



## PATIENT

Lola Fackler

## SPECIES

Canine

## BREED

Standard Poodle

## SEX

Spayed Female

## AGE

8 years

## WEIGHT

68 lbs

## INTERPRETED BY

Beth Johnson, DVM  
DACVIM

## IMAGING PERFORMED BY

Dr. Julia Bakker

## HOSPITAL NAME

Orange Blossom  
Veterinary Imaging

## REFERRING VET

Dr. Tiffany Rimar

## INVOICE

11226

## DATE

2/2/2026

## PRESENTING CLINICAL SIGNS

- History suspicious of insulinoma - patient having seizures and recorded hypoglycemic events. Seizure episodes have reduced with frequent small meals and prednisone.
- FNA of left pancreatic limb nodule taken today and sent for cytology

Abnormal PE/Chem/CBC/UA Results: ALT, ALP, GGT mild elevations VDI panel showed hypovitaminosis D and a folate elevation, but pet is not receiving supplementation Addison's ruled out.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The right kidney is normal is size (5.76 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal is size (6.39 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

### Adrenal Glands

The right adrenal gland is normal in size (1.5 cm at cranial pole and 0.67 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is small (flattened contour) (0.4 cm at the cranial pole and 0.53 cm at the caudal pole). Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

### Spleen

The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

### Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is mildly heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion.

Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

### Gastrointestinal



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The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction or foreign material noted. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction or foreign material noted.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

### *Pancreas*

The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation. In the left limb of the pancreas, there's an approximately 0.6 cm x 0.7 cm in size discrete, homogenous, hypoechoic nodule.

### *Free Abdomen*

There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

## ULTRASONOGRAPHIC FINDINGS

- The pancreatic nodule could be a benign incidental finding. As is seen with pancreatic nodular hyperplasia versus other. However, in a hypoglycemic patient, especially if workup is consistent with an insulinoma, an insulinoma can't be ruled out.
- Mildly heterogenous liver – These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.
- Mild gallbladder debris - Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili.
- Flat left adrenal glands– This can be a normal patient variant and/or a sign of exogenous cortisol administration. If exogenous steroids are not being administered, hypoadrenocorticism (either relative or absolute) should be considered.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given patient's history, I suspect an insulinoma in the left limb of the pancreas. Per history, hypoadrenocorticism has already been ruled out but given the flat left adrenal gland, if not, hypoadrenocorticism should be definitively ruled out. Additionally, if not already evaluated, further



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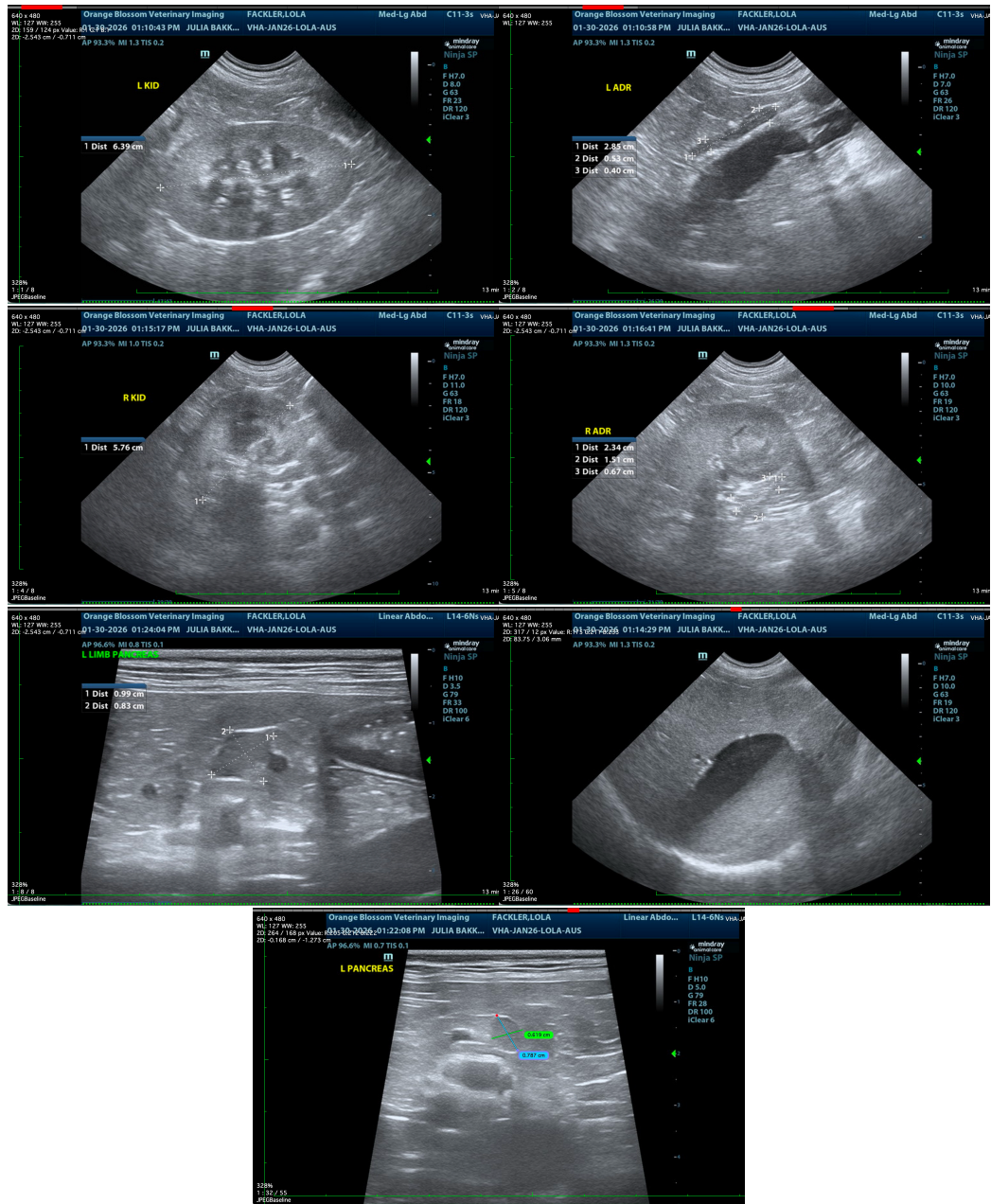
**DATE**

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workup/confirmation of a suspected insulinoma is recommended via a paired insulin to glucose ratio, drawn at a time when the glucose is less than 50mg/dL.

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

Ultimately, an exploratory laparotomy for planned surgical resectional biopsy of the suspected insulinoma may be recommended.



The information and recommendations provided are based on the images presented by the referring



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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.

**Beth Johnson, DVM, DACVIM**  
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