



PATIENT

Gizmo Kaleka

SPECIES

Canine

BREED

Retriever Mix

SEX

MN

AGE

4 years

WEIGHT

26.9

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Dedden

HOSPITAL NAME

Brighton Veterinary
Clinic P. C. Inc.

REFERRING VET

Dr. Fraser

INVOICE

12005

DATE

5/26/2026

PRESENTING CLINICAL SIGNS

Fasted since 5 pm the night before (May 25/26.) Pre-surgical work-up prior to bilateral TPLO. History of intermittent vomiting since January. Historically sensitive GI. Was nauseous on pre-op exam. Discomfort on palpation of cranial abdomen. Elevated amylase and lipase on bloodwork, positive cPLI.

Current medication: cerenia, sucralfate, gabapentin. Previously on meloxicam, last dose 3 days ago. Sedation: butorphanol 0.2mg/kg, medetomidine 0.01mg/kg

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 (6.55 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.

The right kidney has a normal shape and size (7.14 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 0.5 cm at the cranial pole and 0.55 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 0.76 cm at the cranial pole and 0.57 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 (1.63 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. Luminal contents are mild and likely incidental at this time. The cystic and common bile ducts are normal/not visible.

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Gastrointestinal

The stomach is mildly to moderately dilated with fluid and irregular shadowing material most consistent with normal ingesta and gas. It measures at a normal thickness of 0.41 cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layering is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

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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 (0.53 cm in wall thickness) and the jejunum measured as normal (0.38 cm.) Visualized peristalsis appears appropriate. There were no focal lesions consistent with obstruction or a mass effect observed.

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Sections of colon are visualized with non-formed/ fecal material and gas shadowing distally. The descending colon wall measures 0.2 cm with intact wall layering.

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Pancreas

The pancreas is visible/mottled in the right limb. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

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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.

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ULTRASONOGRAPHIC FINDINGS

- Prominent/mottled right limb of the pancreas. Findings could be consistent with pancreatic remodeling +/- chronic pancreatitis.
- Mild/moderate fluid/ingesta distended stomach. Correlate with the feeding history. If the patient adequately fasted this could represent delayed gastric emptying. No evidence of an outflow tract obstruction is visualized.
- Fluid distended descending colon. Findings could be consistent with impending diarrhea.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Changes observed on today's scan are relatively mild. The right limb of the pancreas is visible and mildly mottled. These changes could be consistent with pancreatic remodeling +/- chronic pancreatitis. Consider a quantitative PLI to further evaluate, and empirical treatment for pancreatitis. There is minimal inflammation appreciated in the cranial abdomen.

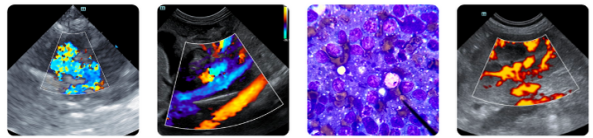
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The stomach is mildly to moderately fluid distended with some non-shadowing ingesta. If the patient was adequately fasted this could be abnormal and could represent mild gastric ileus or an unseen focal lesion.



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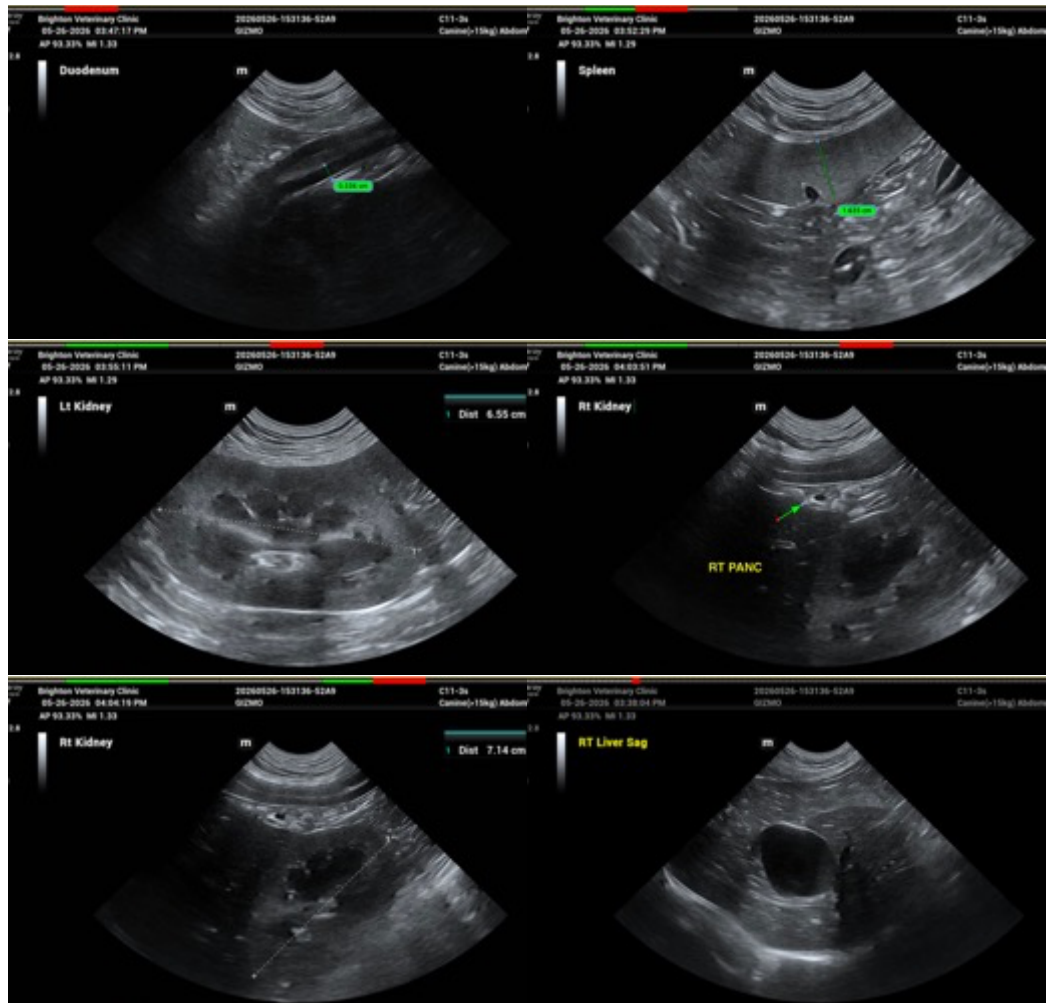
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The descending colon appears moderately distended with non-formed fecal material. Correlate findings with stool quality and the possibility of concurrent small intestinal disease?

Consider the following:

- If not already done recommend parasite screening and empirical deworming.
- Recommend a baseline cortisol.
- 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.
- Consider an ultra-low fat/hydrolyzed protein prescription diet (Royal Canin has this combination.)
- Recommend chronic probiotic therapy

If symptoms are persistent despite taking these measures, ultimately biopsies of the GI tract may be warranted. Additionally, you can consider repeat imaging looking for the progression of today's lesions or the development of new lesions.





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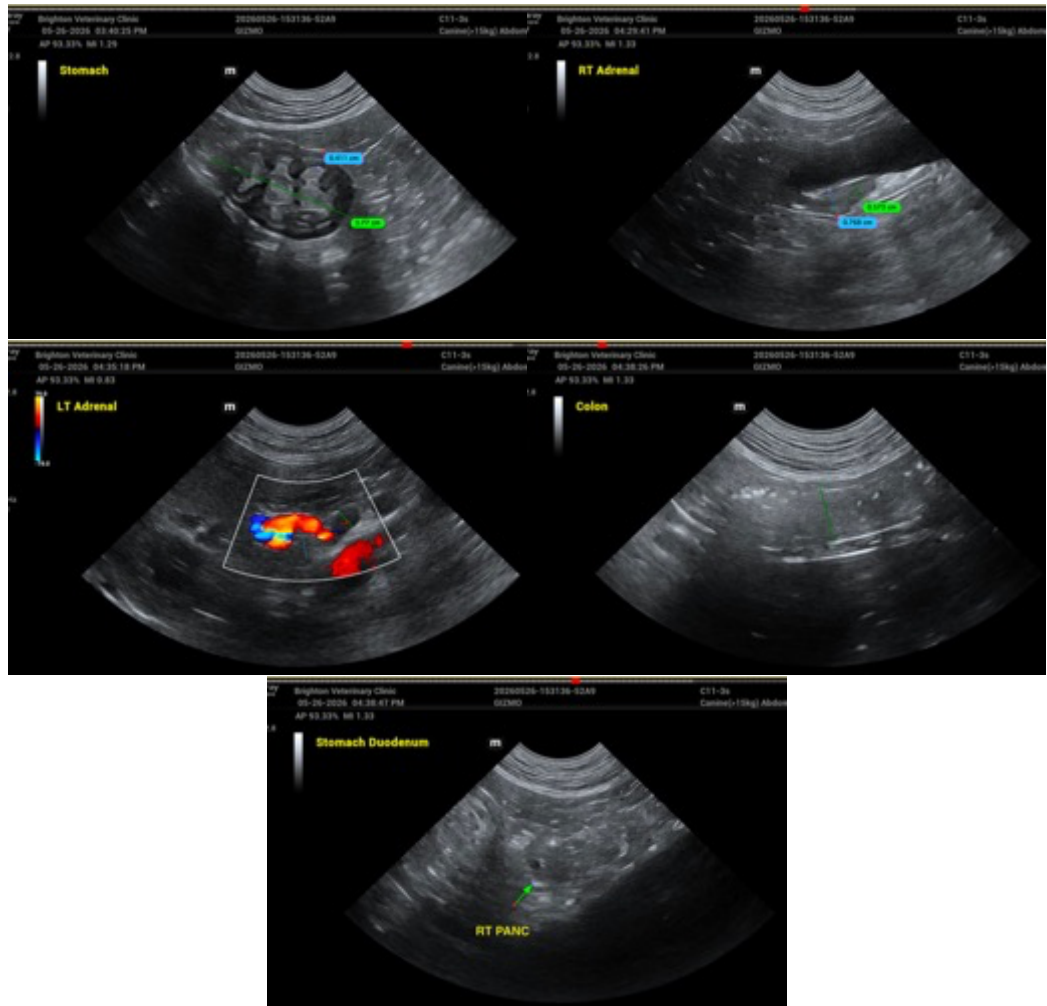
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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