



PATIENT

Frankie Phillips

SPECIES

Canine

BREED

Frenchie

SEX

FS

AGE

9.5 years

WEIGHT

9.2 kg

INTERPRETED BY

Greg Kuhlman, DVM,
DACVIM (SAIM)

IMAGING PERFORMED BY

Danielle, RVT

HOSPITAL NAME

Orchard Veterinary
Care

REFERRING VET

Dr. Ernst

INVOICE

11667

DATE

4/9/2026

PRESENTING CLINICAL SIGNS

P was initially seen mid March by rDVM for inappetence. P was noted to have a fever, anemia (PCV 27%), leukopenia at initial visit, chemistry showed mildly elevated phosphorus, otherwise unremarkable (kidney and liver values / liver function parameters wnl). Placed on clavamox for 6 days although no improvement to PCV, therefor switched to baytril. About 1 week after initial visit, P started having collapsing events (unsure if seizure vs collapse / syncope). O reports P typically falls over and is stiff, then has difficulty using hind legs. P becomes very cyanotic during events and takes a few minutes to recover. Each episode itself lasts only a few seconds and happens multiple times a week. Episodes appear to be induced by excitement. Started on prednisone 5mg PO BID - initial improvement in appetite and leukopenia, hct stable. Was seen at OVC for second opinion and prednisone tapered down - O reports P has been less energetic since tapering and PCV today is 20%, evidence of regeneration on blood smear in house.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The bladder is moderately distended with anechoic urine. No uroliths are seen. The bladder wall is normal in appearance and thickness. No masses are seen.

The left kidney presents normal size with normal shape and architecture. Normal corticomedullary distinction. No pyelectasia, ureteral dilation or nephrolithiasis. The left kidney measured 4.3 cm in length.

The right kidney presents normal size with normal shape and architecture. Normal corticomedullary distinction. No pyelectasia, ureteral dilation or nephrolithiasis. The right kidney measured 4.7 cm in length.

Adrenal Glands

The left adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The cranial pole measures 3.5 mm and the caudal pole measures 3.5 mm.

The right adrenal gland presents normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The right adrenal measures 3.9 mm in width.

Spleen

The spleen is normal in size, shape, margination and echogenicity. No masses are seen.

Liver

The liver presents normal size and shape with smooth lobar margins. The parenchyma has normal echogenicity with normal echotexture. No focal lesions are seen. Intrahepatic bile ducts are normal. Normal vascular pattern.

The gallbladder presents normal size with anechoic contents. Normal gallbladder wall. No evidence of bile duct distention or obstruction.

Gastrointestinal



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The stomach wall is diffusely normal in thickness and layering and contains a small amount of retained fluid. Possibly mild gastric ileus, no mechanical obstruction is seen.

Small intestine is diffusely mildly thick with a relatively thick mucosa compared to other layers. Normal wall layering is preserved; however, the mucosa is more echogenic than normal and contains hyperechoic striations perpendicular to the lumen. The lumen of the small intestine is empty with no evidence of obstruction or foreign material.

Colon contains normal contents with normal wall thickness.

Pancreas

The visible pancreas is normal in size with normal echogenic parenchyma and surrounded by normal peri-pancreatic mesentery.

Free Abdomen

There are no enlarged abdominal lymph nodes seen on this exam. No free abdominal fluid is seen.

ULTRASONOGRAPHIC FINDINGS

- Retained fluid in stomach – Possible gastric ileus.
- Lymphangiectasia – Small bowel findings are most consistent with lacteal dilation. These findings can be observed with protein-losing enteropathies caused by either primary lymphangiectasia or primary infiltrative inflammatory disease with secondary lymphangiectasia. Infiltrative neoplasia is possible but considered less likely. Histopathology is necessary to definitively determine underlying cause.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recommend treating the gastric fluid with supportive care. No obvious gastric ulcerations are seen that would explain patient's anemia.

Changes in the small intestines may be due to a non-fasted state, however, consider a possible pathologic cause. Recommend 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. If a chronic enteropathy is suggestive from the GI panel, then I recommend GI biopsies either surgically or endoscopically (if clinically warranted.)

There is no cause for the patient's seizures versus syncopal episodes is observed on this exam. No cause for the patient's anemia is observed on this exam.

Recommend Three View chest radiographs If not already performed for the syncopal events, to evaluate cardiac morphology.

Consider echocardiogram and ECG to evaluated further for possible syncopal events.

Recommend performing slide agglutination test and submitting a CBC for pathology review to help determine the cause of anemia, or if it is mellitic in nature. Consider submitting a anemia PCR panel to rule out infectious causes for anemia.



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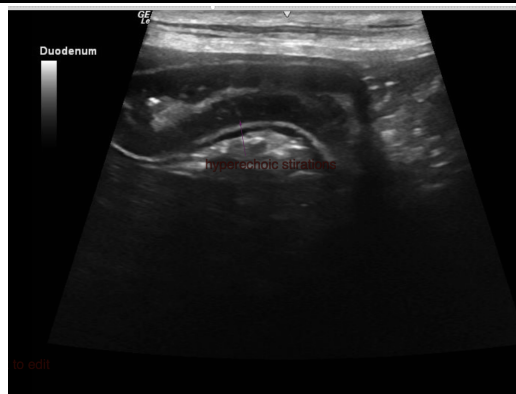
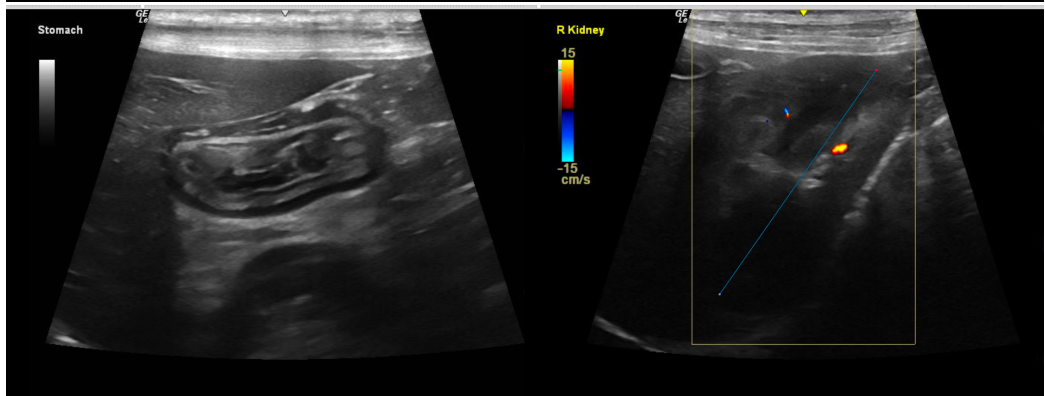
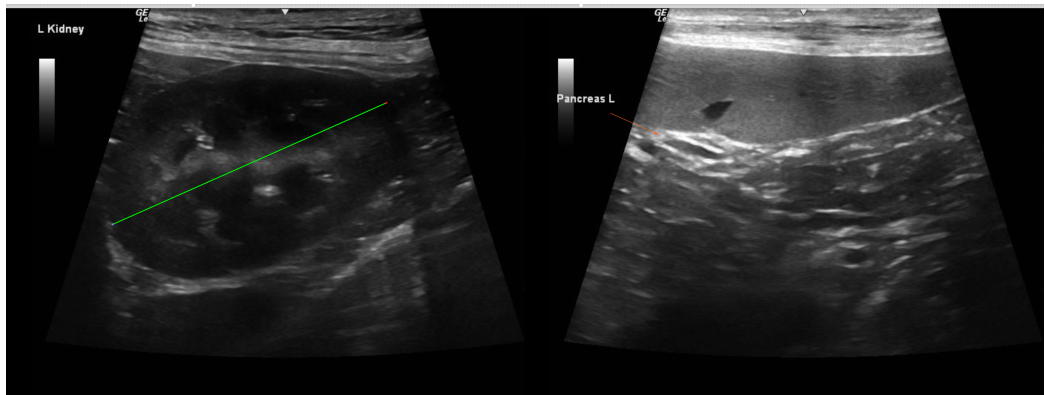
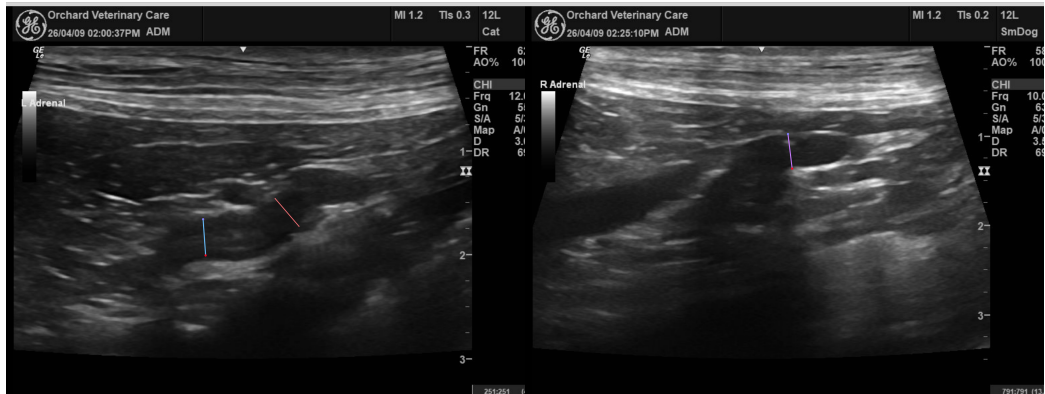
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Greg Kuhlman, DVM, DACVIM (SAIM)

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