

## PATIENT

Frank Trampel

## SPECIES

Canine

## BREED

Chihuahua

## SEX

Neutered Male

## AGE

9 Years

## WEIGHT

9 lbs

## INTERPRETED BY

Beth Johnson, DVM  
DACVIM

## IMAGING PERFORMED BY

Julia Bakker DVM

## HOSPITAL NAME

Orange Blossom  
Veterinary Imaging

## REFERRING VET

Kristen Hillard DVM

## INVOICE

16109

## DATE

05/11/26

## PRESENTING CLINICAL SIGNS

1 week duration of ADR. One episode of vomiting a week ago, since has had diarrhea that ranges from mucoid and bloody to almost normal looking. Anorexia, lethargy. Bloodwork showed a severe neutrophilia and moderate monocytosis w/ depleted electrolytes. Rads show no obstructive pattern, but "stuff" in stomach and intestines. No response to medications: Entyce, Baytril, Metronidazole, Omeprazole, Metoclopramide.

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### *Urinary System*

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 prostate is unable to be well visualized in these images.

Left kidney is normal in size (3.84 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. A hyperechoic band parallel to the corticomedullary border is present.

Right kidney is normal in size (3.69 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. A hyperechoic band parallel to the corticomedullary border is present.

### *Adrenal Glands*

Left adrenal gland is normal in size (0.51 cm at cranial pole and 0.43 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Right adrenal gland is normal in size (0.68 cm at cranial pole and 0.65 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

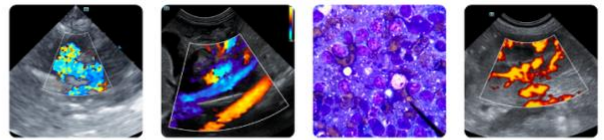
### *Spleen*

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.

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*

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

In some views, the bowel is normal in thickness and layering. In others, thickness remains normal but there's subjectively a mildly prominent muscularis layer relative to the mucosa layer. In the mid to caudal abdomen, there's one loop of bowel that's focally slightly thicker than the remaining bowel loops measuring just over 0.4 cm thick with some subtle loss of layering noted in that area. However, I can't identify which loop of bowel that is. Similarly, in other images, there's one loop of small bowel that contains a 0.5 cm thick by 2 cm long hypo- to anechoic density adjacent to potentially within the far wall. It's difficult to say whether this is a focally thicker wall versus an abnormal luminal structure versus even an adjacent tissue against that bowel loop.

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

## *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.

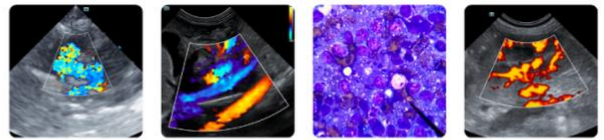
## *Free Abdomen*

There is a moderate amount of very echogenic appearing free fluid.

There is no apparent pathologic lymphadenopathy noted in these images.

## ULTRASONOGRAPHIC FINDINGS

- Suspect moderate acute pancreatitis.
- The enhanced hyperglycemic mesenteric fat and omentum is diffuse in these images extending into the mid to caudal abdomen which is more significant than I would expect with pancreatitis alone. Given the intermittent varied bowel changes described above, concurrent infiltrative bowel disease is also suspected with both benign inflammatory disease as well as infiltrative neoplastic disease being differentials especially if the hypoechoic focal thick area described above is truly bowel wall versus adjacent organ.
- A moderate amount of very echogenic appearing 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.
- Bilateral medullary rim sign- This finding is of unknown clinical significance and can be a normal variant, often idiopathic. Medullary rim sign can be present with renal disease including lymphoma, hypercalcemic nephropathy, Leptospirosis, tubular disease, other and should be interpreted in combination with other more specific indications of kidney disease such as isosthenuria, proteinuria, azotemia, etc. This is a common incidental finding in patients with diabetes mellitus.



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- Moderate 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.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

If not recently evaluated, a general metabolic health screen (CBC, chemistry panel with electrolytes and urinalysis) is recommended.

A routine fecal/Giardia exam is recommended if not recently evaluated.

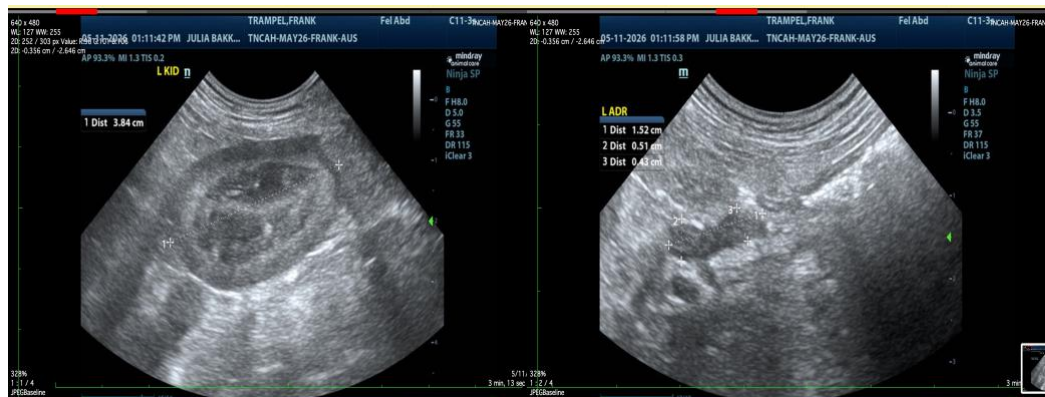
A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

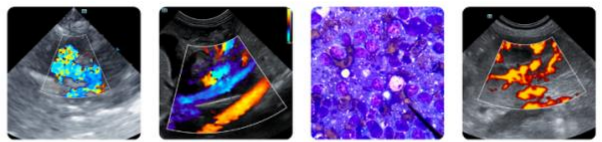
A fecal enteropathogen PCR panel to Texas A&M GI Laboratory could be considered for further evaluation of possible infectious disease. Contact lab for recommendations on how long to discontinue antibiotics (if indicated) prior to obtaining a stool sample for submission.

A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

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. Monitoring of the pancreas with power doppler is recommended to identify possible necrosis as well as other potential sequelae such as abscesses, etc.

Follow-up monitoring/imaging of the bowel wall changes described above and/or alternative imaging such as an abdominal contrast CT scan, contrast radiography, and/or even potentially an exploratory laparotomy may be helpful pending patient's response to medical management, results of additional workup, etc.





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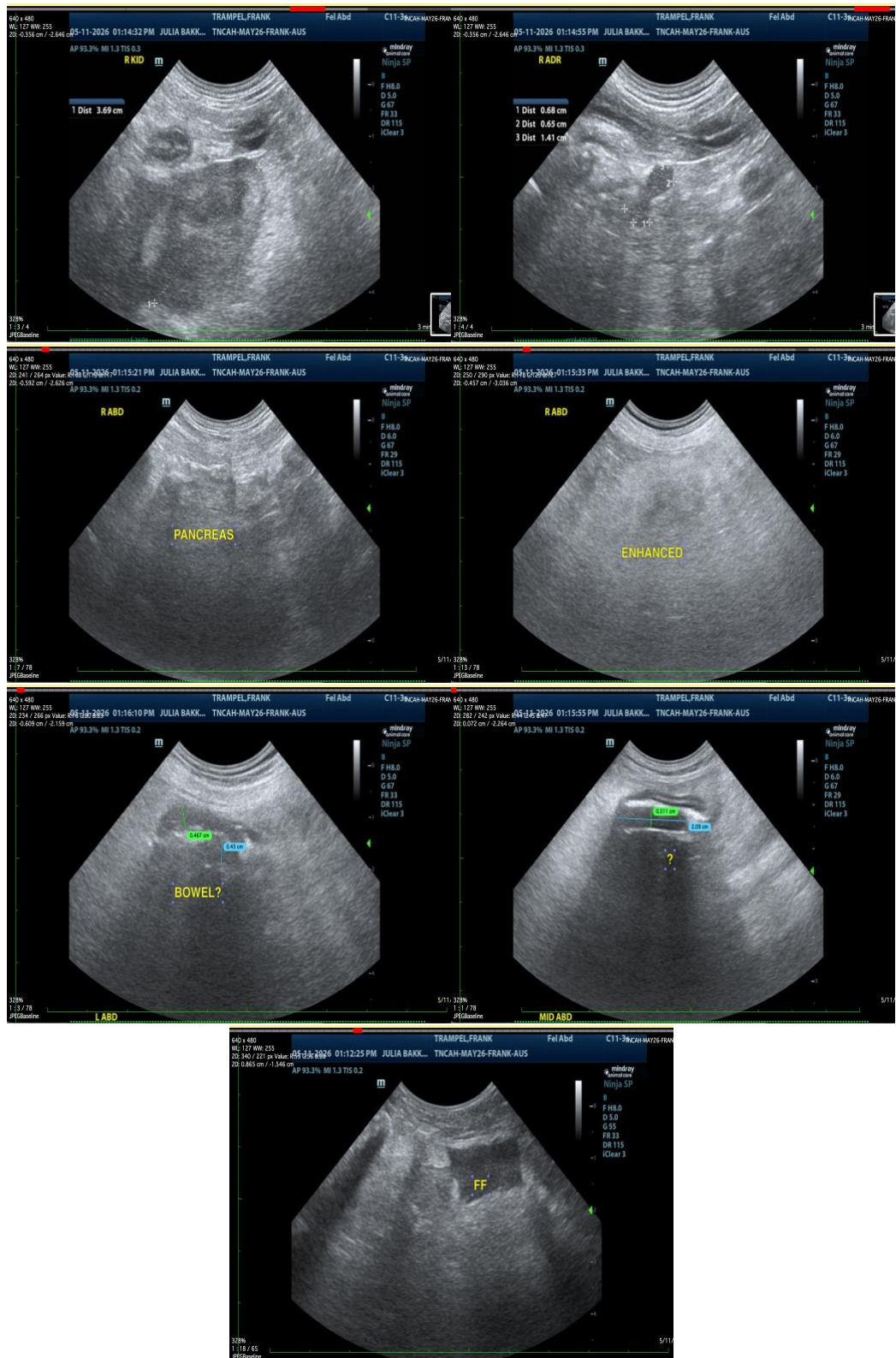
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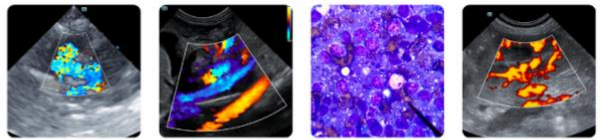
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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**

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