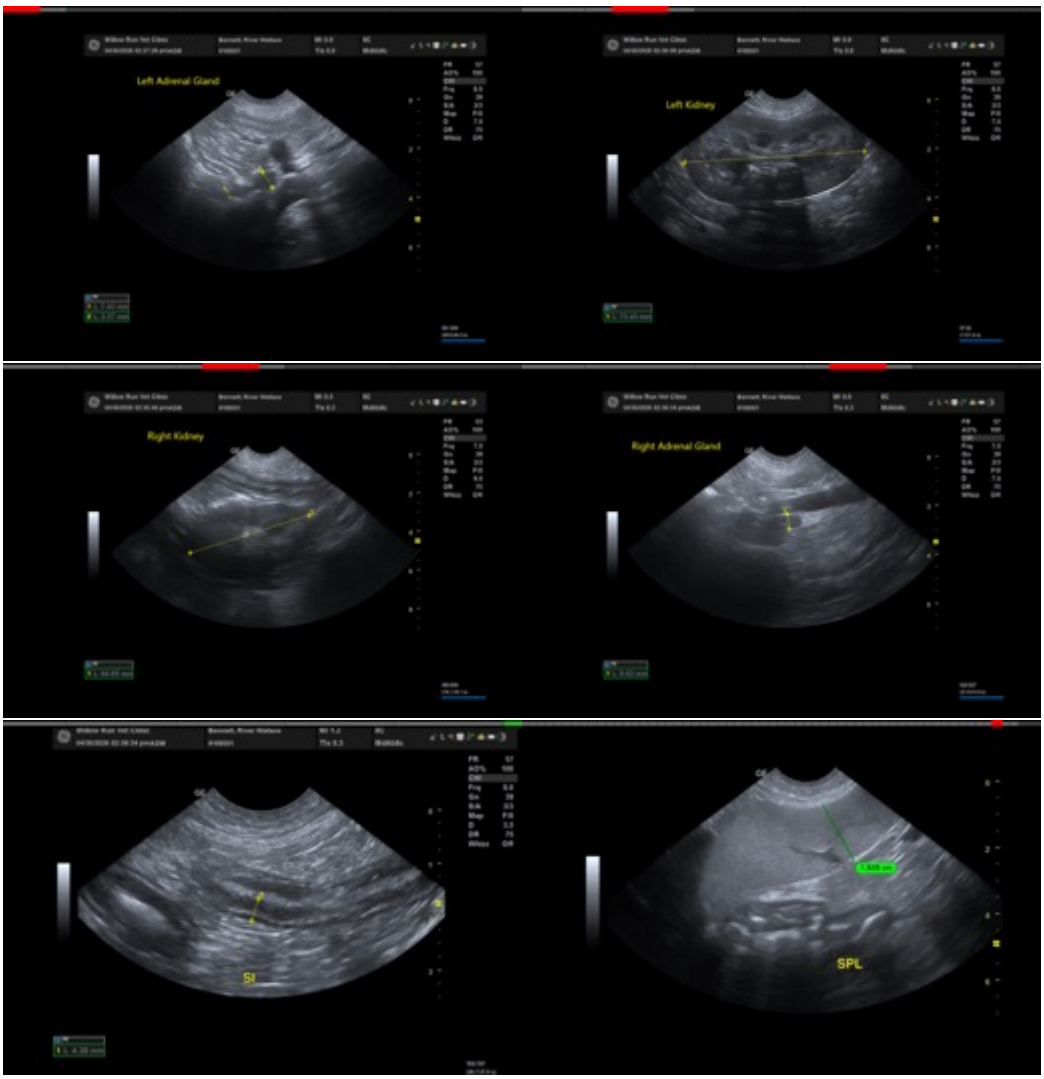
Based on the patient description and the duration of symptoms, more aggressive diagnostics and therapies are recommended. If a metabolic cause for the symptoms described is not identified, you could consider an upper GI endoscopy or similar to further evaluate the stomach and proximal GI tract and obtain biopsies. Additionally, more aggressive symptomatic therapy for possible gastroenteritis. Consider a novel protein/hydrolyzed protein prescription diet and possibly a GI Panel to Texas A&M for a qualitative PLI/TLI, Cobalamin, and Folate looking for evidence of exocrine pancreatic insufficiency, dysbiosis, etc.

If symptoms are persistent, consider repeat imaging in the future looking for the progression of today's lesions or the development of new lesions.



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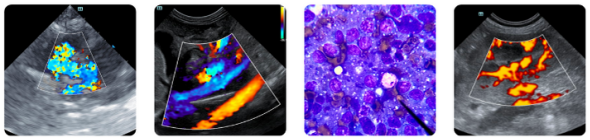

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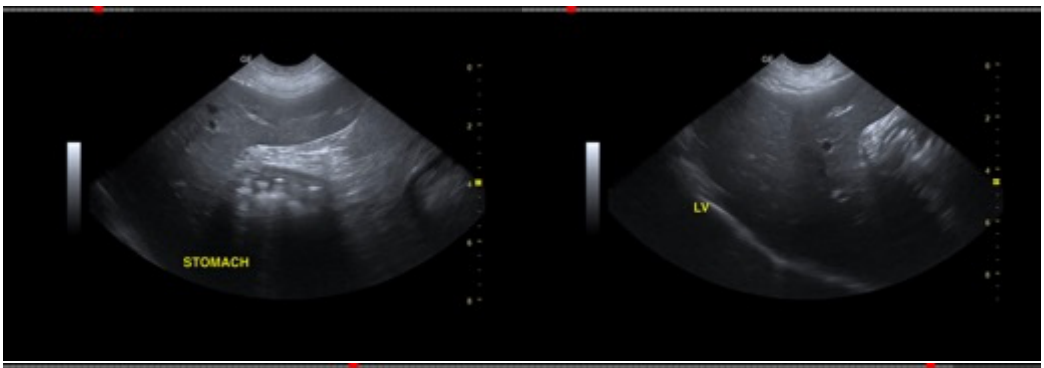

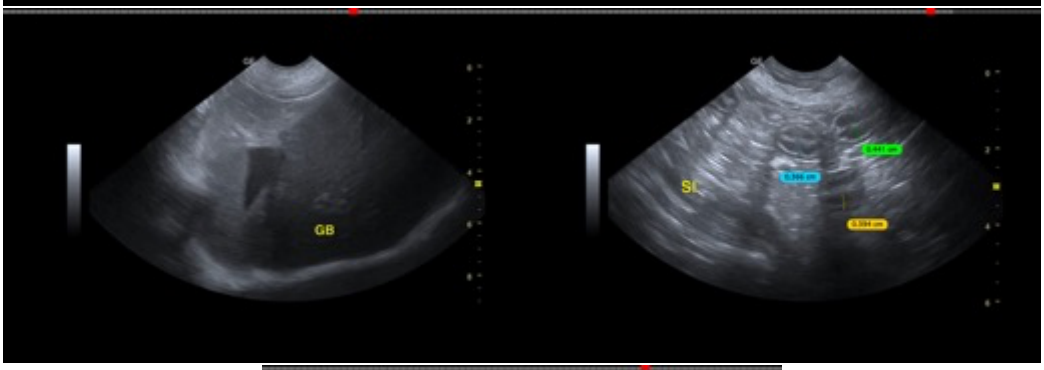

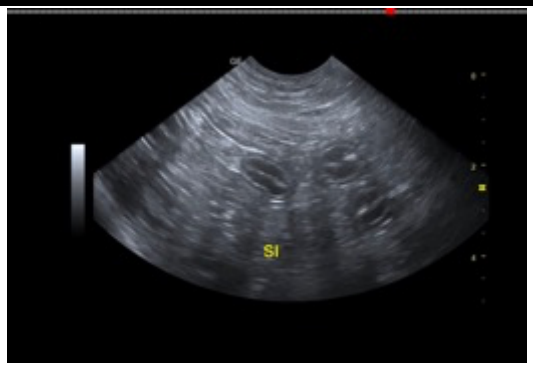

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@sonopath.com