**PATIENT**Mousse Schoepel  
50048C**SPECIES**

Canine

**BREED**

Morki

**SEX**

Spayed Female

**AGE**

21 Weeks

**WEIGHT**

1.75 kg

**INTERPRETED BY**Kathleen Sennello DVM,  
MS, Diplomate ACVIM  
(Small Animal Internal  
Medicine)**IMAGING  
PERFORMED BY**

Tom McNeill

**HOSPITAL NAME**

SVS Imaging CT

**REFERRING VET**Madison Vet  
Specialists**INVOICE**

39061

**DATE**

6/28/22

**PRESENTING CLINICAL SIGNS**

Mousse is presented as a transfer to MVS for inappetence, vomiting and diarrhea. Mousse began to display decreased appetite about 4 days ago. Since then, she has barely been eating, though she has eaten some. Mousse has also been a little lethargic. This morning, Mousse vomited one time. It was watery/yellow in appearance. She has still been urinating and defecating, but her stools are now soft/diarrhea. Owners do not know of anything inappropriate Mousse could have gotten into but mentioned she does eat grass. They also noted that she has been losing her baby teeth and expressed concern that she may have swallowed some. Owners noted that the pcDVM said her abdomen was tender. Mousse had an infected spay scar treated here in April and was treated for tapeworm about 4 weeks ago.

**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 (3.62 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of 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 (3.78 cm). Overall echogenicity is normal with adequate corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of 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 0.30 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 0.34 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.

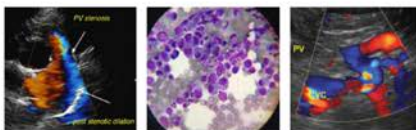
**Spleen**

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 gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.

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***Gastrointestinal***

The stomach contains moderate shadowing debris. 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 (but occasionally mild) 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 measured 0.43 cm. Jejunum wall measured 0.30 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 (0.15 cm). 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 occasional prominent mesenteric lymph nodes visualized. A mesenteric lymph node is noted at 0.60 cm. An iliac lymph node is noted at 0.34 cm. The omentum is generally of normal echogenicity.

**ULTRASONOGRAPHIC FINDINGS**

- Moderate shadowing debris within the gastric lumen – Moderate amount of shadowing material in gastric lumen - Correlate with feedings history and abdominal radiographs. If adequately fasted then consider such differentials as delayed gastric emptying or a partial outflow tract obstruction (none visualized).
- 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**

An obvious cause for the reported vomiting and diarrhea is not visualized. No focal GI lesions are observed.

Initially, recommend ruling out possible metabolic causes for GI signs including an ACTH stimulation test to rule out Addison's disease and liver function test to look for any evidence of a portosystemic shunt (none observed).

If metabolic disease is thought less likely, and primary gastrointestinal disease is suspected, then consider such differentials as dietary intolerance/food allergy, dietary indiscretion, GI foreign body, GI parasitism, acute infectious gastroenteritis, etc. There was some very mild dilation of the small intestine, and the stomach is dilated with some fluid and mildly shadowing debris. Correlate these findings with the feeding history and abdominal radiographs. If the patient was fasted, consider such differentials as delayed gastric emptying, ingested foreign material, or partial outflow tract obstruction (none observed), and consider serial imaging (radiographs), as some types of foreign material can be difficult to visualize with ultrasound.

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fredgromalak@gmail.com



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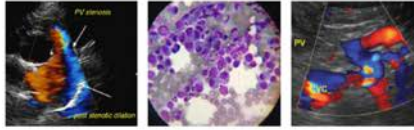
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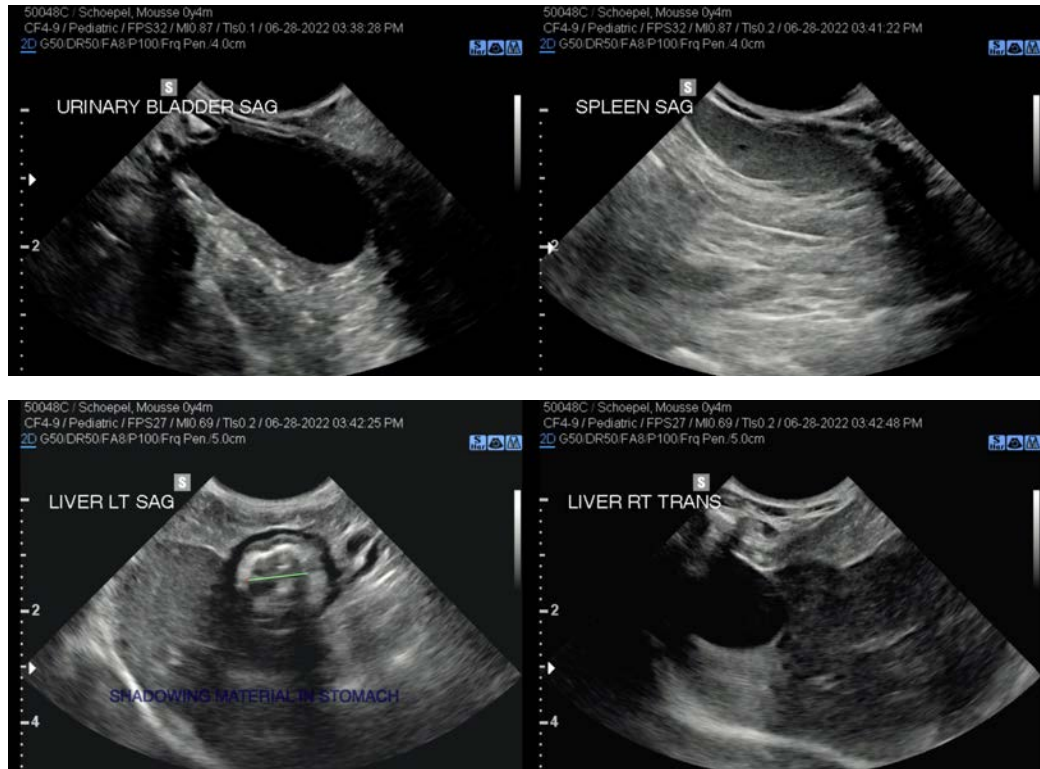
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

kathleen.sennello@sonopath.com