



**PATIENT**

Bruce Dylan Kirsch

**SPECIES**

Canine

**BREED**

Golden Retriever Mix

**SEX**

MN

**AGE**

5 years

**WEIGHT**

90 lbs

**INTERPRETED BY**

Greg Kuhlman, DVM,  
DACVIM (SAIM)

**IMAGING  
PERFORMED BY**

Loetitia Saint-Jacques,  
LVT

**HOSPITAL NAME**

MountainView Animal  
Hospital

**REFERRING VET**

Dr. Pablo Mendoza

**INVOICE**

12087

**DATE**

6/4/2026

**PRESENTING CLINICAL SIGNS**

Evaluation of pancreatitis, r/o GIFB vs other. Patient presented for evaluation of vomiting that acutely started last weekend and has persisted, patient vomited this morning undigested food that was given more than 12hrs prior. Last meal was at 4pm on 6/3/26. On physical examination abdomen is slightly firm but non painful. Mucous membranes are tacky. Radiographs did not show evidence of foreign body or obstruction; laboratory findings are consistent with pancreatitis.

MEDS: Cerenia, SQ Fluids.

**RADS- CONCLUSIONS:** No radiopaque foreign material or evidence of mechanical obstruction is identified. Underlying gastroenteritis secondary to dietary indiscretion, allergies/intolerances, inflammatory and infectious etiologies warrant consideration. Other disease processes such as pancreatitis or systemic abnormalities contributing to the patient's reported clinical signs without radiographic abnormalities cannot be excluded.

Abnormal PE/Chem/CBC/UA Results: LABS- Lipase 2,373 U/L 200 1800 SNAP cPL Abnormal.

**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.

Prostate is normal in size (8.2 mm in width), echotexture, and echogenicity for a neutered male.

The left kidney presents normal size with normal shape and architecture. Normal corticomedullary distinction. No pyelectasia, ureteral dilation or nephrolithiasis. In the ventral mid aspect of the left kidney, there is a small defect within the kidney wall present. This may be due to previous infarction, most likely not clinically significant. The left kidney measured 7.3 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 5.9 cm in length.

**Adrenal Glands**

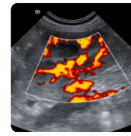
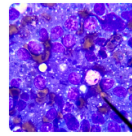
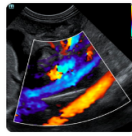
The left adrenal gland is small (flattened contour.) The cranial pole measures 3.6 mm and the caudal pole measures 3.7 mm. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The right adrenal gland presents small in size, normal shape and homogenous parenchyma. The phrenic vasculature is unremarkable. The right adrenal measures 3.5 mm in width.

**Spleen**

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

**Liver**



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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.

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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 stomach is normal in thickness and layering.

**SEX**

The jejunum is diffusely normal in thickness and layering measuring 4.0 mm. Muscularis layering is diffusely prominent, which may be a normal patient variant or may indicate a chronic enteropathy.

MN

. Colon contains normal contents with normal wall thickness.

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**Pancreas**

The pancreas is diffusely hypoechoic with mild surrounding hyperechoic fat.

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**Free Abdomen**

Prominent iliac lymph nodes present with a representative node measuring 4.4 mm in width. Mild mesenteric lymphadenopathy with a representative node measuring 6.1 mm in width.

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No free abdominal fluid is seen.

**ULTRASONOGRAPHIC FINDINGS**

- Iliac and mesenteric lymphadenopathy – Appear reactive and unlikely to be prominent due to neoplasia.
- 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.
- Diffusely hypoechoic pancreas with mild surrounding hyperechoic fat.
- Jejunal muscularis layering is diffusely prominent, which may be a normal patient variant or may indicate a chronic enteropathy.

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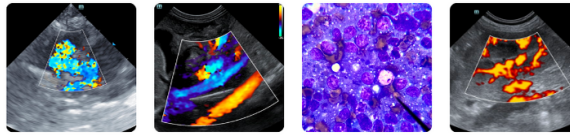
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**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

Given the abnormal snap cPLI, recommend submitting a spec cPLI to screen patient further for pancreatic inflammation, which may be the cause of the patient's clinical signs.

Given that the patient has bilateral small adrenals, recommend performing a low dose dexamethasone suppression test to screen patient for hypoadrenocorticism. Given the appearance of the adrenals, hypoadrenocorticism is a likely differential for the patient's clinical signs.



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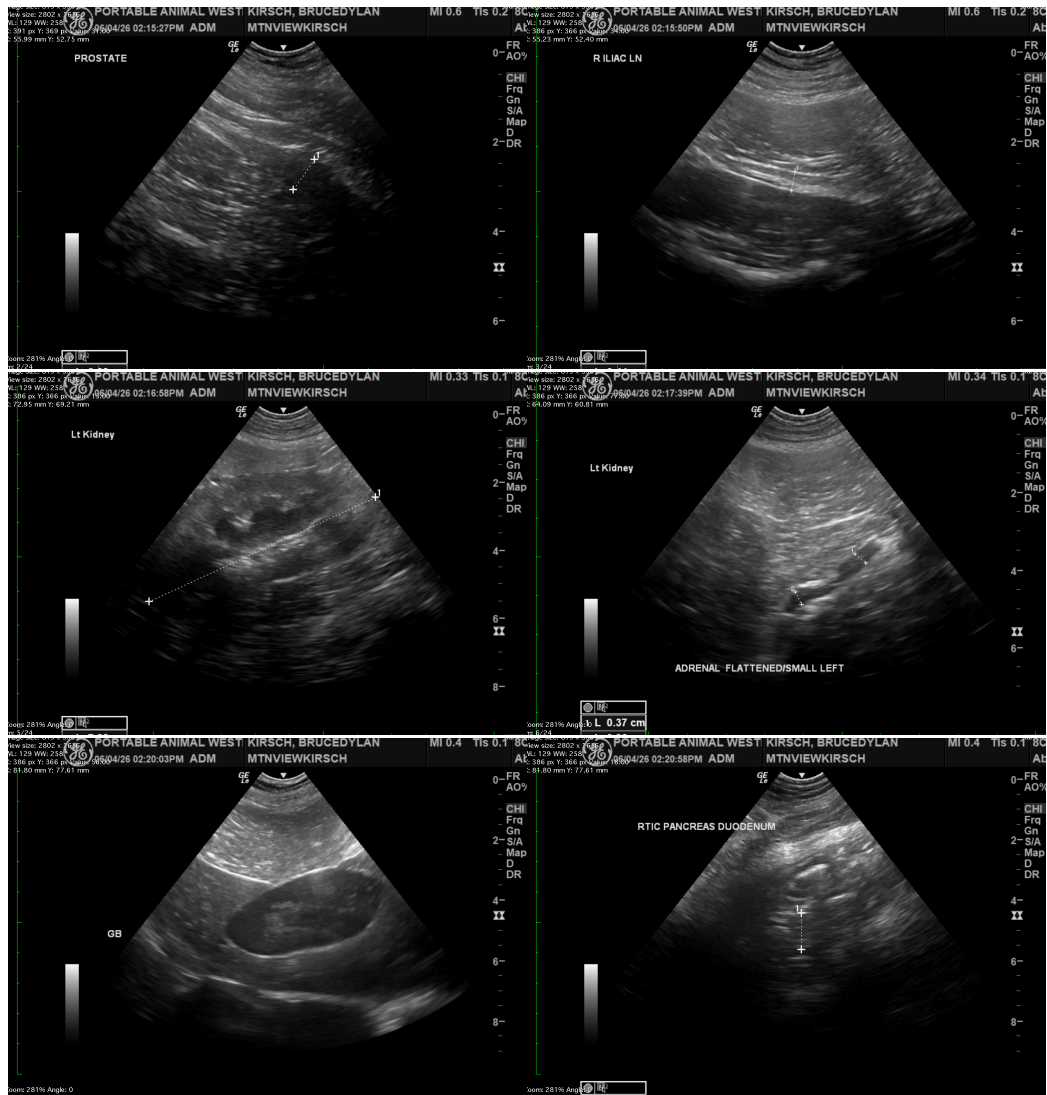
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A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function. If a chronic enteropathy is identified, then I recommend a diet trial with novel protein/hydrolyzed protein diet. Ultimately, if there is no other cause identified (other than a chronic enteropathy) and these clinical signs persist, then consider GI biopsies at that time.

Given the prominence of the mesenteric lymph nodes, and the thickened muscularis. Another differential for the appearance of the GI tract, could potentially be parasitism, 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.

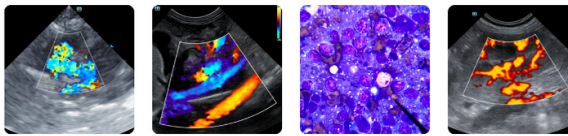
Given that the patient's lab work was reportedly normal, other than elevated amylase, if hypoadrenocorticism is identified, assuming electrolytes are normal, then the hypoadrenocorticism would be considered atypical at this time.



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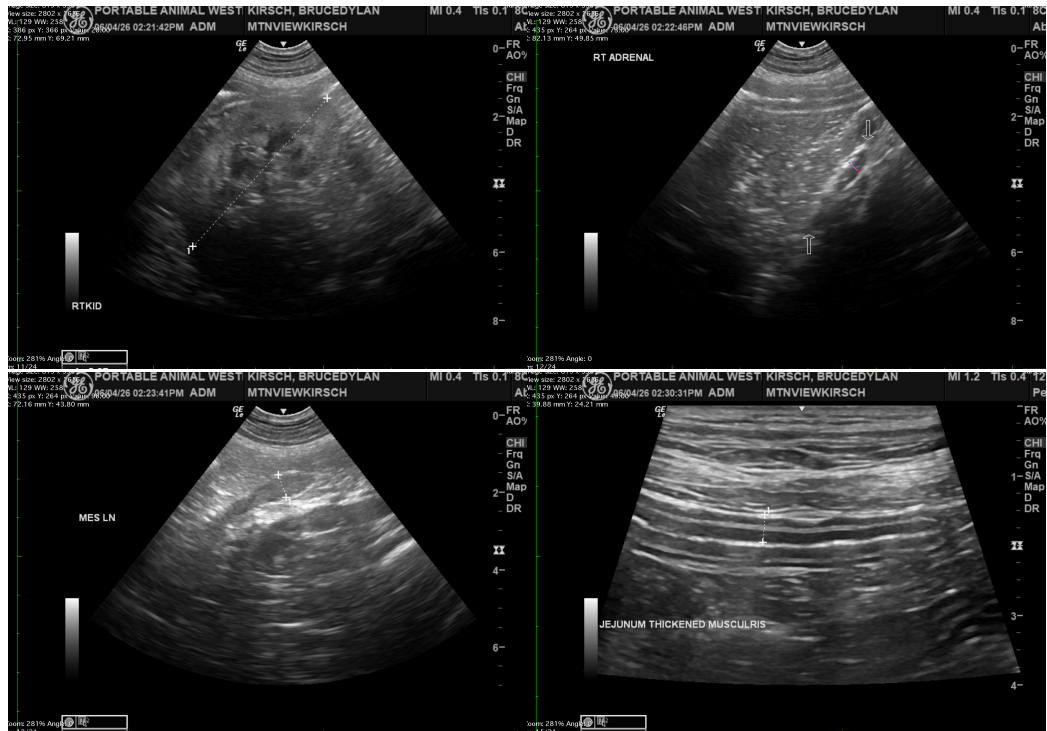
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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