

PATIENT

Sangria Lara

SPECIES

Canine

BREED

Miniature Schnauzer

SEX

Spayed Female

AGE

6 Years

WEIGHT

20.8 pounds

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Gabriel Ferrer
DVM

HOSPITAL NAME

Pulse Pet Ultrasound
Services

REFERRING VET

Dr. Fonseca

INVOICE

15078

DATE

04/14/26

PRESENTING CLINICAL SIGNS

Px presented as a referral for an abdominal ultrasound due to Hx of inappetence, vomiting, and diarrhea. Px originally visited a veterinary clinic two weeks ago due to inappetence, vomiting, diarrhea, lethargy, and a painful abdomen, bloodwork showed elevated renal values and radiographs showed a possible FB. The veterinarian suggested that the FB could be sand, but owner reports that Px has not had any access to sand lately, although Px has been digging in dirt, as per owner. Px then visited rDVM at an emergency clinic due to the persistent clinical signs and labs were repeated, along with radiographs, 4DX, and a urinalysis.

Abnormal PE/Chem/CBC/UA Results: Radiographs and rDVM records attached below for your reference.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended. It has a normal uniform wall thickness. Contents include primarily anechoic fluid with occasional echogenic non-shadowing debris, most consistent with exfoliated cells, mucous and/or small blood clots, as well as dependent mineral "sand" (crystals) debris. Both sterile inflammation as well as urinary tract infection can present with echogenic debris. No masses or discrete definitive cystoliths are observed. The trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Left kidney is normal in size (5.2 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 mineral or infarcts observed. Trace pyelectasia was noted bilaterally.

Right kidney is normal in size (5.9 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 mineral or infarcts observed.

Adrenal Glands

Left adrenal gland is normal in size (0.48 cm at cranial pole and 0.46 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

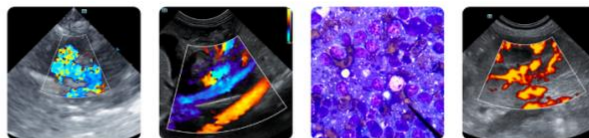
Right adrenal gland is normal in size (0.56 cm at cranial pole and 0.62 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

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 normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.



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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.

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Gastrointestinal

Fundic mucosal hypertrophy with hyperechoic mucosa and some mucosal remodeling is noted. There is no loss of mural detail. Layering is normal. There is mild luminal fluid accumulation. No evidence of masses/nodules or foreign material present.

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The visible small intestine demonstrates areas of mildly thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic, without evident loss of layering appreciated. The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

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

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Pancreas

The observed pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and irregular in shape with a swollen undulating contour. Enhanced hyperechoic ill-defined surrounding fat is noted.

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Free Abdomen

There is a moderate amount of anechoic free fluid noted in these images.

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Mesenteric and medial iliac lymphadenopathy are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

In the cranial abdomen, just caudal to the stomach is a discrete homogenous 1.4 cm in diameter density that could also represent an enlarged lymph node versus pancreas.

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ULTRASONOGRAPHIC FINDINGS

- Suspect moderate to severe acute pancreatitis.
- Concurrent mild inflammatory bowel disease pattern- Thick muscularis has been reported with infiltrative bowel disease including both benign inflammatory disease as well as infiltrative neoplasia such as lymphoma. No loss of layering or distinct characteristics of malignancy are present. Therefore, differentials cannot be further ranked without tissue sampling.
- Concurrent gastritis- Consistent with irritation secondary to dietary indiscretion or intolerance, infection (bacterial, viral, other), parasitic or protozoal disease, toxin, other metabolic disease such as pancreatitis, other. Microulceration cannot be ruled out.
- Moderate amount of free fluid- Free fluid is of unknown origin. Differentials (unless already ruled out) could include increased hydrostatic pressure (cardiac disease and/or vascular or lymph blockage), decreased oncotic pressure (low albumin), vasculitis, paraneoplastic fluid, rupture/leakage of/from an organ (GI, GB, UB, other), blood (hemoabdomen), other.
- Moderately mesenteric and medial iliac lymphadenopathy- infiltrative neoplastic disease cannot be ruled out but is considered less likely.

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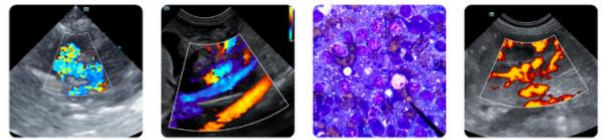
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- Similarly, as described above, a cranial abdominal/possible gastric versus pancreaticoduodenal node can't be ruled out.
- Mild gallbladder debris- Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting 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.
- Trace bilateral pyelectasia.
- A moderate amount of echogenic urinary bladder mineral/sand debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Further gastrointestinal workup and investigation of the changes described above is recommended, beginning with a routine fecal/Giardia exam if not recently evaluated.

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

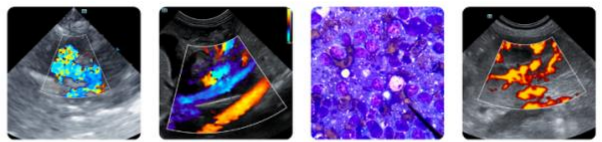
A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

And especially in the face of concurrent azotemia, a baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

Additionally, if the proteinuria persists in otherwise quiet sediment, quantification should be considered via a urine protein to creatinine ratio. Additionally, a blood pressure is recommended if not recently evaluated.

Unless the azotemia is believed to be largely pre-renal, based on response to rehydration, etc., testing for leptospirosis could be considered.

In the meantime, medical management of pancreatitis with anti-emetics, gastroprotectants, appetite stimulants or nutritional support as needed, pain management, broad spectrum antibiotics, and fluid therapy is recommended. If possible, a fresh frozen plasma transfusion and hyperbaric oxygen therapy (HBOT) could be beneficial. Monitoring of the pancreas with power doppler is recommended to identify possible necrosis as well as other potential sequelae such as abscesses, etc.



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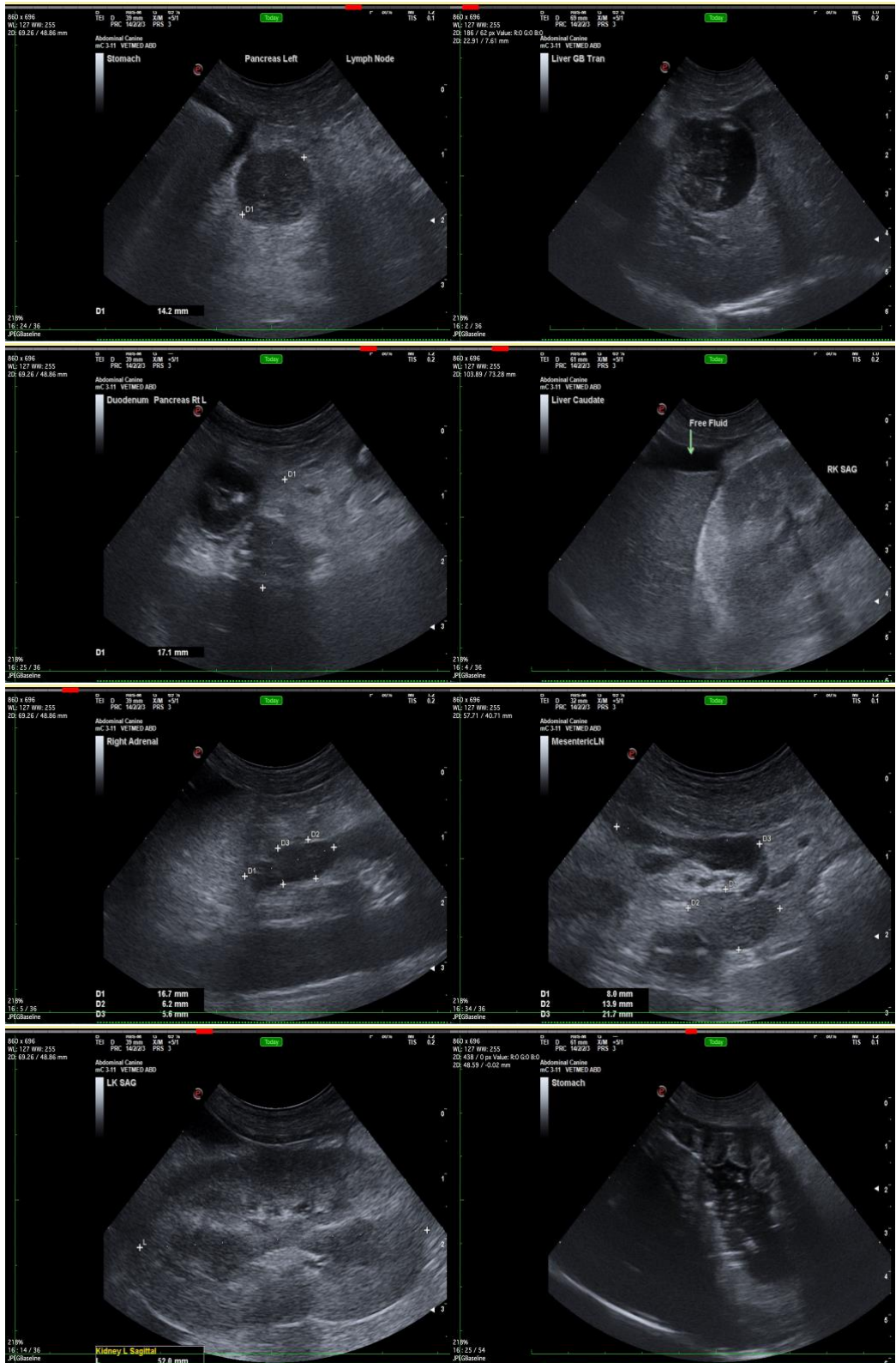
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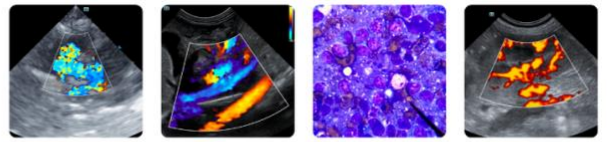
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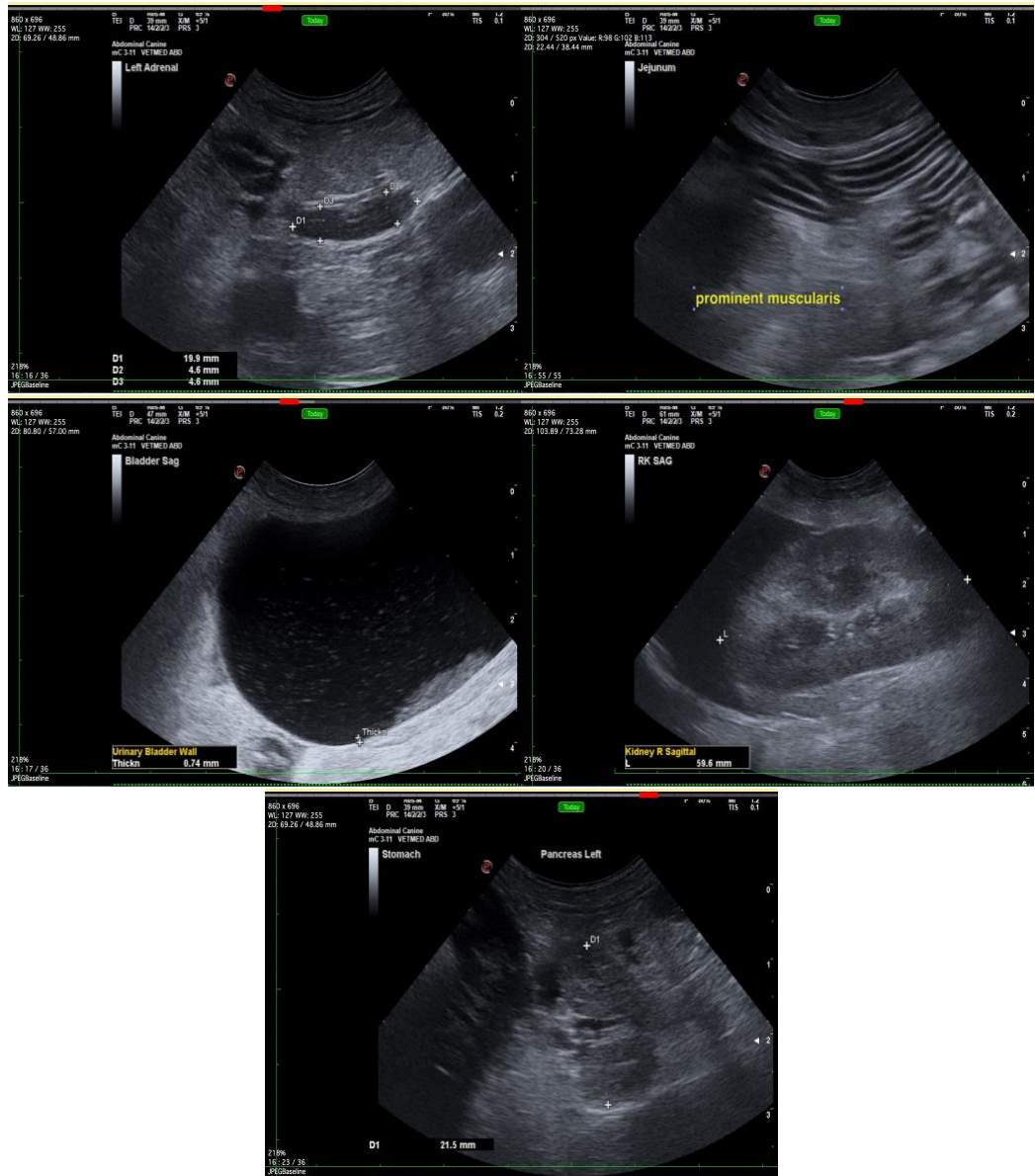
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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

info@sonopath.com