

**PATIENT**

Sophie Snyder

SPECIES

Canine

BREED

Mixed Breed

SEX

Spayed Female

AGE

5 Years

WEIGHT

70 Pounds

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

Amy Mayhew, LVT

HOSPITAL NAME

SVS Imaging MI

REFERRING VETBriarwood Vet
Hospital**INVOICE**

39745

DATE

7/21/22

PRESENTING CLINICAL SIGNS

diarrhea, black watery stools, poor appetite, poor water intake
 Abnormal PE/Chem/CBC/UA Results: increased liver values, exam wnl

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 (5.99 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 (5.99 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 0.49 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 0.61 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.

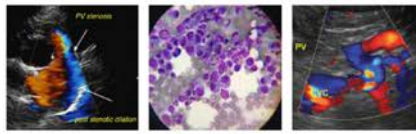
The gallbladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are primarily anechoic. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach is moderately dilated with fluid and irregular shadowing material most consistent with normal ingesta and gas. 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 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. Duodenum wall measured 0.42 cm. Jejunum wall measured 0.34 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. 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 prominent and hypoechoic as 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

- Hypoechoic, prominent pancreas – The pancreatic changes are most consistent with age-related parenchymal remodeling, potentially secondary to a prior inflammatory episode, early fibrosis or chronic pancreatitis.
- Mild/moderate fluid and ingesta visualized within the gastric lumen – correlate with feeding history. If the patient was adequately fasted, consider delayed gastric emptying or a pyloric outflow tract obstruction (none visualized).

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes observed on today's scan were relatively mild. The pancreas is visible, but does not appear overtly inflamed. Additionally, there is a small amount of fluid visualized within the gastric lumen, but no focal lesions. Unfortunately, there are many causes for diarrhea and melena that cannot be diagnosed by ultrasound alone.

- Consider metabolic causes for diarrhea and GI ulceration.
- Recommend screening for Addison's disease.
- Consider a liver function test as well as consideration for viral diarrheas, toxins, etc.
- If metabolic causes are thought unlikely, consider primary gastrointestinal disease such as food allergy/dietary intolerance, GI parasitism, gastric or intestinal ulceration, dysbiosis, IBD, and less likely intestinal neoplasia.

Depending on the duration and the nature of the melena, anti-ulcer therapy could be instituted. Depending on the nature of the liver enzyme elevations, you could consider a liver function test and a fine needle aspirate of the liver. Additionally, consider a GI panel to Texas A&M for a qualitative PLI, TLI, cobalamin and folate to further evaluate the pancreas and small intestine. Recommend chronic probiotic therapy and a novel protein/hydrolyzed protein prescription diet.

If symptoms persist and are not responding to supportive therapy, consider endoscopy for further evaluation of the gastric and proximal small intestinal mucosa.

Consider three view thoracic radiographs to rule out concurrent thoracic disease/involvement.

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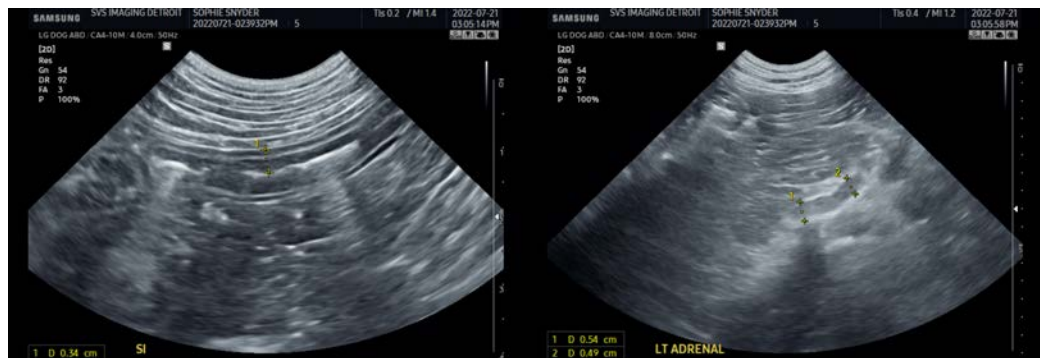
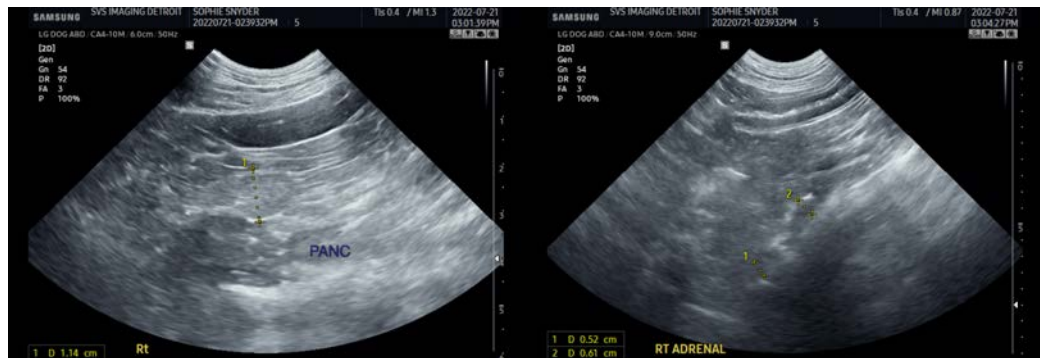
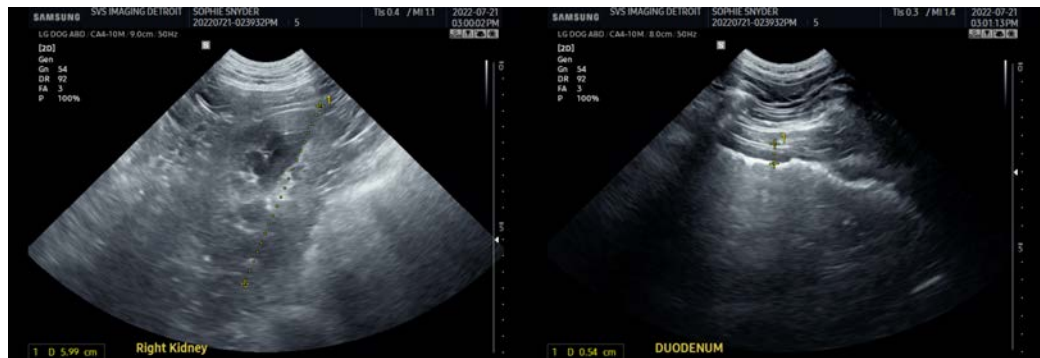
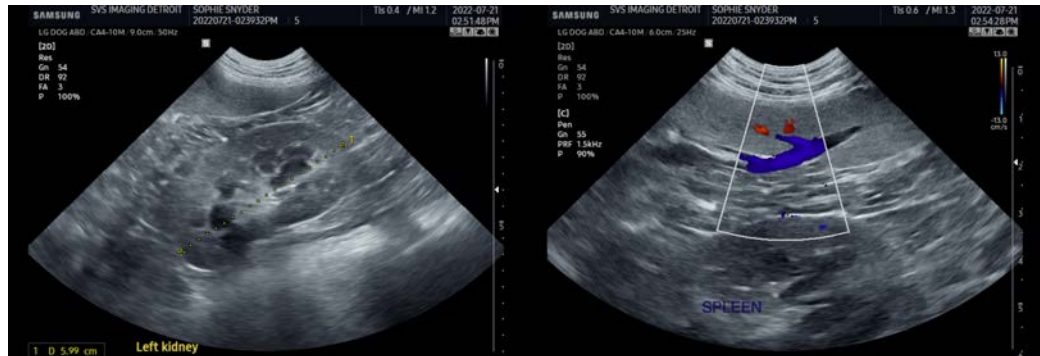
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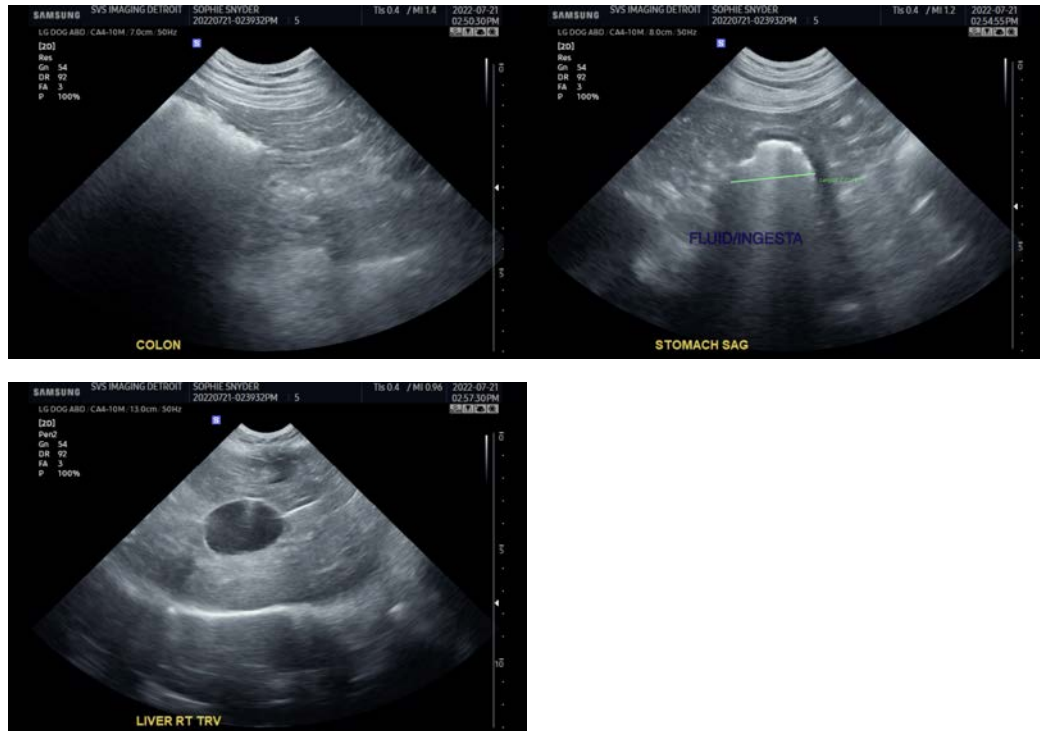
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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