



PATIENT

Mia Ponn

SPECIES

Canine

BREED

Shih Tzu

SEX

FS

AGE

15 years 4 months

WEIGHT

4.36 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Sookhoo

HOSPITAL NAME

Calusa VC

REFERRING VET

Dr. Glotzer

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DATE

5/29/2026

PRESENTING CLINICAL SIGNS

Presented for anorexia and lethargy after recent urinary tract infection (UTI) diagnosis. Initially prescribed oral Baytril two Wednesdays ago, which caused vomiting after the first dose and subsequent reluctance to eat. received Baytril injections and Entyce last Monday, after which her appetite improved. However, an attempt to reintroduce oral Baytril last Tuesday resulted in immediate vomiting. She continued Baytril injections through Friday, but her appetite remained reduced, eating only one meal and part of a second daily. Last Friday, a repeat urinalysis showed persistent bacteria, and she received another Baytril injection, a Convenia injection, and Entyce. ate one meal on Friday but then refused food for 24 hours until Sunday. Yesterday, after receiving Entyce at home, she ate half a meal and some scraps. No appetite - no vomited or diarrhea. Last bowel movement yesterday was normal. Drinking very little water. history of heart disease, elevated liver enzymes (300 points higher than normal on previous blood work), and severe cognitive dysfunction syndrome (dementia), manifesting as staring, barking at night, pacing, and walking into walls. She is also deaf and blind. She has not been on Trazodone for her dementia for a while. No pimobendan recently.

Abnormal PE/Chem/CBC/UA Results: CBC/Chemistry/Electrolytes: BUN 47 (H), Na 163 (H), Cl (125) Spec cPL / CPL Bionote: declined verbally.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall appears mildly thickened and irregular measuring 0.24 cm. The region of the trigone, ureteral papillae and proximal urethra appear free of any mass lesions or calculi.

The left kidney has a normal shape and size (3.71 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. Occasional small cortical cysts noted. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (3.82 cm) and irregular in shape (likely due to previous infarcts). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. Occasional small cortical cysts noted. There is no evidence of pyelectasia, nephroliths or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is normal in size measuring 0.51 cm at the cranial pole and 0.48 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 region of the right adrenal (between right cranial kidney and vena cava) is unremarkable, but the adrenal is not distinctly visualized. No evidence of a mass effect.

Spleen

The spleen is subjectively normal in size (1.73 cm) and the echotexture is homogenous. The splenic capsule is smooth with no visible irregularities. Rare discrete focal hyperechoic, perivascular parenchymal abnormalities are present. The appearance of these lesions is most consistent with



PATIENT

benign splenic myelolipomas. The blood flow through the hilus and splenic parenchyma appears normal.

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Liver

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The liver is large in size, and normal in echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. There is an occasional ill-defined hyperechoic nodule with an example measuring 0.63 cm.

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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.

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Gastrointestinal

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The stomach contains mild intraluminal fluid and gas. Gastric wall is prominent and measures 0.53 cm with intact wall layering. 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.

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The visualized areas of duodenum (0.35 cm), jejunum (0.25 cm) and ileum have a uniform diameter with minimal to mild fluid and gas distension. There is rare mucosal speckling visualized associated with the duodenum. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. 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 formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

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Pancreas

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The pancreas is prominent and 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

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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

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- Mildly thickened irregular urinary bladder wall. Findings could be consistent with mild cystitis.
- Age related changes visualized associated with both kidneys.
- Irregular, hyperechoic parenchymal lesions visualized in the spleen. Findings are most consistent with benign myelolipomas. Recommend continued monitoring.
- Pancreatic changes most consistent with chronic pancreatic remodeling +/- mild chronic pancreatitis.
- Large, heterogenous liver with an occasional hyperechoic nodule. The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia,

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inflammatory/immune-mediated disease, infiltrative neoplasia (less likely) or other hepatopathy. The hyperechoic nodule has a benign appearance at this time. Recommend continued monitoring.

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- 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.

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- Mild gastroenteritis pattern with a small amount of fluid and gas visualized within the stomach and some sections of small intestine.

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- Mild mucosal speckling visualized associated with the duodenum. Bright mucosal speckling has been postulated to represent dilated lacteals or focal accumulations of mucus, cellular debris, etc.. in the mucosal crypts.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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The majority of the changes observed on today's scan are likely unrelated to the acute GI signs reported. There is some mild fluid and gas visualized within the stomach and some sections of small intestine, potentially consistent with acute gastroenteritis. Additionally, some sections of small intestines appear mildly thickened with mild mucosal speckling which can be seen with some chronic enteropathies. If this patient has symptoms associated with a chronic enteropathy, further workup may be warranted.

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The right limb of the pancreas is visible but does not appear overtly inflamed. Correlate with a quantitative PLI level. If this is significantly elevated, then recommend treatment for pancreatitis.

There are chronic changes visualized associated with both kidneys. Correlate with renal values, urine concentrating ability, a blood pressure evaluation, and a urine culture.

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The liver is large and heterogenous and there is some moderate debris visualized within the gallbladder. At this time these changes are most consistent with a vacuolar hepatopathy, although other hepatopathies are possible. If further workup for a primary hepatopathy is desired, you could consider liver function testing and a fine needle aspirate.

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If not already done, recommend a urinalysis and culture off of antibiotics to assess if this is bacteria or true cystitis, and if the patient is symptomatic and requiring treatment. Based on sensitivity results, are there options other than Baytril? It seems like it is poorly tolerated in this individual and alternate treatment options may be needed. It's possible that vomiting has set a cascade of gastritis and enteritis which may need empirical treatment. Additionally, consider probiotic treatments spaced at least 2 hours from antibiotics to help with GI tolerance.

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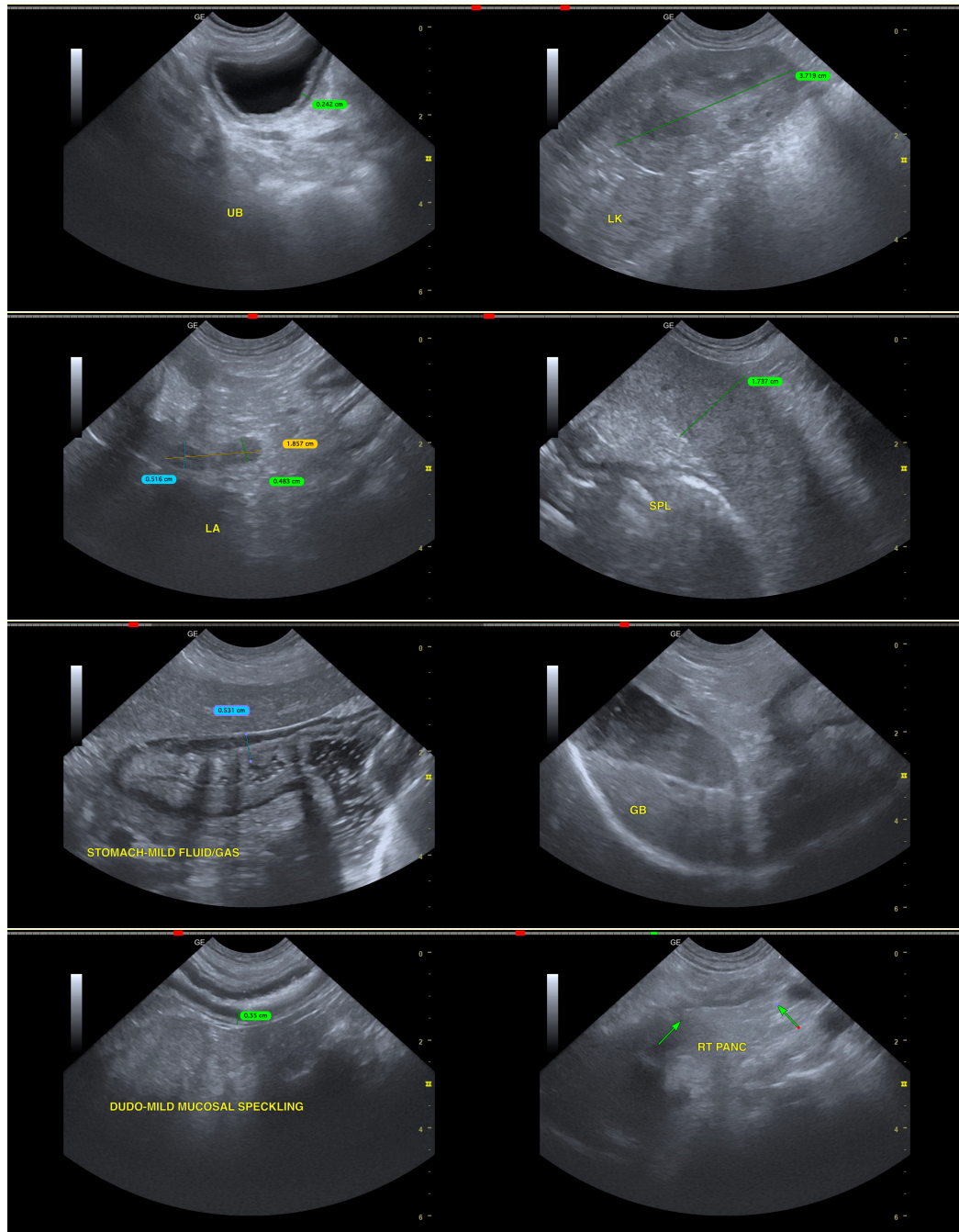
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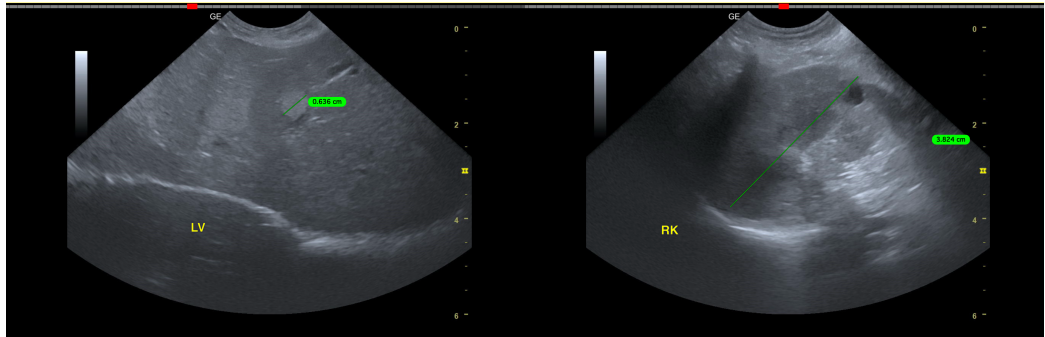
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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