



PATIENT

Roxy Schelhaas

SPECIES

Canine

BREED

Chihuahua

SEX

Spayed Female

AGE

15 Years

WEIGHT

3.6 kg

INTERPRETED BY

Dr Brittany Sinclair,
 BVSc(hons),
 DACVECC

IMAGING PERFORMED BY

Amanda Stewart

HOSPITAL NAME

Woodstock Veterinary
 Hospital

REFERRING VET

Dr. Norris

INVOICE

75381

DATE

5/22/26

PRESENTING CLINICAL SIGNS

History of new hyporexia/picky appetite over the past 1-2 months. Over past weekend, developed full anorexia. Began vomiting 24 hours ago (May 20) - 5 episodes of mainly bilious fluid, no blood. No diarrhea noted. Has been lethargic. Tense in abdomen on exam, and suspicious of hepatomegaly but difficult to palpate deeply. Weight has been trending downward and has lost 0.2 kg in 2 weeks.

Cardiac - Low grade murmur first noted in 2024, VHS was normal (< 11) at that time. Murmur today grade 2/6 left systolic, no pulse deficits. ProBNP normal on recent bloodwork (May 4). Asymptomatic in regards to heart/lungs; hoping to proceed with anesthesia for dental procedure in future, so evaluating if good candidate for anesthesia. Current Medications: Cerenia injection May 21/26 1230pm

Abnormal PE/Chem/CBC/UA Results: Full wellness performed recently on May 4th (at annual exam) all WNL other than non-regenerative anemia (38%) and lymphopenia. 4Dx negative. CBC repeated today (May 21) which showed HCT at 44.5% (was not significantly dehydrated on exam but has had reduced fluid intake), and cPL was WNL. Previous history of pancreatitis in 2021 but has been on low fat diet since. Primary Question to Be Answered in This Exam hoping to proceed with anesthesia for dental procedure in future, so evaluating if good candidate for anesthesia. suspicious of hepatomegaly but difficult to palpate deeply. Weight has been trending downward and has lost 0.2 kg in 2 weeks.

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 kidneys have a smooth capsule and with hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. No evidence of pelvic dilation was present. Hyperechoic, shadowing foci present in renal parenchyma and calyces consistent with nephrocalcinosis. Left kidney measured 3.04 cm. Right kidney measured 3.63 cm.

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 measures 1.32 cm in length x 0.46 cm at the caudal pole and 0.37 cm at the cranial pole. Right measures 1.23 cm in length x 0.32 cm at the caudal pole and 0.48 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.



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Gall bladder is moderately distended with generally anechoic bile. There is a small amount of gravity dependent non-shadowing hyperechoic debris. The proximal cystic duct is slightly dilated with partially organized debris noted within the lumen. The common bile duct appears to taper normally. The duodenal papilla is not distinctly visualized.

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.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. There were no focal lesions consistent with obstruction or a mass effect observed.

Sections of colon are visualized with formed fecal material and gas shadowing distally. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The area of the pancreas was isoechoic to surrounding tissue with no overt inflammation. Pancreatic tissue was not distinctly visualized which is common.

Free Abdomen

No clinically significant lymphadenopathy or abnormalities noted. No free fluid noted.

ULTRASONOGRAPHIC FINDINGS

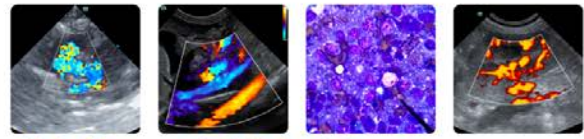
- Gallbladder debris with mild cystic duct dilation.
- Aging renal changes with nephrocalcinosis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Significant hepatomegaly is not appreciated on this ultrasound. Abdominal radiographs are more sensitive at detecting liver size. With no significant disruption to liver parenchyma, a clinically significant hepatopathy is not strongly suspected.

Gallbladder debris is usually an incidental finding but can be cause of GI distress. No other cause of reported inappetence and vomiting was identified on abdominal ultrasound.

Pancreas and GI tract are within normal limits. Consideration for dietary indiscretion, infectious etiologies (bacterial, viral, parasitic), food sensitivity/allergy or mild inflammatory bowel disease is reasonable. While not sonographically evident, pancreatitis cannot be completely ruled out. Empiric treatment for GI signs including anti-nausea, appetite stimulant and fluid support as clinically indicated is warranted. Ursodiol could be added when patient is able to take oral medications due to small amount of gallbladder debris. A diet trial with hydrolyzed protein or select protein diet could be considered if food sensitivity is suspected clinically. If signs are persistent or recurrent, additional diagnostics to be considered include baseline cortisol +/- ACTH stimulation test, GI panel (TLI/PLI/cobalamin/folate), fecal pathogen panel, thyroid testing, bile acid profile, and thoracic radiographs to rule out occult neoplasia, cardiac disease and esophageal disease as potential causes. Ultimately GI biopsy may be required for more definitive diagnosis if the patient is not responsive to medical treatment.



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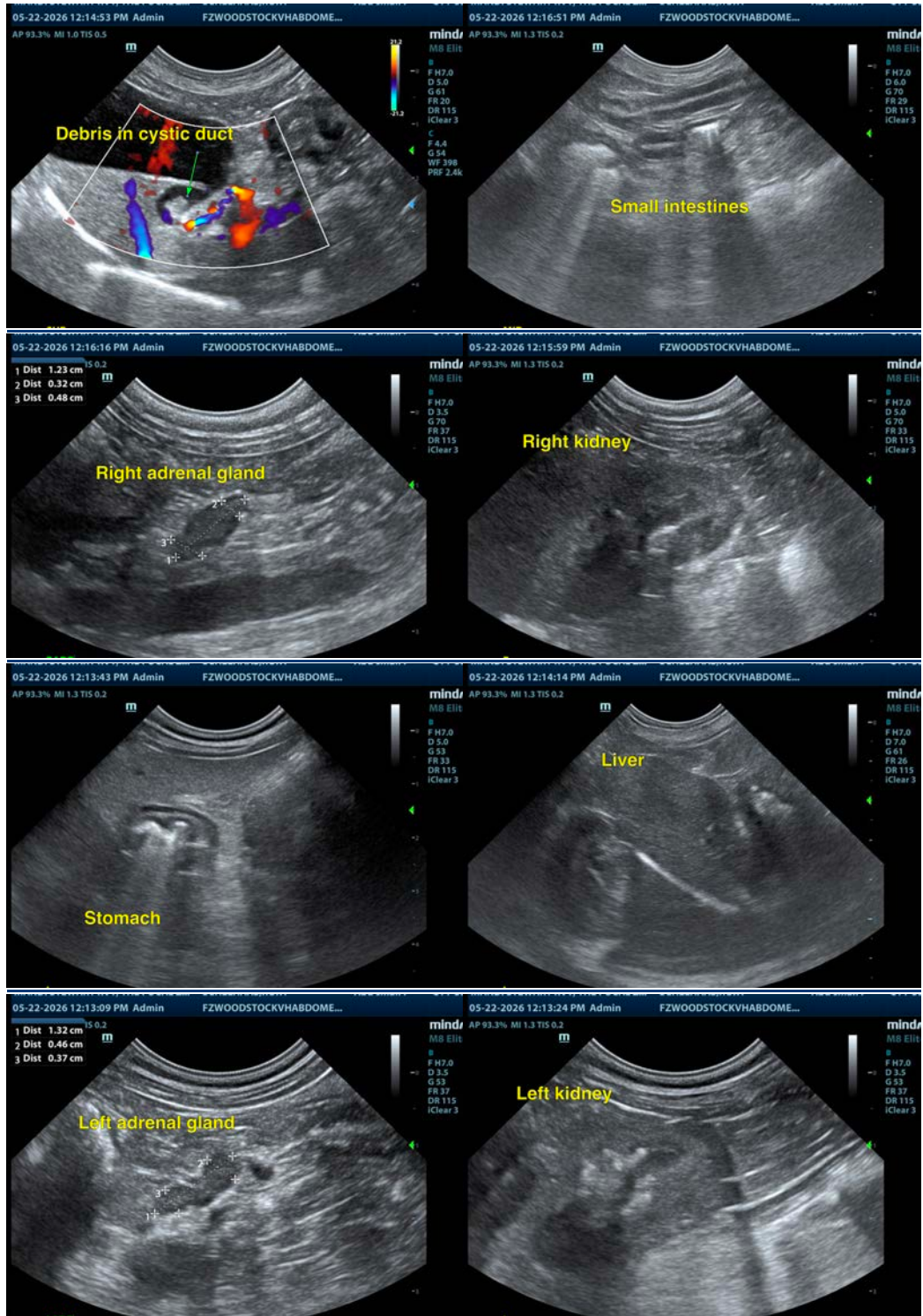
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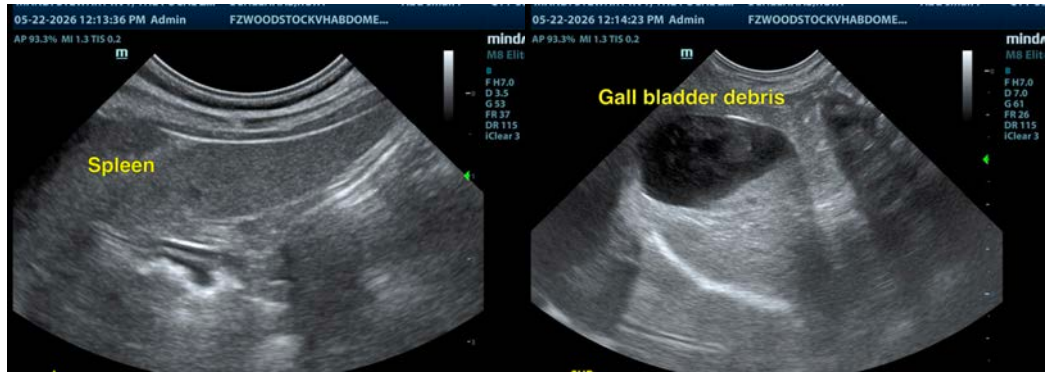
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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