



PATIENT

Roxy Rodriguez

SPECIES

Canine

BREED

Mini Schnauzer

SEX

FS

AGE

6 years

WEIGHT

16.4

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Gabriel Ferrer

HOSPITAL NAME

Pulse Pet Ultrasound
Services

REFERRING VET

Dr. Alejandra Garcia

INVOICE

11980

DATE

5/20/2026

PRESENTING CLINICAL SIGNS

Px presented as a referral for an abdominal ultrasound due to being Dx with Pancreatitis and suspected renal failure. Owner reports inappetence, weight loss, lethargy, and vomiting.

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

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.

Kidneys are bilaterally normal in size, irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. Punctate non-obstructive nephroliths, mild pyelectasia, and cortical cysts are present bilaterally. Left kidney measures 4.6 cm, and the right kidney measures 4.26 cm.

Adrenal Glands

The right adrenal gland is normal in size (0.39 cm at cranial pole and 0.4 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.36 cm at cranial pole and 0.42 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. 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

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.

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 empty with no evidence of obstruction, foreign material or infiltrative disease.



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The distal descending colon is mildly to moderately thick measuring 0.41 cm thick with normal intact layering. The lumen is empty with no evidence of obstruction, foreign material, or infiltrative disease.

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.

Free Abdomen

There is a mild amount of free fluid present in these images.

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

ULTRASONOGRAPHIC FINDINGS

- Mild to moderate bilateral chronic kidney disease changes with mild bilateral pyelectasia and punctate non-obstructive nephroliths bilaterally.
- 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.
- The thick colon trends in appearance toward benign as is seen with parasitic, infectious, dietary related, other benign inflammatory colitis or even some normal patient variant with infiltrative neoplasia being possible but considered less likely.
- Very mildly reactive mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- A mild amount of 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.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given patient's reported gastrointestinal signs, combined with the mildly thick colon, weight loss, etc. further gastrointestinal workup recommendations include:

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



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- 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.

Additionally, especially when combined with the azotemia, etc., a baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

Having said that, the appearance of the kidneys is consistent with emerging chronic kidney disease. Therefore, continued evaluation for concurrent kidney insults, and beginning medical management for emerging chronic kidney disease may be warranted.

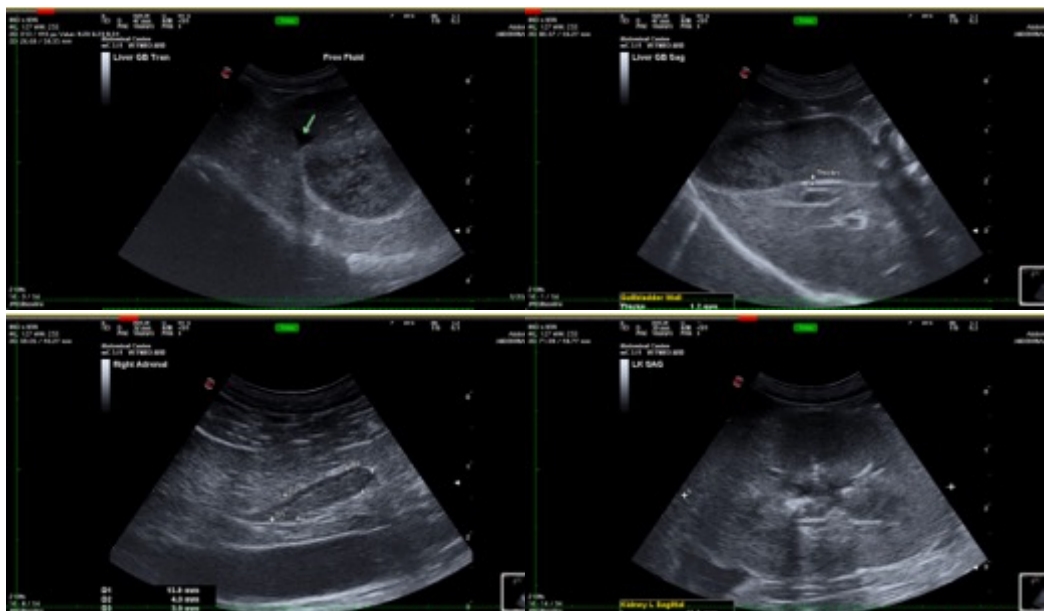
If not recently evaluated, urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

If not recently evaluated, a blood pressure is recommended if not recently evaluated.

Recommendations regarding the fluid therapy, and if that can be contributing to the free abdominal fluid is dependent on duration and rate of fluid therapy, patient's level of hydration prior to receiving fluid therapy, patient's ongoing weights, urine production, etc. Therefore, a full consultation with a veterinary internist and/or referral to one could be considered.

For an additional charge an internal medicine consult can be utilized through [Sonopath.com](http://sonopath.com). You can select the internalmedicine drop down at <http://spa.sonopath.com/>.

One of the world's top internists & SonoPath associate Dr. Remo Lobetti BVSc, MMedVet, PhD, DECVIM can evaluate your case through SonoPath. <https://sonopath.com/resources/sonopath-services/internal-medicine-teleconsultation-services>





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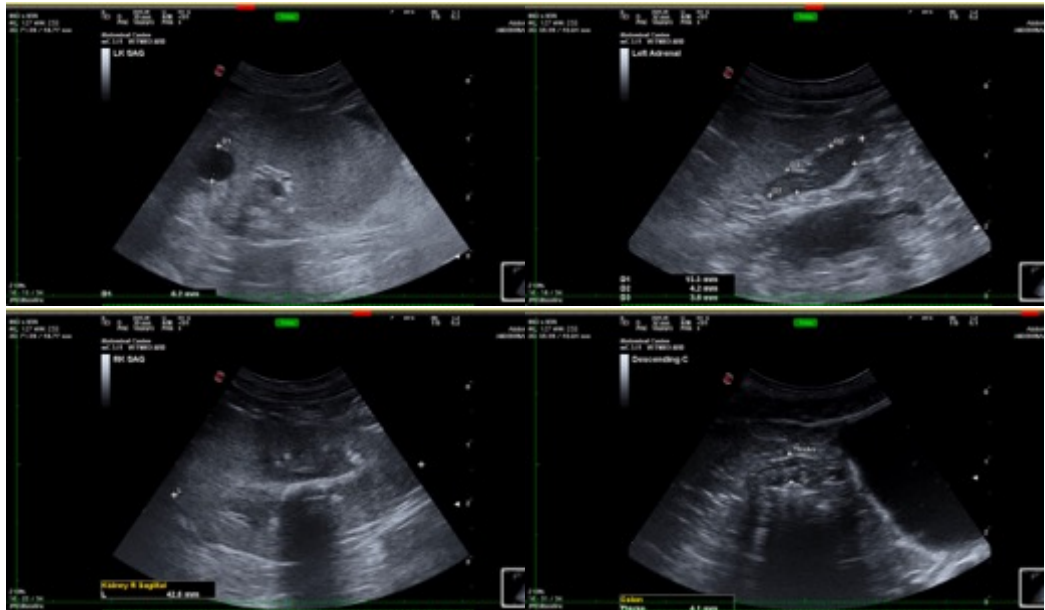
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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