



PATIENT

Sophie Chelius

SPECIES

Canine

BREED

Chinese Pug

SEX

FS

AGE

13yr

WEIGHT

6.9kg

INTERPRETED BY

R. McKenzie Daniel,
DVM, DABVP
(Canine and Feline)

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

Blue Pearl Wyomissing,
ER

REFERRING VET

Blue Pearl Wyomissing

INVOICE

23185

DATE

12/9/2025

PRESENTING CLINICAL SIGNS

AUS to further evaluate DKA in a known Diabetic. Is losing weight, hx of necrotizing pancreatitis, elevated liver enzymes, elevated GGT and increased RE. Currently hospitalized. Now not eating, lethargic, PU/PD over the past 2-3 weeks. DKA - r/o concurrent pancreatitis, Cushing's, UTI, cholangiohepatitis, etc. In Sept 2024, hospitalized at BP-Malvern for necrotizing pancreatitis, elevated LES, partial GB mucocele, mixed hepatopathy. Other PMH: chronic lower airway disease Meds: Vetsulin 8 U BID Hospitalized on: IVF, insulin CRI, Cerenia, Ondansetron, Unasyn, Pantoprazole

Abnormal PE/Chem/CBC/UA Results: rDVM 12/8 CBC: Hct 41%, WBC 17.5k H, lymph 1.44k, mono 1.3k H, neut 14.6k H, plt 372k Chem: alb 2.7, glob 2.7, Na 136 L, Cl 95 L, K 5.2, BG 640 H, Cr 0.9, BUN 38 H, SDMA 21 H, ALP 1132 H, ALT 450 H, tbili 0.8, P 5.0, GGT 45, chol 423 H TT4: <0.5 UA: 1.031, pH 5, 2+ ptn, 4+ glu, 1+ ket, no bact ER PCV/TP: 45/8.4 EPOC: pH 7.247 L, Cr 0.82, BUN 37 H, BG 673 H, Na 130 L, Cl 108, K 4.7, lact 2.76, bicarb 17.4, iCa 1.11 L serum ket: 2.7 UC: PENDING CXR: Mod diffuse poor pulm inflation w/interstitial & bronchial pattern. Pts resp signs susp secondary to pulm pattern. Portion of this is 2ndary to atelectasis, however given the reported c+ and persistent opacity on the better inflated VD view, a diffuse lung abnorm i.e chronic bronchitis, infection, or interstitial/fibrotic lung dz is suspected.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The cystourethral junction, and visible pelvic urethra to a depth of 3 cm exhibited normal thickness and tone. Anechoic urine was present in the lumen with mild non-dependent particulate sediment. A small dorsal trigone sessile based mass lesion with confirmed blood flow within the mass lesion measuring ~ 1.5 in diameter was present.

Normal size and margination were 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 loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. Bilateral areas of mild medullary mineral were present. The left kidney measured 4.0 cm in length. The right kidney measured 4.8 cm in length.

The area of the aortic trifurcation was free of pathology.

Adrenal Glands

The left adrenal gland was uniform in size and contour with a uniformly hypoechoic parenchyma. The left adrenal gland measured 0.67 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 0.50 cm width at the caudal pole.

Spleen

The spleen exhibited normal size and primarily symmetrical contour. Heterogeneous parenchyma exhibiting multiple to coalescing hyperechoic parenchyma foci were present which may indicate focal to coalescing areas of microinfarction, fibrosis, or mineralization.

Liver/Gallbladder



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The liver presented enlarged in size. The parenchyma of the liver was subjectively normal in echogenicity compared to the spleen and renal cortices. The liver parenchyma was uniform with a mildly coarse echotexture. The capsule of the liver was symmetrically rounded to mildly swollen in margination. The hepatic and portal vasculature were normal in appearance without signs of congestion.

The gallbladder was mildly distended in size with normal gallbladder wall. Congealed to organized non-mineralized bile sediment was present. No evidence of gallbladder/peripheral gallbladder inflammation or wall edema was present.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach was empty with no signs of ileus, obstruction or foreign material.

The small intestine presented intact wall layering with 1:3 muscularis/mucosa ratio. Focal to intermittent mild hyperechoic intestinal mucosal speckling was present. The lumen of the small intestine was empty with no signs of mechanical/metabolic ileus, obstruction or foreign material.

Normal visible colon wall layers were present with apparent formed feces in lumen.

Pancreas

The parenchyma of the pancreas base and right limb 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.

Free Abdomen

No omental masses, overt lymphadenopathy or peritoneal effusion was present.

ULTRASONOGRAPHIC FINDINGS

Primary

- Benign hepatopathy pattern with gallbladder mucocele -no overt current pericholecystic inflammation.
- Chronic renal changes exhibiting mild medullary mineral.
- Non-enlarged mild age related adrenal glands- no evidence of adrenal neoplastic criteria.
- Chronic pancreatitis / pancreatic fibrosis.
- Overall normal gastrointestinal tract with possible mild enteritis.
- Mild urine sediment.

Secondary

- Hyperechoic to coalescing splenic parenchyma foci-benign
- Small sessile-based dorsal trigone urinary bladder mass lesion



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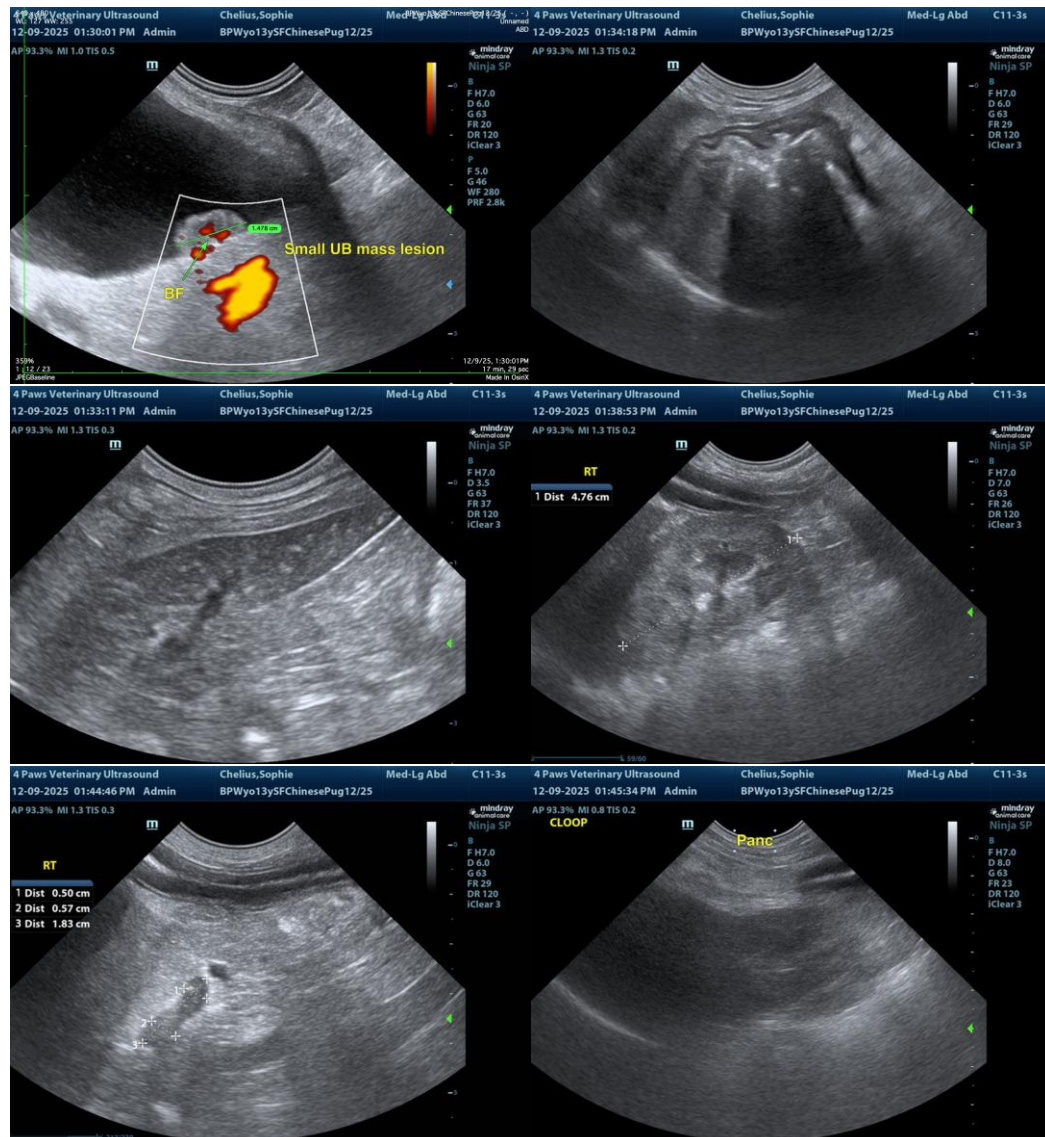
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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Correlation of pending urine C/S is recommended. No overt evidence of adrenal pathology, although adrenal workup if diabetic dysregulation may be considered. Empirical therapy for DKA / chronic pancreatitis with hepatogastrointestinal support and clinical monitoring would be reasonable. Sonographic reassessment and monitoring of the gallbladder indicated if evidence of progressive hepatopathy or cholestasis. A screening BRAF assay is recommended.



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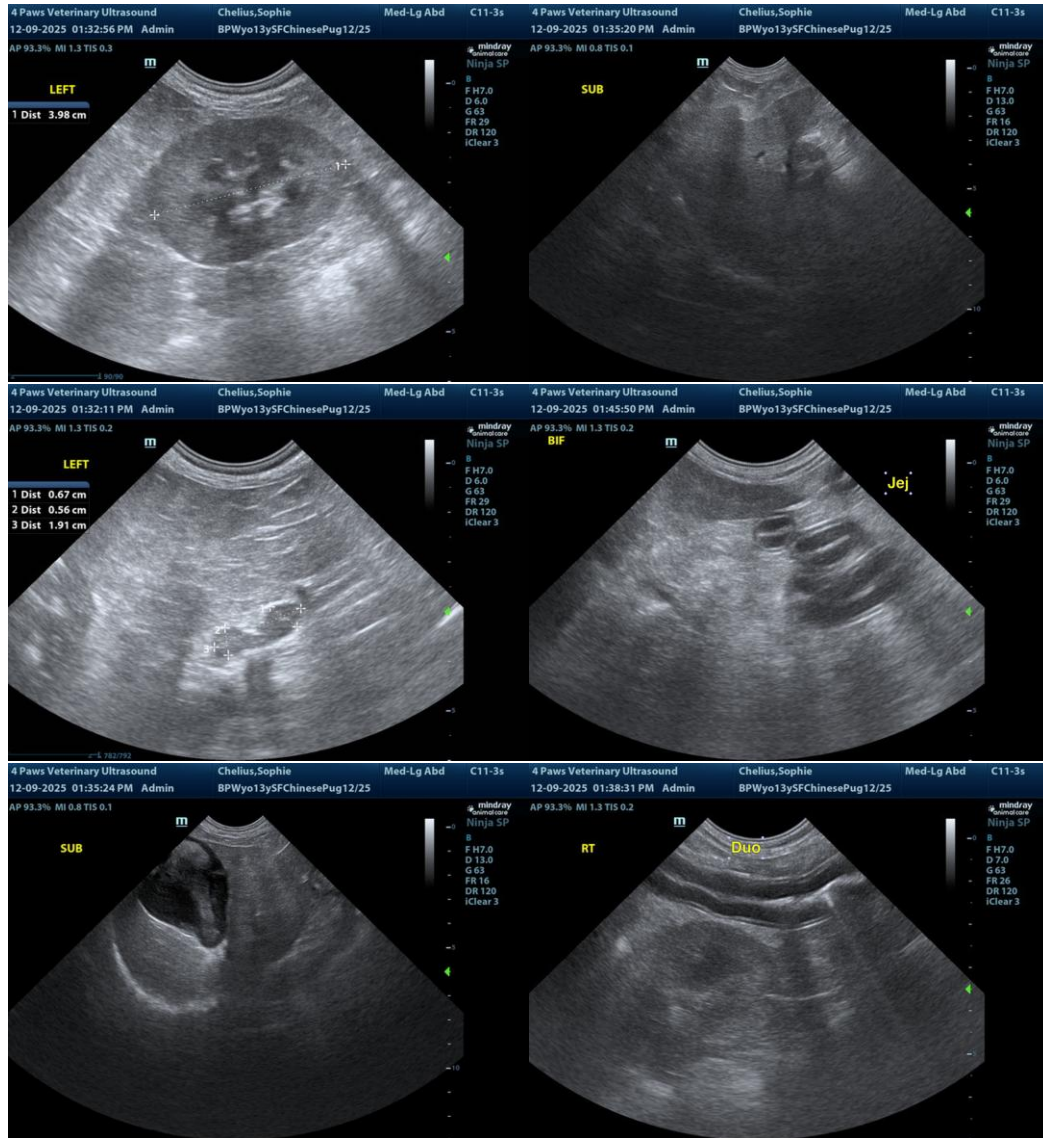
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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