



PATIENT

Gordie Herring

SPECIES

Canine

BREED

Mini Schnauzer

SEX

Male

AGE

7 years

WEIGHT

24 lbs

INTERPRETED BY

Alicia Angosto
Guerrero, DMV,
PgDip, MSc.

IMAGING PERFORMED BY

Dr. Michael Ferber

HOSPITAL NAME

East Meadow
Veterinary Center

REFERRING VET

Dr. Michael Ferber

INVOICE

12098

DATE

6/5/2026

PRESENTING CLINICAL SIGNS

Starting yesterday, seemed to have abdominal pain - cried when abdomen touched. Seems weak and reluctant to stand and not acting right. Vomited once yesterday and poor appetite today.

Abnormal PE/Chem/CBC/UA Results: UA pending In-house CBC/chem - elevated ALP (chronic - no PUPD noted) Radiology with consult - decreased serosal detail in the cranioventral abdomen with mass effect most consistent with regional steatitis, enlarged pancreas, or scant effusion.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is moderately distended, and the urinary bladder wall appears thin and smooth. The urine is predominantly turbid with suspended echogenic debris. Normal appearance of the trigone and proximal urethra is observed. There are no calculi, and no evidence of inflammatory or neoplastic changes.

The left kidney is normal in shape and size, measuring 4.59×2.63 cm, with a cortical thickness of 0.43 cm in the sagittal plane. The renal cortex demonstrates normal echogenicity. The corticomedullary ratio is normal, and corticomedullary distinction is preserved. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler evaluation demonstrates a normal vascular pattern.

The right kidney is visualized and demonstrates normal cortical echogenicity, corticomedullary distinction, and renal architecture. There is no evidence of pyelectasia, nephrolithiasis, or hydronephrosis. Color Doppler evaluation demonstrates a normal vascular pattern.

Adrenal Glands

The left adrenal gland measures 0.58 cm at the cranial pole and 0.53 cm at the caudal pole. The right adrenal gland is not visualized.

Spleen

Splenic thickness is 2.05 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.

Liver

The liver is subjectively normal in size, with sharp edges and a regular contour. The liver parenchyma looks uniform and isoechoic compared to the falciform fat, with a normal echotexture. No hepatic lymphadenopathy is observed.

The gallbladder lumen is normally distended. The wall is thin, and the contents contain a mild to moderate amount of biliary sludge. No dilation of the cystic duct or common bile duct is identified.

Gastrointestinal tract

The stomach is empty and folded, with a mural thickness of 2.93 mm and preserved wall layering.

The duodenal wall measures 3.48 mm and demonstrates mild corrugation.

The jejunal wall measures 3.26–3.53 mm with preserved wall layering.



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No evidence of gastrointestinal obstruction, ileus, foreign material, or infiltrative gastrointestinal disease is identified.

The colonic wall measures 1.25 mm and contains minimal luminal contents.

Pancreas

The right pancreatic lobe measures approximately 1.65 cm in thickness. The pancreatic margins are mildly irregular. The pancreatic parenchyma is diffusely hypoechoic relative to the adjacent mesenteric fat. Marked hyperechogenicity and edema of the surrounding mesenteric fat are present, consistent with active peripancreatic inflammation and steatitis.

Free Abdomen

A small volume of focal peripancreatic effusion is present. Associated peripancreatic steatitis and inflammatory change of the surrounding mesenteric fat are identified. No generalized abdominal effusion is observed. No sonographic evidence of abdominal lymphadenomegaly is identified. The iliac trifurcation region is unremarkable.

PRIMARY FINDINGS

- Diffuse enlargement of the right pancreatic lobe with mild contour irregularity and diffuse hypoechoogenicity.
- Marked peripancreatic fat inflammation with associated steatitis and edema. Mild focal peripancreatic effusion.
- Reactive duodenal corrugation.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The right pancreatic lobe is enlarged, hypoechoic, and mildly irregular in contour, with marked inflammation of the surrounding mesenteric fat, associated steatitis, and a small volume of focal peripancreatic effusion. These findings are consistent with active pancreatitis.

The presence of peripancreatic edema, steatitis, and regional fluid accumulation indicates extension of the inflammatory process beyond the pancreatic parenchyma into the surrounding tissues.

Mild duodenal corrugation is present and is considered most likely reactive to the adjacent pancreatic inflammation. No evidence of gastrointestinal obstruction, foreign material, or infiltrative gastrointestinal disease is identified.

A mild to moderate amount of biliary sludge is present. This finding is often incidental but may occur secondary to altered biliary motility and can be seen in association with pancreatobiliary disease.

The elevated alkaline phosphatase activity may reflect reactive hepatobiliary enzyme induction secondary to pancreatic inflammation. No sonographic evidence of clinically significant hepatobiliary disease is identified.

Recommendations:

- Continued treatment and close monitoring for clinically significant pancreatitis are recommended.
- Monitoring of pancreatic lipase concentrations and serial biochemical parameters may be helpful for



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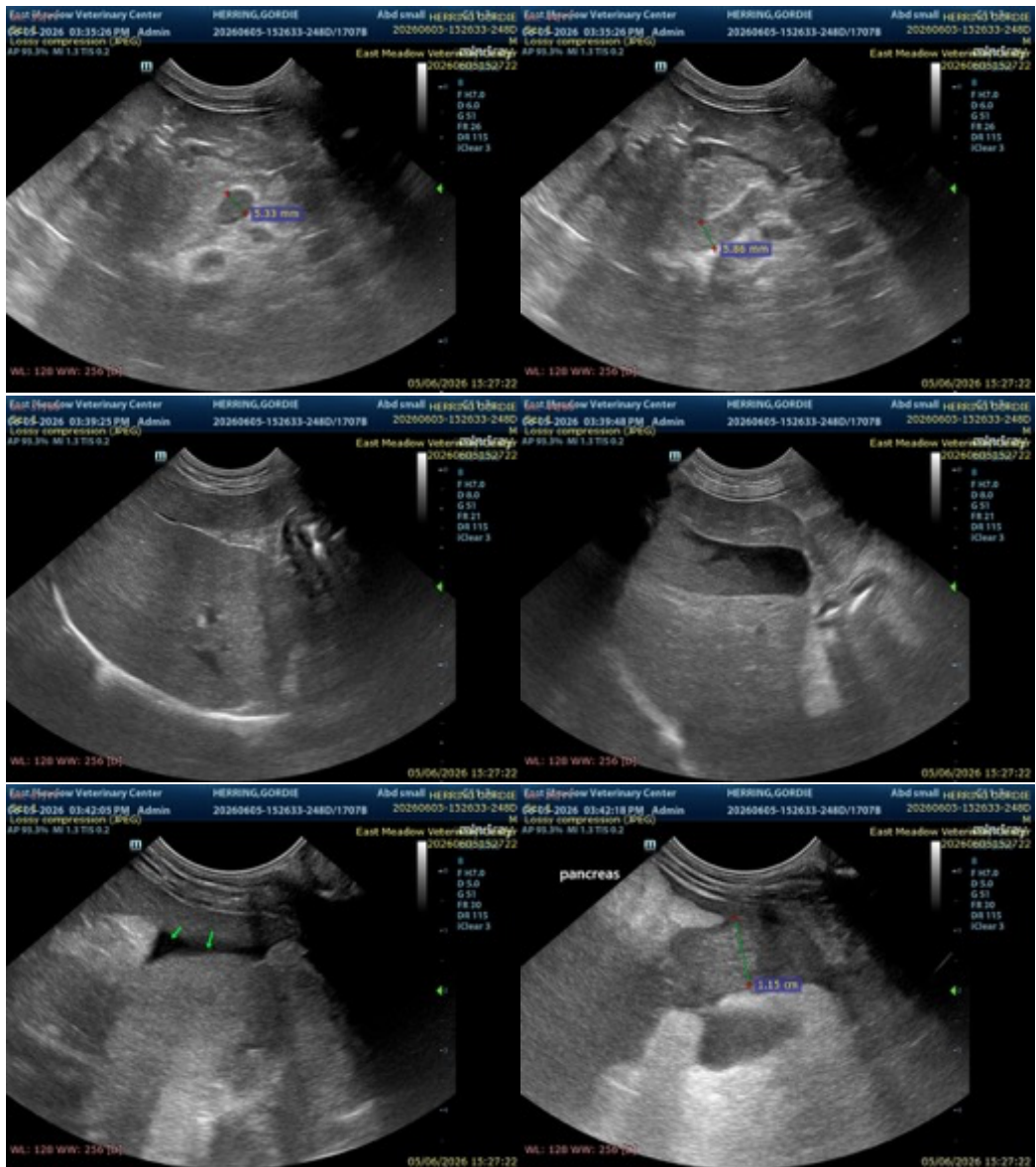
DATE

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assessing response to therapy.

- Given the breed predisposition, evaluation of serum triglyceride and cholesterol concentrations may be considered if not recently performed.

Final diagnostic and therapeutic decisions should be made by the attending veterinarian, who can best integrate these findings with the patient's clinical status.





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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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

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