



## PATIENT

Emma Estrada

## SPECIES

Canine

## BREED

French Bulldog

## SEX

Spayed Female

## AGE

10 Years

## WEIGHT

18.6 pounds

## INTERPRETED BY

R. McKenzie Daniel,  
DVM, DABVP

## IMAGING PERFORMED BY

Dr. Gabriel Ferrer  
DVM

## HOSPITAL NAME

Pulse Pet Ultrasound  
Services

## REFERRING VET

Dra. Soleil Gonzalez

## INVOICE

13069

## DATE

01/09/2026

## PRESENTING CLINICAL SIGNS

Px presented as a referral for an abdominal ultrasound in order to confirm the Dx of nonspecific gastritis/gastroenteritis. Client first took Px to referring DVM due to multiple episode of vomiting since December 31st. Px has also presented with episodes of lethargy and excessive salivation since January 6th. No diarrhea reported by the client. Px vomited while in the waiting room prior to the abdominal ultrasound and owner reported that Px vomited bile because she was fasted.

Abnormal PE/Chem/CBC/UA Results: Bloodwork and radiographs attached below for your reference: LYM (Low - 0.95K/uL)

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder, trigone, cystourethral junction, and visible pelvic urethra to a depth of 3.0 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with no uroliths or sediment. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic change were noted.

Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 4.3 cm in length. The right kidney measured 4.3 cm in length.

### Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.40 cm width at the caudal pole.

The right adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The right adrenal gland measured 0.41 cm width at the caudal pole.

### Spleen

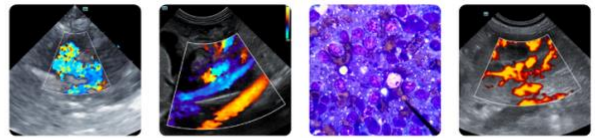
The spleen exhibited a finely textured and homogenous parenchyma which was hyperechoic to the liver and renal cortical parenchyma. The capsule was smooth and regular without apparent expansion. The splenic vasculature at the hilus was normal in volume with no evidence of congestion or thrombosis. Acute to chronic inflammatory, neoplastic, or benign parenchyma changes were not noted.

### Liver & Gallbladder

The liver was subjectively normal in size, structure, and contour. The liver parenchyma was uniform and hypoechoic to the spleen with a mild coarse echotexture. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was non distended in size with mild to moderate nonorganized biliary sludge. The cystic duct and common bile ducts were normal without evidence of dilation.

### Gastrointestinal



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The stomach exhibited mild to moderate retained fluid. Thickened stomach wall most notable in the subjective pylorus with associated indistinct gastropyloric mural detail. Thickened stomach wall measured up to 0.72 cm. Concurrent gastric lumen gas.

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The small intestine presented overall intact wall layering exhibiting propensity for prominent intestinal mucosa most notable in the duodenum with concurrent mild duodenal hyperechoic mucosal speckling. The small intestine was empty without evidence of mechanical/metabolic ileus to the level of the colon. The duodenum wall measured 0.57 cm width. The jejunum wall measured 0.44 cm width. The ileocolic wall measured 0.43 cm width.

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Normal visible colon wall layers were present with semi formed fecal matter in lumen.

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### *Pancreas*

The parenchyma of the pancreas was hyperechoic to adjacent omental fat with diffuse parenchyma remodeling. The capsule of the pancreas was mildly asymmetrical in contour without evidence of peripancreatic inflammation. These changes may suggest chronic inflammation, fibrosis, or saponification if previous history of pancreatitis. No overt signs of pancreatic neoplasia.

## AGE

10 Years

### *Free Abdomen*

Intermittent mesenteric lymph nodes were present. The lymph nodes were essentially isoechoic to adjacent omentum without evidence of peripheral inflammation and maintaining a normal width: length ratio (<0.5). An example measured 1.4 cm in diameter. No evidence of peritoneal effusion.

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## ULTRASONOGRAPHIC FINDINGS

### Primary Findings

- Hypomotile stomach with regional thickened wall exhibiting indistinct mural detail-subjectively primarily involving the pylorus.
- Intact small intestine wall exhibiting prominent mucosa with duodenal mucosal speckling.
- Chronic pancreatitis pattern with possible fibrosis.
- Normal bilateral adrenal glands.

### Secondary Findings

- Mild age-related renal changes.
- Nonorganized gallbladder debris (non-mucocele).

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DVM

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The gastrointestinal presentation may indicate inflammatory, infectious or neoplastic etiologies subjectively and primarily involving the upper gastrointestinal tract yet potential for more generalized gastroenteropathy in conjunction with potential chronic pancreatitis is possible. Concern for emerging neoplastic criteria involving the stomach is warranted given indistinct gastric mural detail yet inflammatory disease with gastric wall edema may exhibit similar presentation.

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A definitive diagnosis would require endoscopic upper gastrointestinal biopsies with histopathology and suggested if available. Smaller more frequent feedings of a canned novel protein or hydrolyzed diet, broad spectrum gastroprotectants and consideration for empirical helicobacter coverage with avoidance of dry food and serial sonographic monitoring pending clinical response would be more conservative approach.



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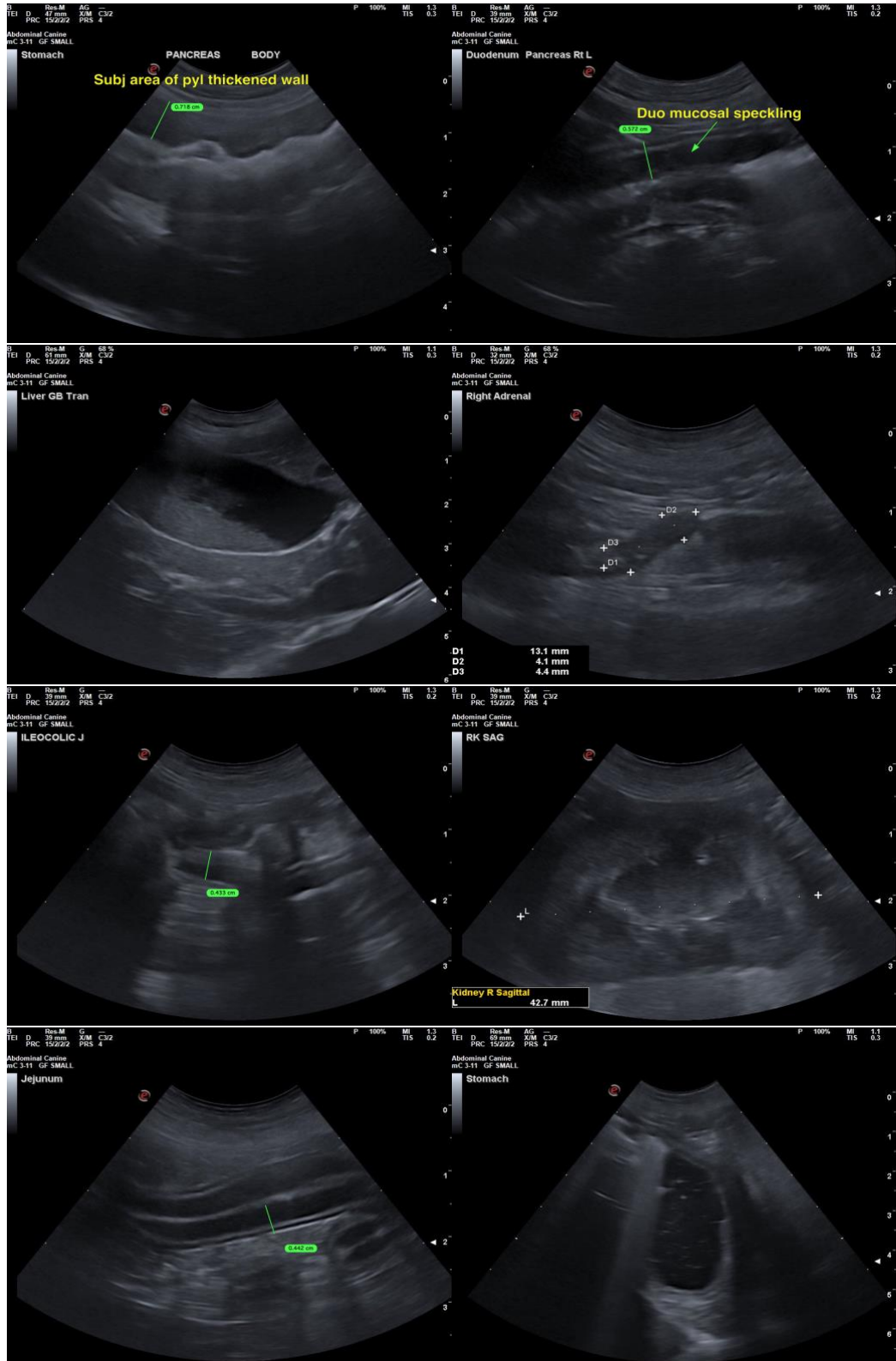
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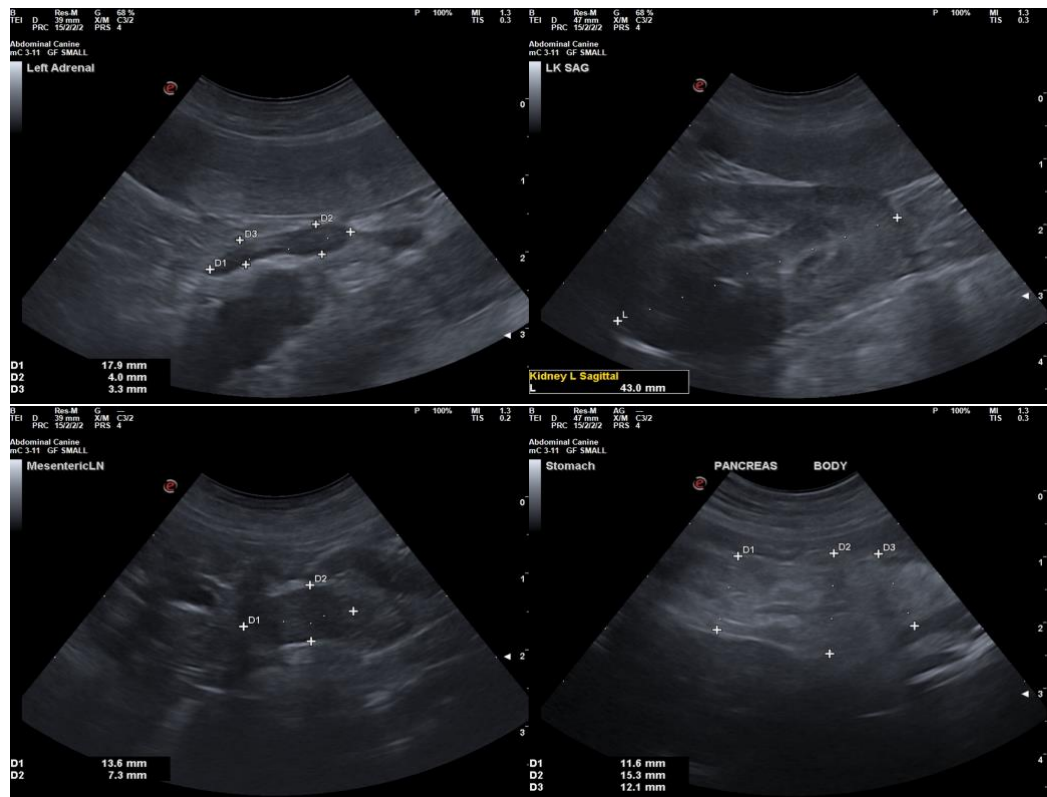
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

R. McKenzie Daniel, DVM, DABVP (Canine / Feline Practice)

[info@SonoPath.com](mailto:info@SonoPath.com)