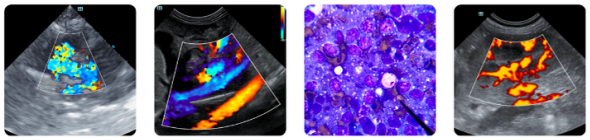


PATIENT

Koko Velez

SPECIES

Canine

BREED

Yorkshire Terrier

SEX

MN

AGE

15 years

WEIGHT

6.2 lbs

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Dr. Gabriel Ferrer

HOSPITAL NAME

Pulse Pet Ultrasound Services

REFERRING VET

Dr. Lionel Ricci

INVOICE

11377

DATE

2/26/2026

PRESENTING CLINICAL SIGNS

- Px presented as a referral for an abdominal ultrasound due to chronic anorexia, Hx of pancreatitis, vomiting, and diarrhea
- Px has been having episodes of vomiting and diarrhea since mid Feb
- Previously suffered from Gastritis and Colitis in 2022

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

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The left kidney has a smooth capsule and with hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. Hyperechoic, shadowing foci present in renal parenchyma and calyces consistent with nephrocalcinosis is noted. Spherical anechoic fluid accumulation consistent with cortical cysts are also noted. No evidence of pelvic dilation was present. Left kidney measures 3.39 cm in length.

The right kidney has a smooth capsule and with hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. Hyperechoic, shadowing foci present in renal parenchyma and calyces consistent with nephrocalcinosis is noted. Spherical anechoic fluid accumulation consistent with cortical cysts are also noted. Right kidney measures 3.73 cm in length.

Adrenal Glands

Both adrenal glands were visualized and recognized as having normal shape, size, position and echogenicity for this breed and age. The visible phrenic vasculature was unremarkable.

Left adrenal measures 1.8 cm in length, 0.5 cm at the caudal pole and 0.53 cm at the cranial pole. Right adrenal measures 1.62 cm in length, 0.61 cm at the caudal pole and 0.65 cm at the cranial pole.

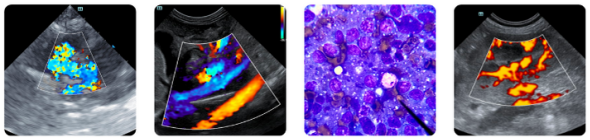
Spleen

The spleen was normal with age appropriate homogeneous parenchyma and a smooth capsule with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

Liver

The liver is subjectively normal in size with normal contours and structure. There is age appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion.

The gall bladder is moderately distended with anechoic fluid, with hyperechoic non-shadowing partially organized debris present. There is no surrounding free fluid or signs of active inflammation.



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Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate. No masses or focal lesions were observed.

Duodenum is mildly thickened with a somewhat corrugated appearance and mild fluid dilation with no visible foreign material. Some jejunal loops are thickened with a prominent muscularis layer with mild fluid dilation with no significant distension noted. Some jejunal loops are visualized with normal wall thickness and layering.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The right limb of the pancreas is enlarged and hyperechoic.

ULTRASONOGRAPHIC FINDINGS

- Gastroenteritis with some thickened loops, some with prominent muscularis layer.
- Prominent right limb of the pancreas – Possible mild pancreatitis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

GI changes are consistent with nonobstructive gastroenteritis and in the absence of chronic GI signs, acute gastroenteritis is most likely. Pancreatic changes are consistent with mild pancreatitis and concurrent pancreatitis is likely given abnormal CPL. The muscularis thickening of some loops of jejunum may be secondary to inflammation or may reflect infiltration disease such as IVD. Consideration for dietary indiscretion, food sensitivity/allergy, toxin, infectious (bacterial, viral, parasitic) or mild inflammatory bowel disease is reasonable. Occult neoplasia cannot be completely ruled out. Treatment is supportive and involves fluid support, GI support (anti-nausea, appetite stimulant), analgesia and enteral nutrition as needed. Panaquel could be considered if available. Antibiotics are generally not warranted. Serial imaging is indicated if clinical signs are not resolving. GI panel (TLI/PLI/cobalamin/folate), fecal pathogen PCR, and empiric broad spectrum deworming and treatment with probiotics should be considered as clinically warranted. Ultimately GI biopsy may be required for more definitive diagnosis.

Gall bladder debris is likely an incidental finding and is often subclinical and often does not warrant specific treatment or further investigation. Given the lack of elevated liver values, this is not likely contributing to clinical signs. Correlate clinical significance with bloodwork findings and clinical signs. Serial imaging for monitoring could be considered especially if liver enzymes subsequently become elevated.

Renal changes are likely age related degenerative changes. Correlate clinical significance with blood work/urinalysis findings and clinical signs. Nephroliths may act as a nidus of infection and predispose to urinary tract infections. They can also cause sterile inflammation leading to renal hematuria. They have the potential to move into the ureters or bladder causing obstructive uropathy.

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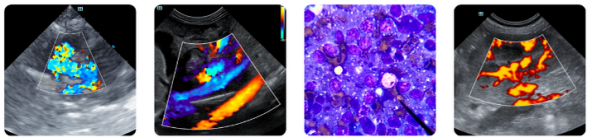

Clinical Sonography & Telecytology
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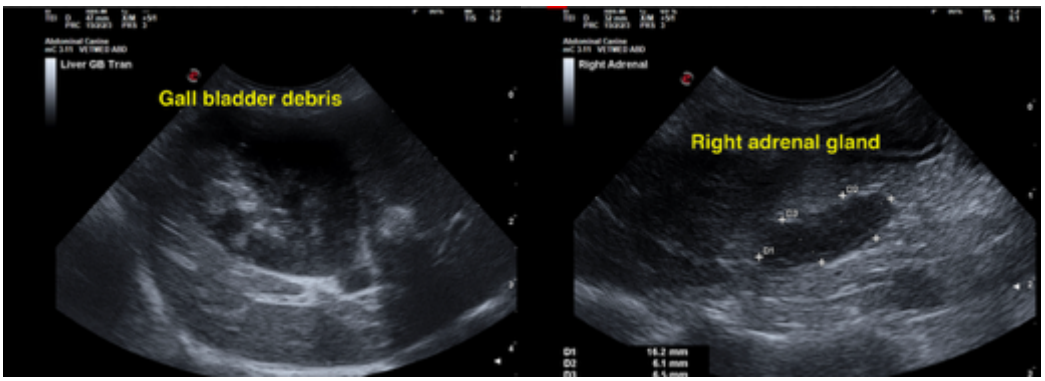

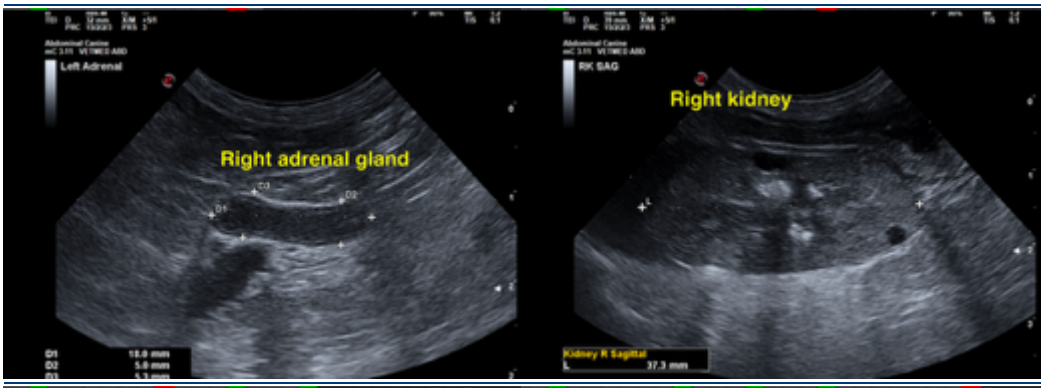

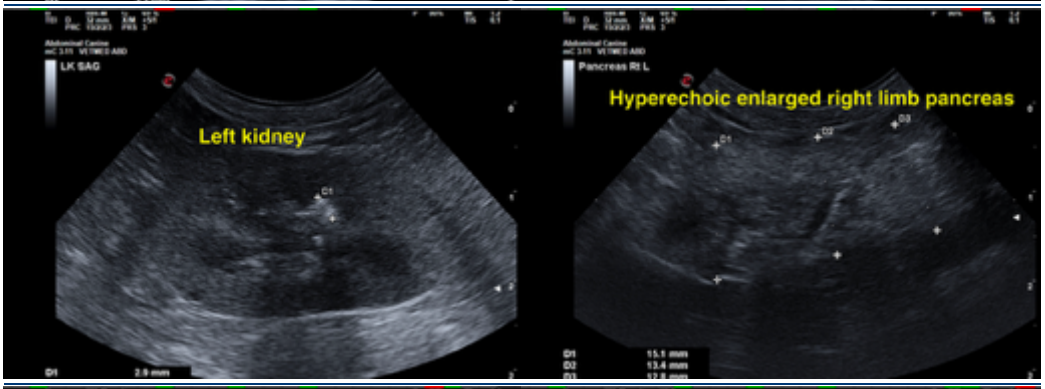

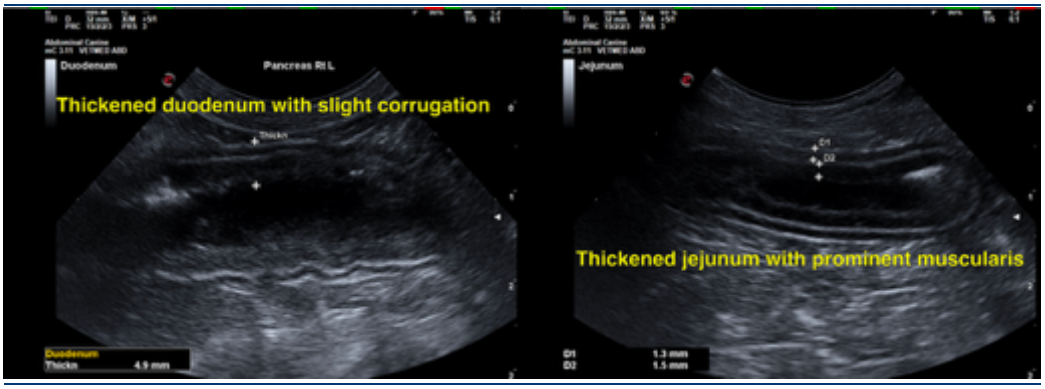

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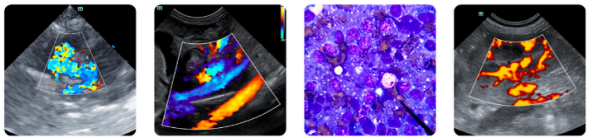

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC

info@SonoPath.com