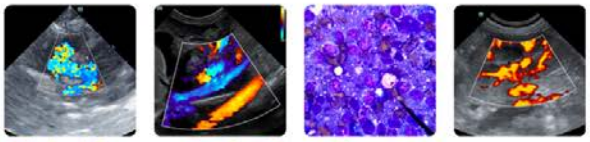


PATIENT

Lily Kornish

SPECIES

Canine

BREED

Cavalier King Charles

SEX

Spayed Female

AGE

4 Years

WEIGHT

8.6 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Meghan Myers

HOSPITAL NAME

Hershey Animal Emergency Center

REFERRING VET

Dr. Cara Sinopoli

INVOICE

75985

DATE

6/18/26

PRESENTING CLINICAL SIGNS

Lily's housemate/sibling was a 5 yr Cavaliver and both are fed commercial raw diet. 3 days ago both were hospitalized for THC toxicity and were hospitalized for 24 hours and did well and went home. Owner bought raw ground sirloin from the butcher and has been feeding them that since discharge. This morning Sugar broke with bloody diarrhea and by the time she presented this morning she was severely compromised, hypoglycemic, hypotensive and arrested a few hours after presentation.
Lily was brought in later this morning around 11am with progressive signs. mm pale pink, tacky, CRT 2sec, dull mentation, painful on abdominal palpation, defecating large amounts of hemorrhagic mucoid diarrhea

Abnormal PE/Chem/CBC/UA Results: Parvo: negative PCV/TS: 63/6.6 EPOC: glu 182 H CBC: HCT 42.6%, unremarkable Chem: glu 155 H, unremarkable BP: 135/89 (103) PT/PTT: 17.1/111.5

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with mild primarily suspended echogenic debris present. 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 calculi. Echogenic debris of this type can be associated with small crystals, cellular debris and proteinaceous debris.

The left kidney has a normal shape and size (4.59 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 (4.61 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.

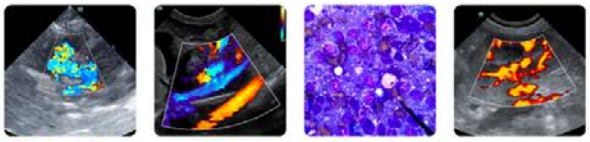
Adrenal Glands

The left adrenal gland is normal in size measuring 0.43 cm at the cranial pole and 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 0.40 cm at the cranial pole and 0.42 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 (1.2 cm), 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.



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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. Luminal contents are mild and likely incidental at this time. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach contains mild fluid. It measures at a normal thickness of 0.35 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. No masses or focal lesions were observed.

Most of the visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal to mild fluid and gas 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 0.48 cm. Jejunum wall measures 0.30 cm. Visualized peristalsis appears appropriate. There are occasional sections of small intestine that have mild corrugation consistent with an enteritis type pattern.

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 left limb of the pancreas is prominent and mottled compared to the surrounding isoechoic 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

- Mild echogenic debris in the urinary bladder – The echogenic debris in the bladder lumen could be consistent with cells, crystals, and/or mucus.
- Pancreatic changes in the left limb most consistent with chronic pancreatic remodeling +/- mild inflammation/pancreatitis.
- Mild fluid distention of the stomach and some sections of small intestine as well as focal corrugation – Findings are suggestive of an enteritis type pattern.

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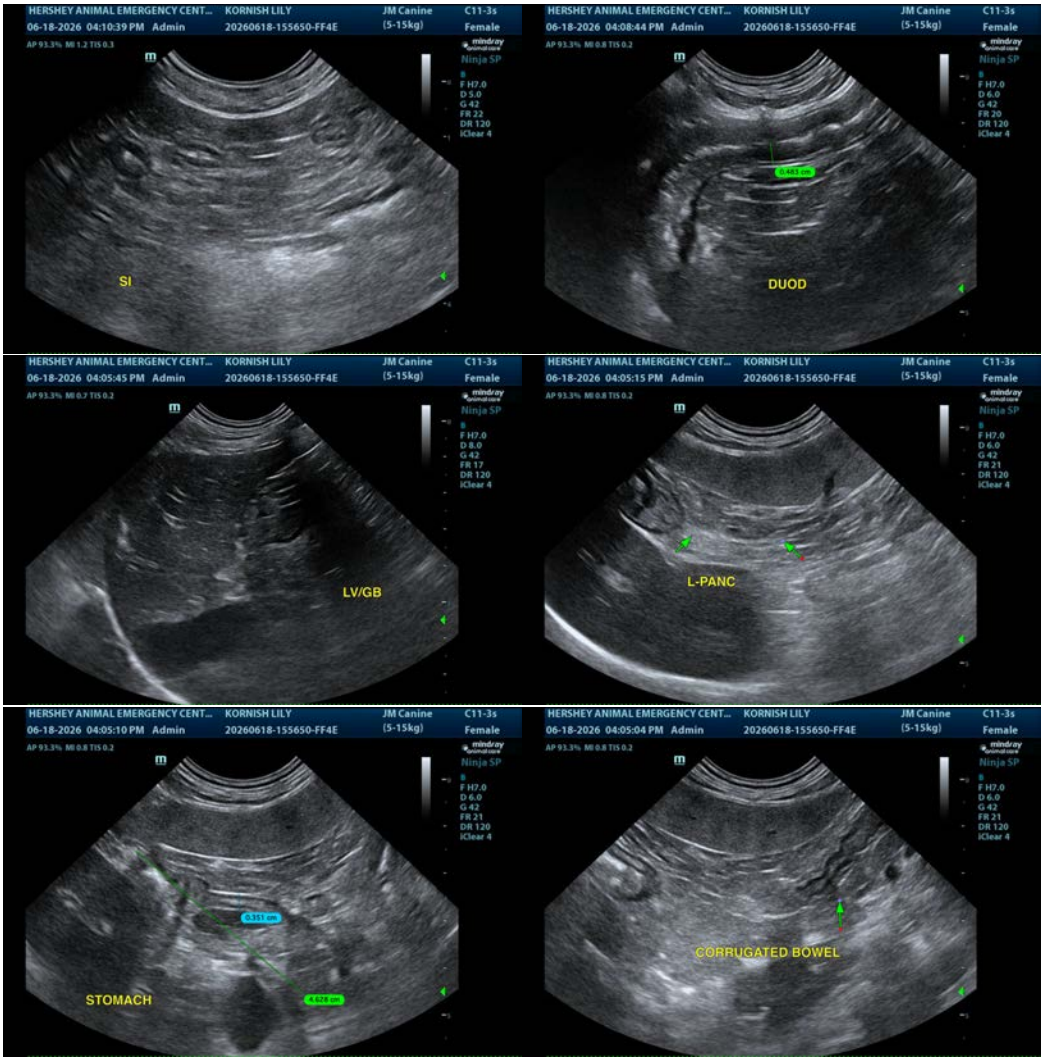
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

No focal lesions are visualized associated with the GI tract to explain the symptoms reported. There is a generalized mild enteritis type pattern with some areas exhibiting segmental mild fluid and gas distention and some areas exhibiting mild corrugation. Given the history provided, findings could be consistent with an acute hemorrhagic diarrhea type process +/- developing pancreatitis. Recommend aggressive supportive care for potential endotoxemia, pancreatitis, etc. If the patient is not improving with treatment, consider repeat imaging in the future, looking for progression of today's lesions or the development of new lesions.



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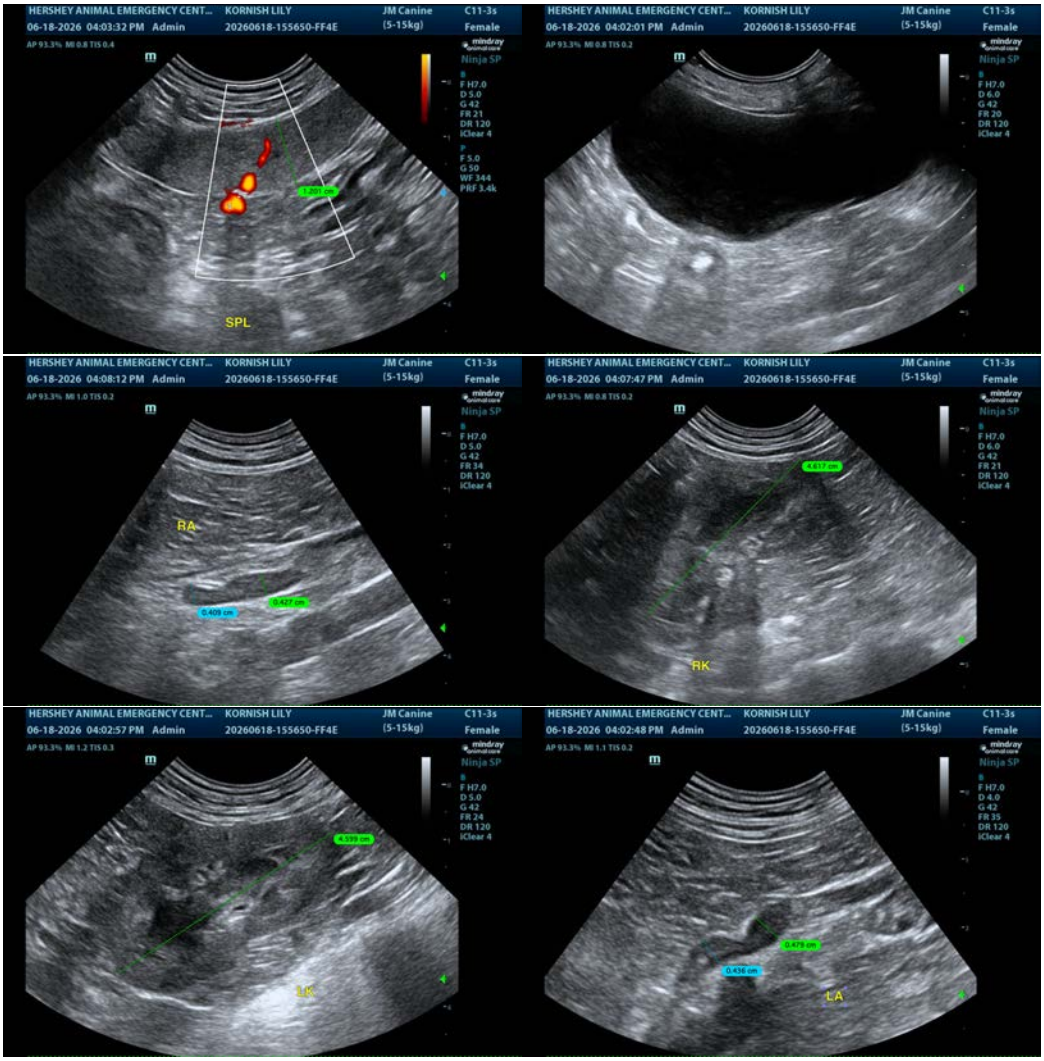

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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