



PATIENT

Bambi Waldner

SPECIES

Canine

BREED

Chihuahua

SEX

SF

AGE

13 years

WEIGHT

3.8 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Mariusz
Chmielinski

HOSPITAL NAME

Apex Veterinary
Services Ltd.

REFERRING VET

Alpine 24/7 – ER Dr.

INVOICE

11899

DATE

5/7/2026

PRESENTING CLINICAL SIGNS

Presented for progressive lethargy, severe anorexia, vomiting/regurgitation, diarrhea, weakness, and failure to urinate since evening of May 5, 2026. Previously seen by rDVM earlier same day and reportedly treated with IV fluids, maropitant, famotidine, metronidazole, bloodwork, and abdominal radiographs. Historical GI sensitivity reported by owner. Frequent large-volume vomiting/regurgitation noted, including after drinking water. Recent hind-end pain treated with gabapentin and buprenorphine prior to onset of GI signs. Known grade III/VI systolic heart murmur; cardiac medication reportedly prescribed previously but not yet started.

Abnormal PE/Chem/CBC/UA Results: Vital Parameters: Initial hypothermia developed overnight (36.5–37.3°C), BP this morning: 171/123 (MAP 139) Grade III/VI systolic heart murmur present
Significant Laboratory Findings - CBC/Chemistry: Severe azotemia: Creatinine 555 µmol/L, BUN 49.3 mmol/L, SDMA 83 µg/dL, Hyperphosphatemia: 6.3 mmol/L, Mild hypercalcemia: 3.0 mmol/L, Hypokalemia: 3.9 mmol/L, Severe hypochloremia: 60 mmol/L, Elevated bicarbonate/TCO2: 41 mmol/L, Elevated anion gap: 48, Elevated osmolality: 332 mmol/kg, Severe inflammatory leukogram: WBC 37.5 x10⁹/L, Marked neutrophilia and monocytosis, Elevated CK: 938 U/L Radiographic Findings - mineralization/calcification in region of kidneys.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with a small amount of dependent echogenic debris . The Bladder wall, trigone, ureteral papillae and visible urethra (to a depth of 2cm) appear normal with no evidence of wall thickening, mucosal irregularities, masses or cystic calculi.

The left kidney has a normal shape and size (3.37 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. Pyelectasia noted measuring 0.3 cm, and numerous shadowing nephroliths visualized within the renal pelvis. The largest of which measures 0.7 cm. There is no evidence infarcts or hydroureter. Renal vasculature is normal.

The right kidney has a normal shape and size (3.72 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 plump in size measuring 0.45 cm at the cranial pole and 0.75 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 plump in size measuring 0.73 cm at the cranial pole and 0.88 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



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The spleen is subjectively normal in size (0.99 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.

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Liver

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

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The gall bladder lumen is moderately distended. The wall of the gall bladder is not thickened and has a smooth mucosal surface. There is a moderate amount of non-organized echogenic debris. The cystic and common bile ducts are normal/not visible.

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Gastrointestinal

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The stomach is moderately dilated with large fluid and irregular shadowing material most consistent with normal ingesta and gas. It measures at a normal thickness of <0.7cm 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. Large amount of fluid extends into the region of the pylorus, which appears thickened and with an irregular mucosal surface.

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The visualized areas of duodenum (0.49 cm), jejunum (0.3 cm) and ileum have a uniform diameter with minimal fluid distension. Wall thickness is increased (enter measurement if given). Bowel loops follow a typical curvilinear path. Visualized peristalsis appears appropriate. There is diffuse thickening of the small bowel with a prominent muscularis layer, and some areas of corrugated bowel. The duodenum in particular is thickened up to 0.55 cm. No definitive evidence of an obstruction is visualized, but the pyloroduodenal junction appears somewhat irregular and thickened.

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The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. 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.

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Pancreas

The pancreas is large and hypoechoic to surrounding mesentery. There is no evidence of nodules or cystic lesions. There is evidence of regional mesenteric inflammation. Consistent with mild pancreatitis in the right limb.

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Free Abdomen

Evaluation of the peritoneal cavity did not reveal any evidence of effusion. There are occasional prominent mesenteric lymph nodes. A jejunal lymph node is visualized measuring 0.41 cm. The omentum is hyperechoic particularly in the region of the pyloroduodenal junction and the right limb of the pancreas.

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ULTRASONOGRAPHIC FINDINGS

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- Mild dependent echogenic debris in the urinary bladder.
- Bilateral adrenomegaly. The bilateral adrenomegaly could be consistent with bilateral hyperplasia (e.g., secondary to pituitary-dependent hyperadrenocorticism), bilateral infiltrative neoplasia, inflammatory adrenal disease, other. Correlation with clinical findings is



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recommended.

- Age related change visualized associated with both kidneys, in addition to mild pyelectasia and nephroliths in the left renal pelvis.
- Moderate pancreatitis in the right limb.
- Moderate gallbladder debris. The significance of the aggregated gallbladder debris is unclear. This could represent an early mucocele, cholestasis, or may be secondary to fasting but seems unlikely to be causing a current issue. Recommend continued monitoring.
- Large, fluid distended stomach with a thickened pylorus and proximal duodenum. An obstruction is not visualized (cannot be definitively ruled out.) Findings could be consistent with gastritis/duodenitis, or early infiltrative disease.
- Diffusely thickened small intestine with a prominent muscularis layer and areas of corrugation. Findings are most consistent with a significant chronic enteropathy, and enteritis.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The small intestine appears diffusely thickened with corrugation and a very prominent muscularis layer. These changes are most consistent with significant inflammatory type change, although early neoplastic change cannot be ruled out. Additionally, the stomach is significantly fluid distended. The pylorus appears fluid distended, and there is regularly and thickening to the pyloroduodenal junction of uncertain nature (inflammatory versus neoplastic, etc.) The right limb of the pancreas is in this region and there is significant focal inflammation. Recommend aggressive care for pancreatitis and gastroenteritis with close continued monitoring. If symptoms are not improving, consider repeat evaluation looking for an unseen focal lesion. Additionally, consider thoracic radiographs to evaluate the esophagus for any evidence of esophageal disease, aspiration pneumonia, etc. If the patient stabilizes, you can consider a hydrolyzed protein prescription diet trial, a GI panel to Texas A&M for evaluation of B12 levels, folate, PLI/TLI etc. Ideally, this patient should be biopsied with full thickness surgical biopsies as the changes to the small intestinal tract are significant, particularly in the region of the pylorus.

There are changes visualized associated with both kidneys and the left kidney has mild pyelectasia and small stones visualized in the renal pelvis. No evidence of a significant obstruction is evident at this time, but this could develop and should be monitored.

Recommend a urinalysis, culture, and a blood pressure as a baseline.



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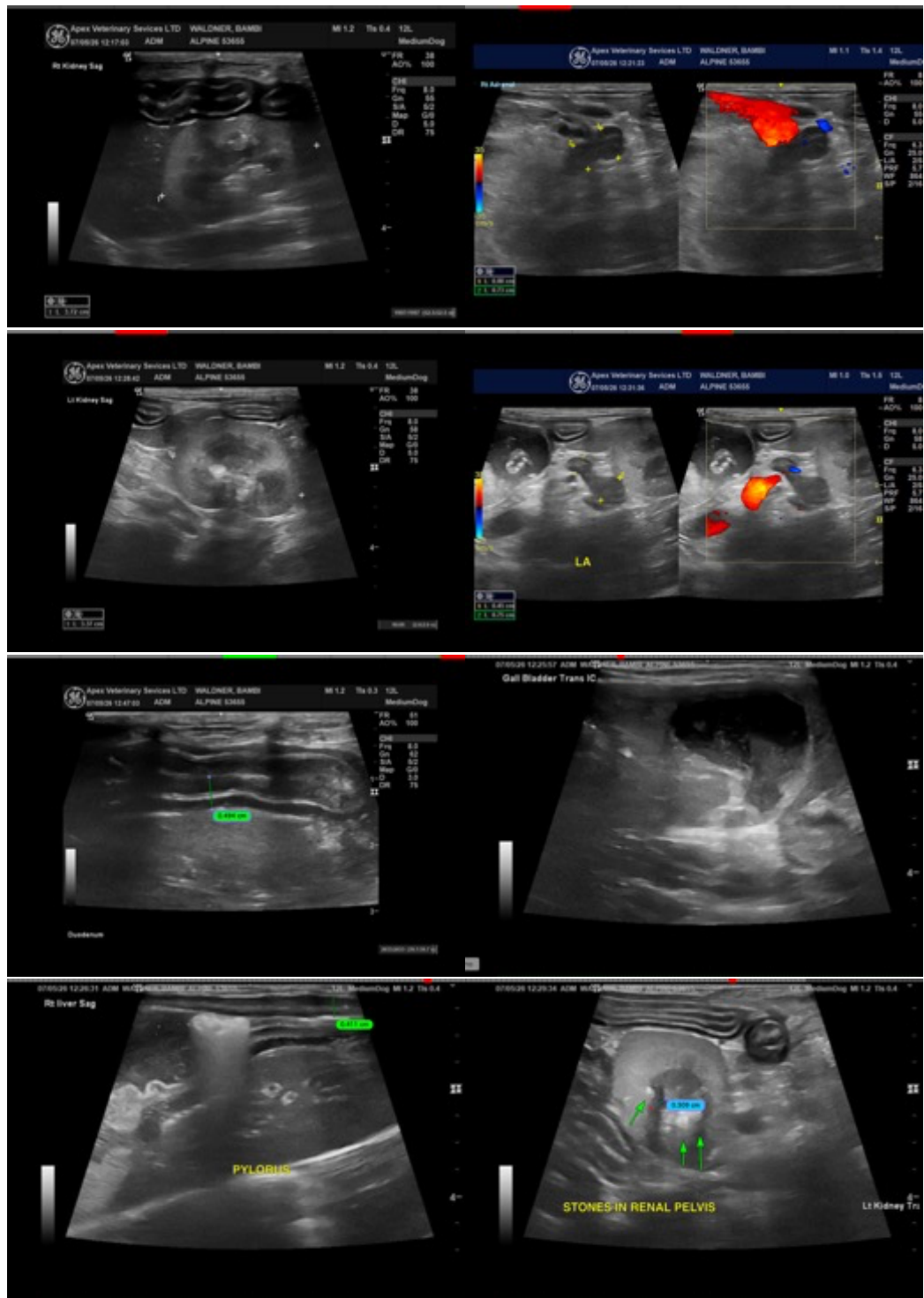
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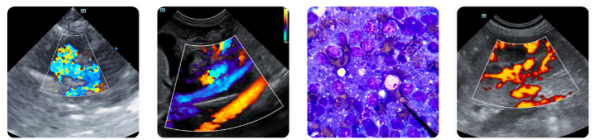
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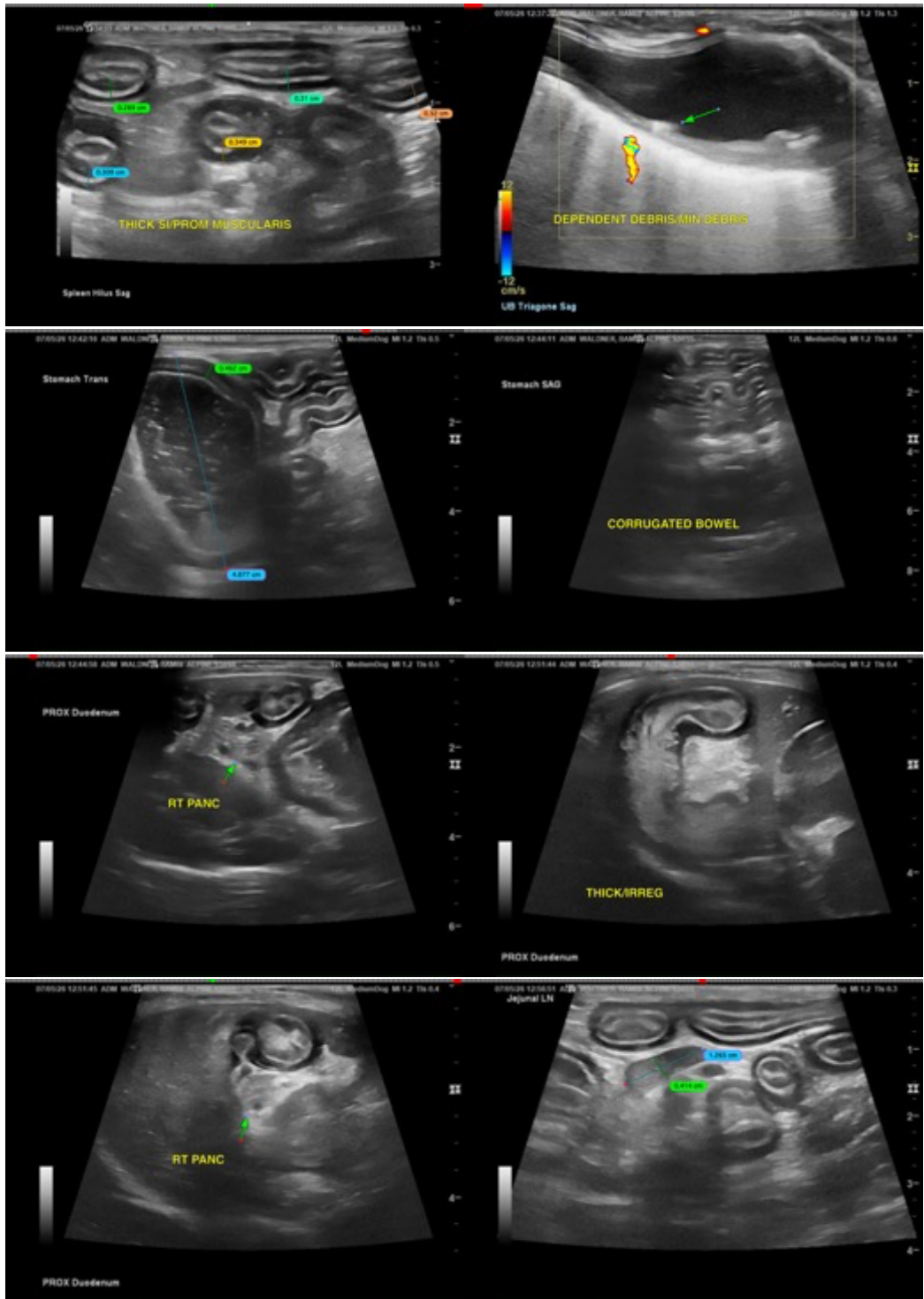
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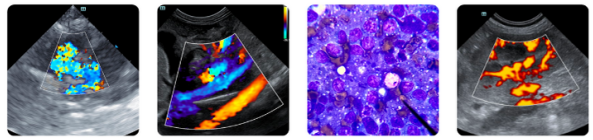
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.



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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.

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