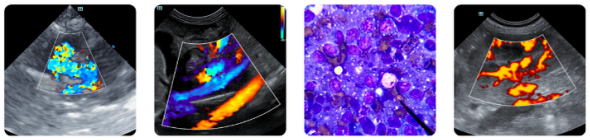


PATIENT

Mimosa Carrion

SPECIES

Canine

BREED

Mixed

SEX

SF

AGE

15 years

WEIGHT

5.3 lbs

INTERPRETED BY

Kathleen Sennello DVM, MS, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Dr. Gabriel Ferrer

HOSPITAL NAME

Pulse Pet Ultrasound Services

REFERRING VET

Dr. Ernesto Casta

INVOICE

11509

DATE

3/18/2026

PRESENTING CLINICAL SIGNS

- Px presented as a referral for an abdominal ultrasound due to Hx of chronic pancreatitis.
- Px has had episodes of pancreatitis since November 2025.
- Symptoms include vomiting, diarrhea, and inappetence.
- Px is currently hospitalized and fluid therapy is being administered via IV (LRS)
- Px is currently taking the following Mx: Enalapril, Famotidine, SQ fluids 3x a week

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

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine. The Bladder wall largely appears normal thickness with a smooth mucosal surface. There's a small irregular region visualized near the trigone measuring 0.35 cm x 0.72 cm, most consistent with a prominent ureteral papillae. Although a small area of adhered dependent debris or an early mass effect cannot be ruled out. This measures 0.35 cm x 0.72 cm.

The left kidney has a normal shape and size (3.47 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. Large cortical cyst in the caudal pole measuring 1.6 cm in diameter. There is pyelectasia noted measured 0.27 cm. There is no evidence of nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.04 cm). Overall echogenicity is slightly hyperechoic with poor corticomedullary distinction and a typical 1:3 cortex:medulla ratio. There is no evidence of focal perinephric inflammation or effusion. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

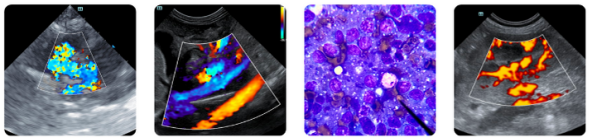
The left adrenal gland is normal in size measuring 0.33 cm at the cranial pole and 0.39 cm at the caudal pole. It is observed in its normal position cranial to the left renal artery. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

The right adrenal gland is normal in size measuring 0.54 cm at the cranial pole and 0.45 cm at the caudal pole. It is observed in its normal position between the cranial aspect of the right kidney and the caudal vena cava. It is normal in appearance (uniformly hypoechoic) and shape with no evidence of a mass effect.

Spleen

The spleen is subjectively normal in size (0.75 cm) and the echotexture is homogenous. The splenic capsule is smooth with no visible irregularities. The blood flow through the hilus and splenic parenchyma appears normal. No focal parenchymal abnormalities are visualized.

Liver



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The liver is normal in size, and normal in echogenicity with smooth peripheral margins. The parenchyma is heterogenous in echotexture with subtle, indistinct focal mottling. The visible portions of the vasculature and biliary tract appear normal. No focal nodules or cystic lesions are observed.

The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. Luminal contents are mild and likely incidental at this time. The cystic and common bile ducts are normal/not visible.

Gastrointestinal

The stomach is moderately dilated with fluid and irregular shadowing material most consistent with normal ingesta and gas. It measures at a normal thickness of 0.34 cm with some variability due to the presence of rugal folds. The distinction of the gastric wall layering is adequate and there is no impression of reduced peristaltic activity. No masses or focal lesions were observed.

The visualized areas of duodenum (0.39 cm), jejunum (0.34 cm) and ileum have a uniform diameter with minimal to mild fluid distension. Wall appears subjectively, mildly increased. Bowel loops follow a typical curvilinear path with distinct wall layering. Visualized peristalsis appears appropriate. Some sections of small intestine have mild fluid/chyme distension, and some areas have a prominent muscularis layer.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. The entirety of the colon appears moderately distended with fluid and occasional shadowing fecal material/ingesta. The descending colon wall measures 0.15 cm with intact wall layering.

Pancreas

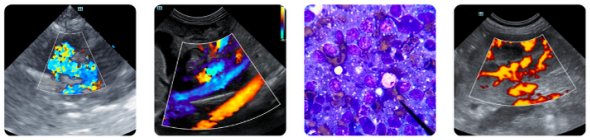
The pancreas is visible and heterogenous in both limbs. There is no evidence of nodules or cystic lesions. There is no evidence of regional mesenteric inflammation or fluid.

Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion, or subjective lymphadenomegaly. The Medial iliac nodes appear normal and there was no evidence of a caudal aortic thrombus at the bifurcation. The omentum is of normal uniform echogenicity.

PRIMARY FINDINGS

- Decreased corticomedullary distinction in both kidneys with left sided pyelectasia and a large left cortical cyst. Mild loss of corticomedullary distinction in both kidneys could be consistent with chronic degenerative disease or interstitial nephrosis.
- Pancreatic changes most consistent with chronic pancreatic remodeling +/- chronic pancreatitis.
- Heterogenous liver. The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, nodular hyperplasia, inflammatory/immune-mediated disease, infiltrative neoplasia (less likely) or other hepatopathy.



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- Mild/moderate fluid distension of the stomach and some areas of the small intestine. Findings are suggestive of delayed gastric emptying/ileus. An unseen partial obstruction or similar cannot be ruled out.

- Mildly thickened small intestine. The mild small intestinal wall changes may be a normal variant in this patient or could be consistent with an inflammatory process (e.g., inflammatory bowel disease).

- Fluid distended colon. Findings are most consistent with a diarrhea reported and possibly passing ingested material (food, foreign material, etc.) and/or more solid stool.

SECONDARY FINDINGS

- Focal irregularity in the urinary bladder wall. Findings are suspicious for prominent ureteral papillae. Recommend continued monitoring as an early mass lesion cannot be ruled out.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Both kidneys have changes consistent with chronic renal disease. If not already done, recommend a blood pressure, urinalysis, culture +/- urine protein-creatinine ratio to further evaluate. Correlate these findings with the patients' renal values and urinalysis findings. When the patient is well hydrated and not having an episode of GI disease to assess their baseline and try and determine if these are acute on chronic episodes or this is baseline current renal function.

There's no evidence of severe pancreatitis. The pancreas is visible, possibly consistent with pancreatic remodeling. Correlate with a quantitative PLI level. If this is significantly elevated, mild chronic pancreatitis is possible.

The liver is heterogenous. This is a non-specific finding. If further evaluation is desired, you could consider a fine needle aspirate and a liver function test.

The small intestine appears mildly thickened with some areas exhibiting mild fluid distension, and the stomach is fluid/ingesta distended. If the patient was adequately fasted this likely represents a degree of ileus, possibly underlying gastrointestinal disease. Although, uremia can cause GI stasis. Consider the following:

- I believe Royal Canin has a combination Renal/hydrolyzed protein prescription diet. This could be a consideration.
- Consider a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc.. to further evaluate for pancreatic/small intestinal disease.
- Recommend chronic probiotic therapy.

If there is evidence of significant GI dysfunction based on the GI panel (low B12 levels, etc.) further evaluation such as endoscopic GI biopsies or similar could be considered.

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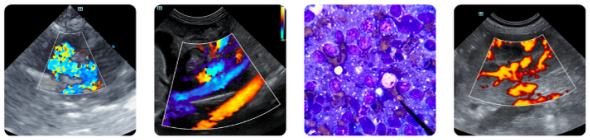

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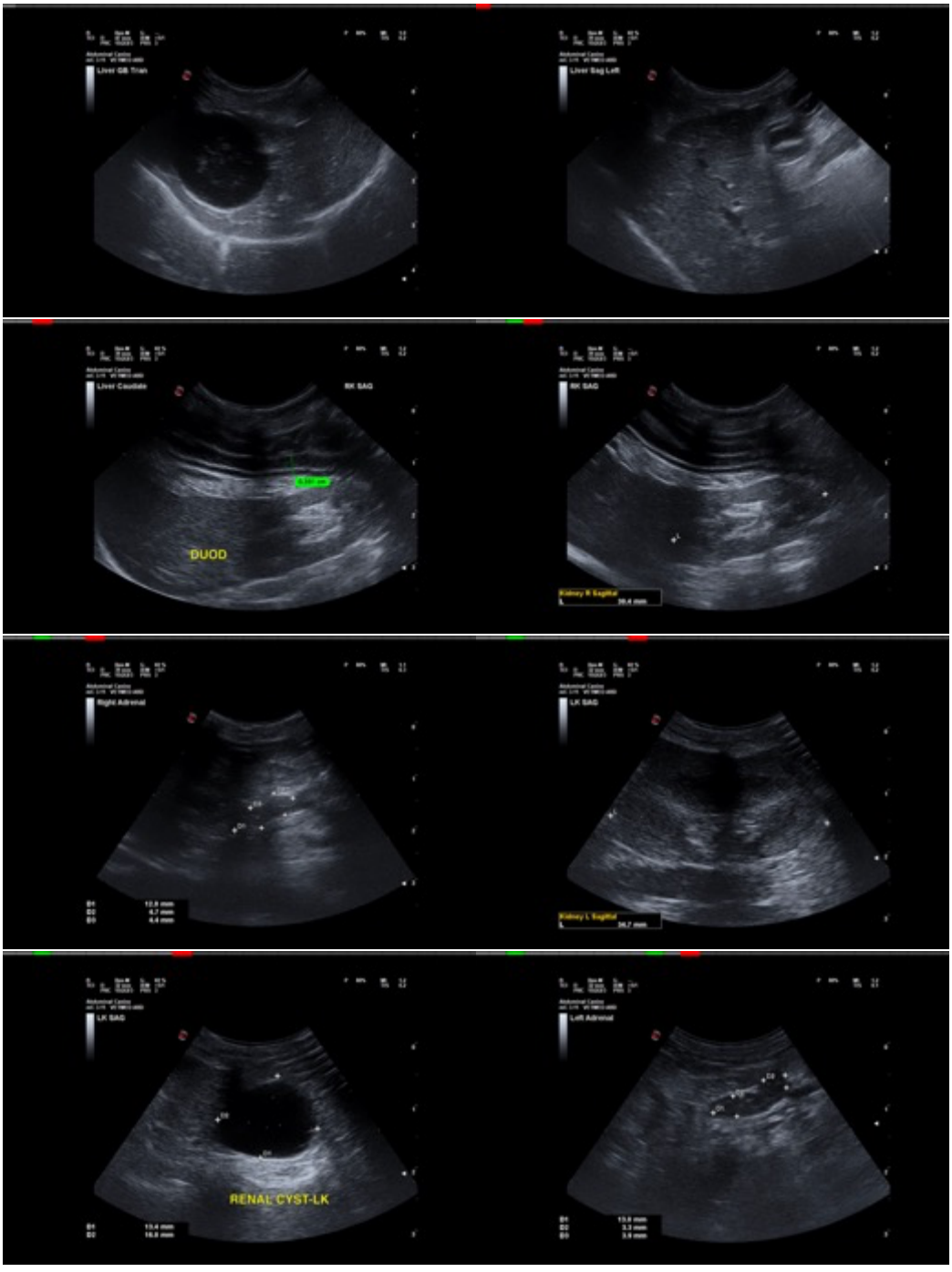

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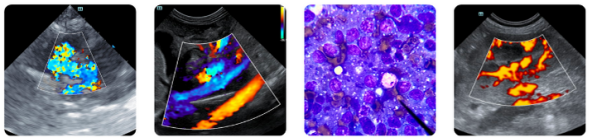

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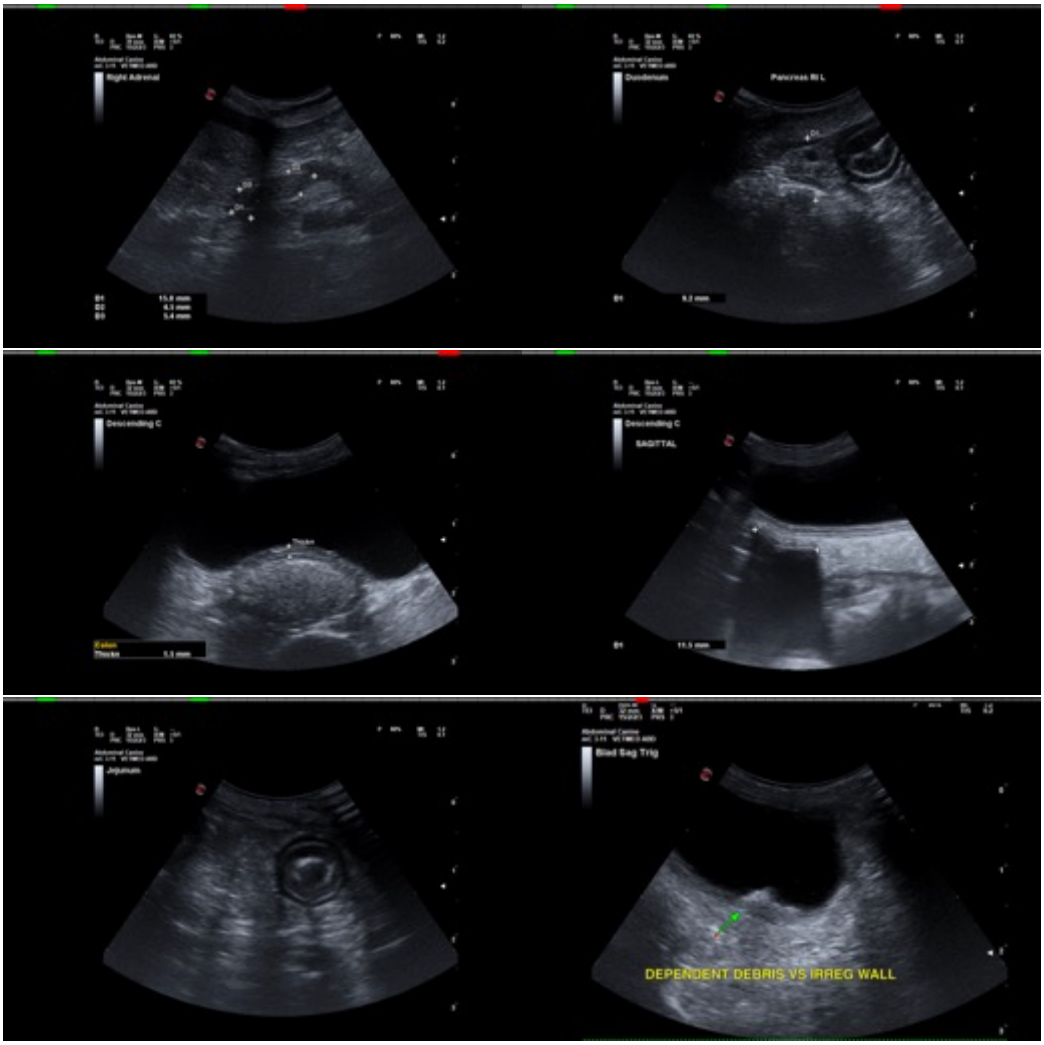

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Kathleen Sennello DVM,MS, Diplomate ACVIM (Small animal Internal Medicine)

info@sonopath.com