

**PATIENT**

Lute Entwistle 51947A

**SPECIES**

Canine

**BREED**

Labrador Retriever

**SEX**

Intact Male

**AGE**

7 Months

**WEIGHT**

24.1 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 - Dr. Keller**INVOICE**

39292

**DATE**

7/8/22

**PRESENTING CLINICAL SIGNS**

Lute presented on 7/6 for acute onset of vomiting and anorexia, as well as lethargy for 24 hours. He has a history of chronic diarrhea for 1 month. Abdominal radiographs were unremarkable. He was treated conservatively and discharged. When Lute was released last night it seemed like he barely recognized his owner and has not acting like himself. He has shown very little to no interest in food, he has not wanted to eat any of the canned food the owners have offered at home and may ate 5-10 pieces of kibble since going home. Since getting home he has gotten much worse, and much more lethargic. His water consumption has also greatly decreased. Last night his stool was loose but this morning he urinated and defecated which was both normal. He has not been vomiting but he had two episodes of hacking, retching with no production last night at 9pm and this morning. Dad could barely get him up and moving out of the kennel this morning. He has also been drooling excessively. Thoracic radiographs performed today revealed bronchopneumonia.

Abnormal PE/Chem/CBC/UA Results: Mild fever on presentation yesterday (103F). Bloodwork yesterday revealed an elevated SDMA (16), remainder 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 prostate is normal in size (0.97 cm) and shape for this neutered male dog. The parenchyma is homogenous and the external margins are smooth. The prostatic urethra appears normal with no evidence of irregularity, invasion, mass effect or calculi.

The left kidney has a normal shape and size (7.03 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 (6.34 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 0.74 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 0.69 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.

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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 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 contains mild fluid and ingesta. 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.

Most of 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 0.44 cm. Jejunum wall measured 0.36 cm. Visualized peristalsis appears appropriate. The proximal duodenum appears somewhat fluid dilated and hypermotile. There is a small, non-obstructive intraluminal structure visualized measuring 0.61 cm, and a small amount of shadowing material proximal to the discrete object, the nature of which is less clear.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness (0.16 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 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. There is a mild mesenteric lymphadenopathy visible with mesenteric lymph nodes measuring 0.66, 0.60, and 0.51 cm. The omentum is of normal echogenicity.

**ULTRASONOGRAPHIC FINDINGS**

- Mild fluid and ingesta visualized within the gastric lumen – Correlate with feeding history. There is a small amount of fluid with occasional small shadowing structures visualized, most consistent with ingesta.
- Somewhat hypermotile and fluid dilated proximal duodenum with a small intraluminal structure and a more proximal shadowing structure that is less delineated. These structures do not appear large enough to cause an obstruction, but can be associated with larger areas of material that are not clearly visualized.
- Mild mesenteric lymphadenopathy – The prominent abdominal lymph nodes are most consistent with reactive lymphadenitis or lymphoid hyperplasia. Neoplastic infiltration is considered less likely.



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- Prominent, hypoechoic pancreas – The pancreatic changes are most consistent with mild pancreatitis or a recent episode of pancreatic inflammation.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

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There is no overt obstructive process visualized, and the pancreas is visible but not overtly inflamed. There is a small amount of fluid and shadowing material both within the gastric lumen and the proximal duodenum. Continued monitoring and serial imaging may be necessary to try and ensure that this does not constitute foreign material, but a complete obstruction is not currently evident. Recommend aggressive medical management for aspiration pneumonia and gastroenteritis while monitoring these lesions. Additionally, evaluate the esophagus on chest radiographs for evidence of regurgitation, etc.

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**SEX**

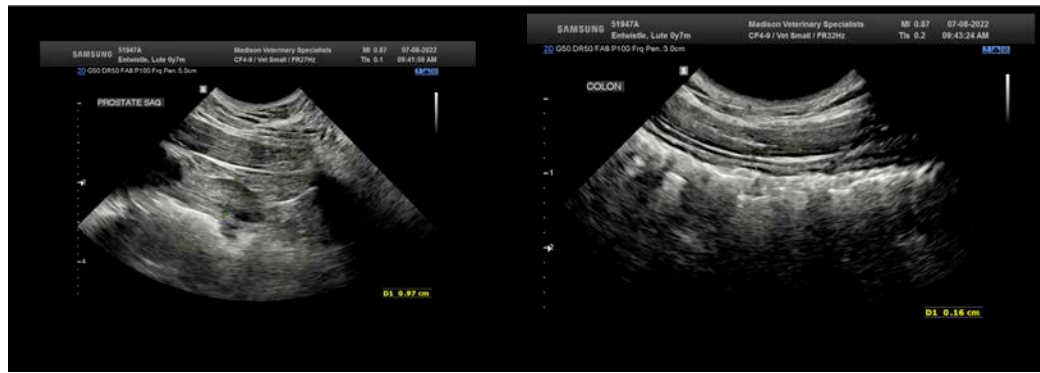
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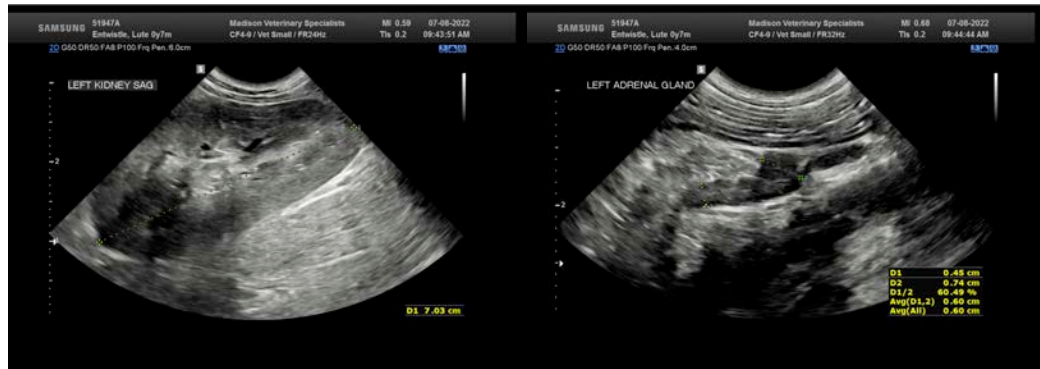
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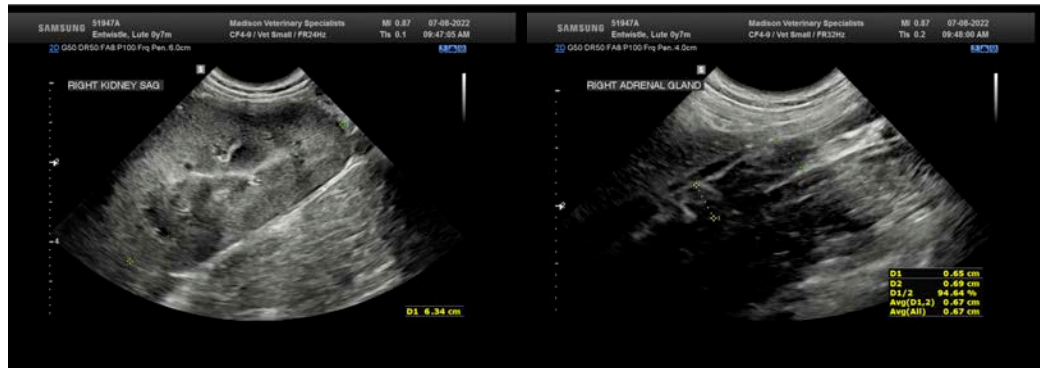
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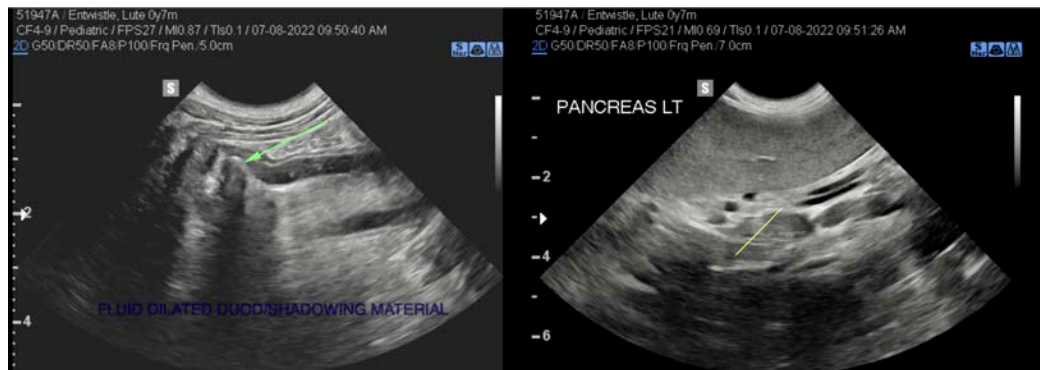
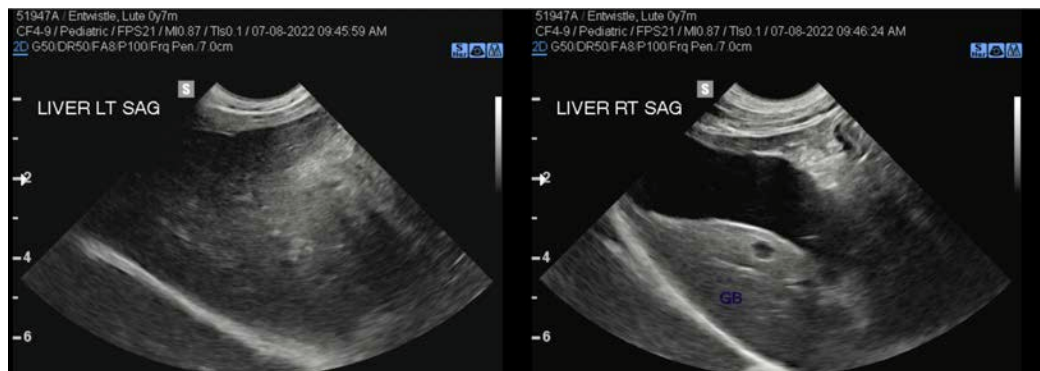
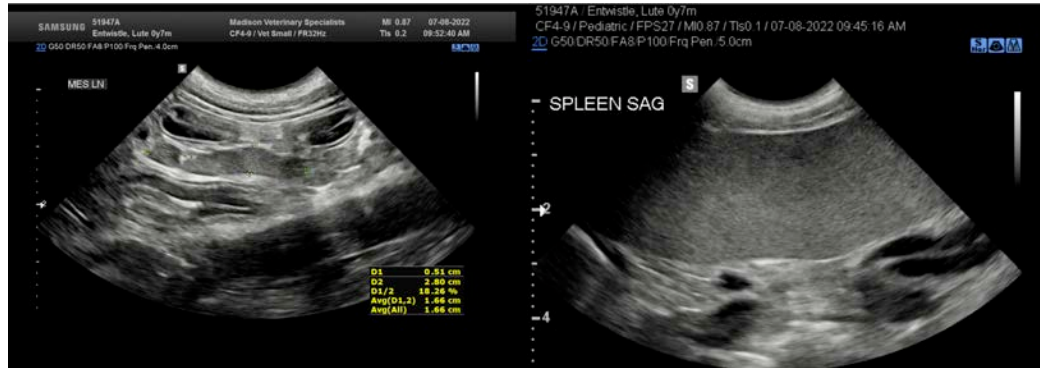
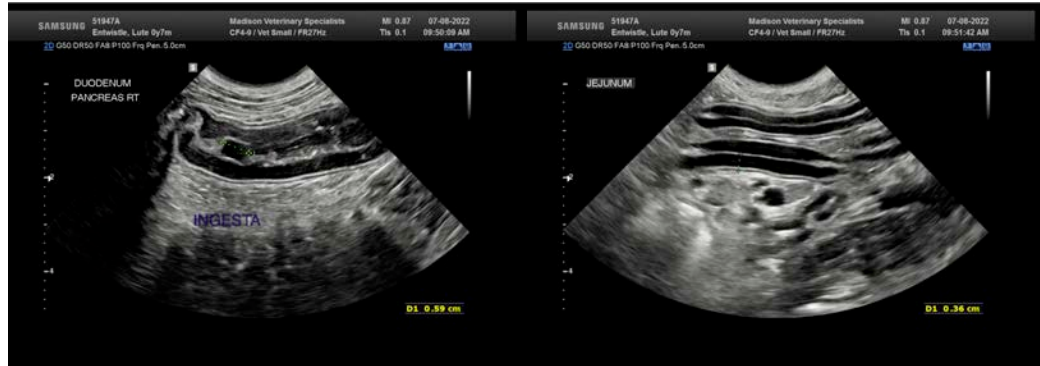
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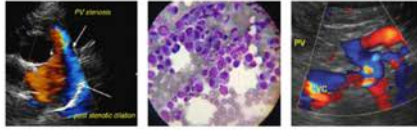
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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)

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