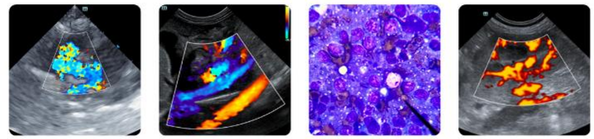


PATIENT
Emma Chagnon

SPECIES
Canine

BREED
Chihuahua

SEX
SF

AGE
12Y

WEIGHT
3.76

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

IMAGING PERFORMED BY
Carter

HOSPITAL NAME
Willamette Veterinary Hospital

REFERRING VET
Carter

INVOICE
73828

DATE
2-18-26

PRESENTING CLINICAL SIGNS

- rDVM chart notes indicate vomiting started April 2025 , thickened loops of intestine were palpated and IBD was suspected. Was recommended to feed hydrolyzed diet. In May vomiting was reported to have resolved but owner had not tried hydrolyzed diet. rDVM visit in Sept for anorexia and intermittent vomiting. Started Pred @ 0.6 mg/kg q 12 hr x 5 days, and then taper. Started Purina HA diet.
- Was then getting pred 1.25 mg three times a week and albumin had improved and weight was stable. Was beginning to have adverse signs from pred (muscle wasting) so Pred was stopped in Nov
- Dec recheck albumin back down to 1.5; Back on Pred at 1.25 mg q 12 for 14 days, then taper to 1.25 mg q 48 hrs.
- Ongoing weight loss, down to 3.82, from initial 5#
- started weekly B12 injections in Jan
- Presented here Feb 5. ongoing wt loss, 25% of body wt in a year. Wt loss and initial improvement in albumin with pred and hydrolyzed diet, but now persistently low albumin.
- On HA diet but does sneak treats
- Dental disease

Abnormal PE/Chem/CBC/UA Results: Sept 2025, mild basophilia, albumin 1.6, TP 4.6, globulin 3.0. ALT was normal. USG 1.035 with trace protein. Liver values were normal, 3+ bilirubinuria though. Oct 2025, albumin 2.1, TP 5.0,, now ALT 208 (on Pred) then two week later albumin 2.5 and ALT down to 121 Nov albumin 1.5 Jan albumin 1.8 Feb, albumin 1.5, creatinine 0.4, globulin 2.5, monocytes 1.18, platelets 867 (platelets have always been elevated since 2024) Negative urine protein in Feb 2026

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 changes were noted.

No evidence of pathology in the area of the aortic trifurcation.

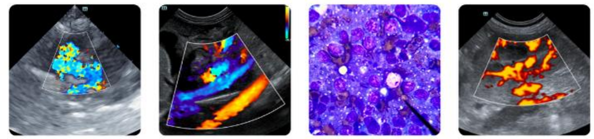
Normal size and margination was present in the kidneys. A normal 1:3 cortex / medulla ratio was maintained. The medulla and cortices were uniform in texture with some increased echogenicity and mild loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. The left kidney measured 2.9 cm in length. The right kidney measured 3.0 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 0.31 cm width at the caudal pole.

The right adrenal gland was not definitively visualized.

Spleen



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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. Normal hepatic vascular volume was present. 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 thin walls and mild nonorganized gallbladder debris. The cystic and common bile ducts were normal.

Gastrointestinal

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild echogenic, nonshadowing ingesta without signs of obstruction or foreign material.

Overall intact thickened small intestinal wall exhibiting thickened mucosa and generalized mucosa hyperechogenicity and striations. There was no evidence of an obstructive pattern or foreign material. The appearance of the small intestine is most consistent with protein losing enteropathy or lymphangiectasia. There was no evidence of infiltrative or neoplastic intestinal disease which is considered unlikely but cannot be ruled out without full thickness or endoscopic biopsies.

Normal visible colon wall layers were present with soft fecal matter in the lumen.

Pancreas

The area of the pancreas was sonographically normal.

Free Abdomen

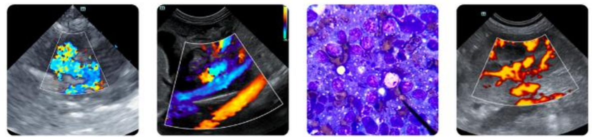
Mild volume peritoneal effusion was present.

No visualized significant or swollen mesenteric lymphadenopathy.

Mild peri-intestinal hyperechoic omentum was seen.

ULTRASONOGRAPHIC FINDINGS

- Intact thickened small intestinal wall exhibiting mucosal hyperechogenicity/ hyperechoic striations – consistent with PLE intestinal pattern.
- Mild non-shadowing gastric ingesta – consistent with food echogenicity.
- Soft fecal matter in colon.
- Normal volume liver.
- Age related renal changes.
- Mild volume peritoneal effusion and mild peri-intestinal to generalized hyperechoic omentum.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

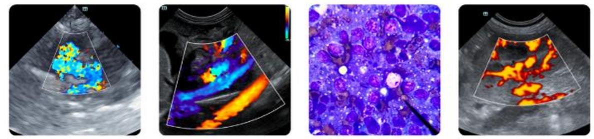
IBD or other inflammatory enteropathy, lymphangiectasia, or infiltrative intestinal disease such as neoplasia, and less likely fungal, are all potentials.

A GI panel to include PLI/TLI/Cobalamin/Folate is recommended.

Empirical therapy for protein losing enteropathy in conjunction with the intestinal presentation, hypoalbuminemia and lack of proteinuria indicated. Intestinal biopsies required for definitive diagnosis yet contraindicated if albumin level < 2.0.

Part or all of this protocol may be considered based on your clinical impression of the patient:

OBJECTIVE: keep albumin levels > 2 g/dl, avoid thromboembolism and cavitary effusions, monitor concurrent PLN and liver disease:
Plasma 10 mL / kilogram IV over 4 hours
Or **Human albumin** 2 ml/kg/h over 10 hours. Total daily volume 20.l/kg/day
And Colloids/Hetastarch
10 to 20 mL per kilogram per day and dogs
10 to 15 mL per kilogram per day cats
(Can bolus first 1/3 of dose over 15 minutes)
& maintain on LRS maintenance otherwise.
High colony count probiotic Proviable or Visbiome
Famotidine 1 mg/kg Iv Im po dc Sid /bid
Sucralfate 0.5-1 g po tid dogs, 0.5 g bid cats in slurry **Or Misoprostol** 1-5 ug/kg po tid
Diet: Highly digestible high quality protein, low fiber, low fat diet (< 15% of dry matter). Hydrolyzed protein or novel protein. Purina HA or Royal Canine HP or similar.
Prednisone or prednisolone 2 mg/kg bid x 3-5 days then 2 mg/kg sid. **Chlorambucil** in refractive severe IBD/alimentary lymphoma cases (monitor cbc for rare bone marrow suppression) 4 mg/m^2 Q 24-48 hours.
Cobalamine (B12) 250-1500 ug/dog weekly x 6 weeks.
Calcium supplementation if necessary.
Aspirin 0.5-1 mg/kg/day **or Clopidrel** (Plavix) 1-5 mg/kg/day.



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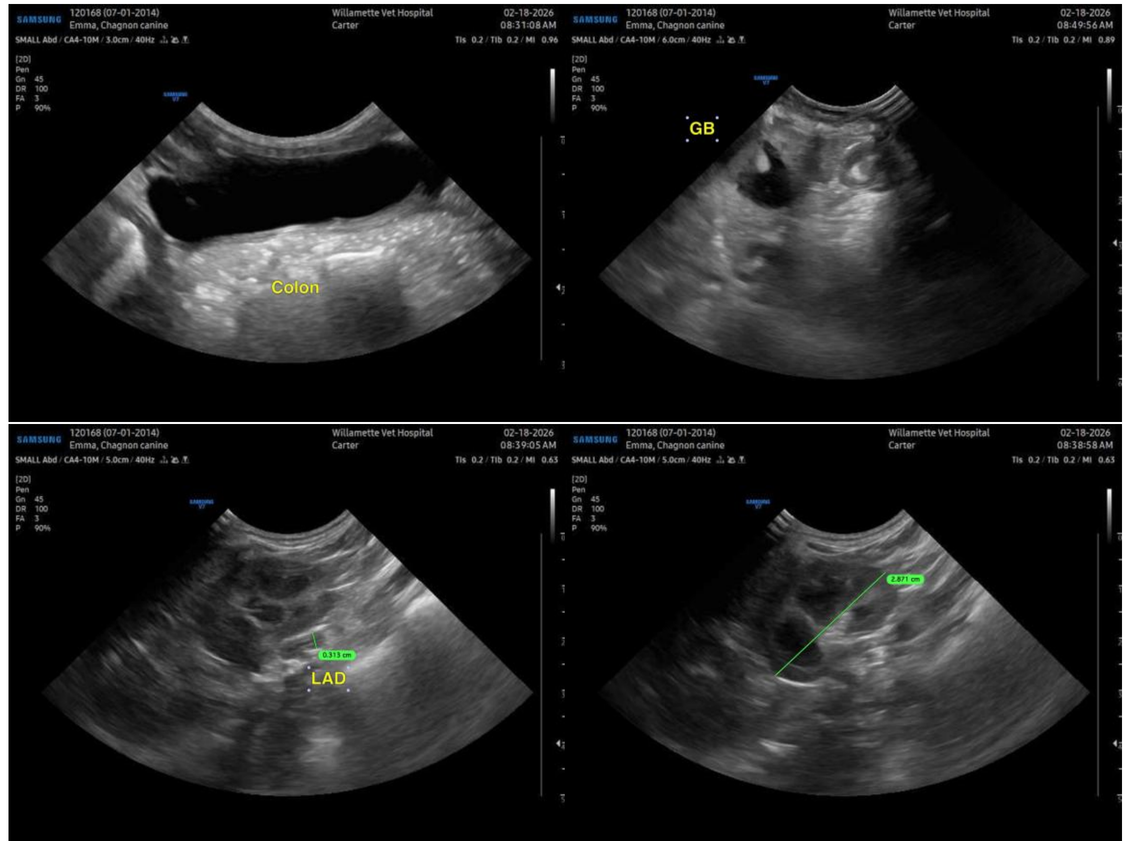

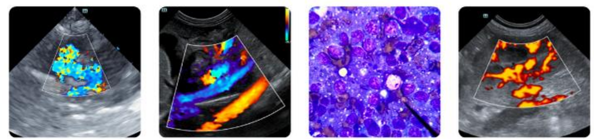

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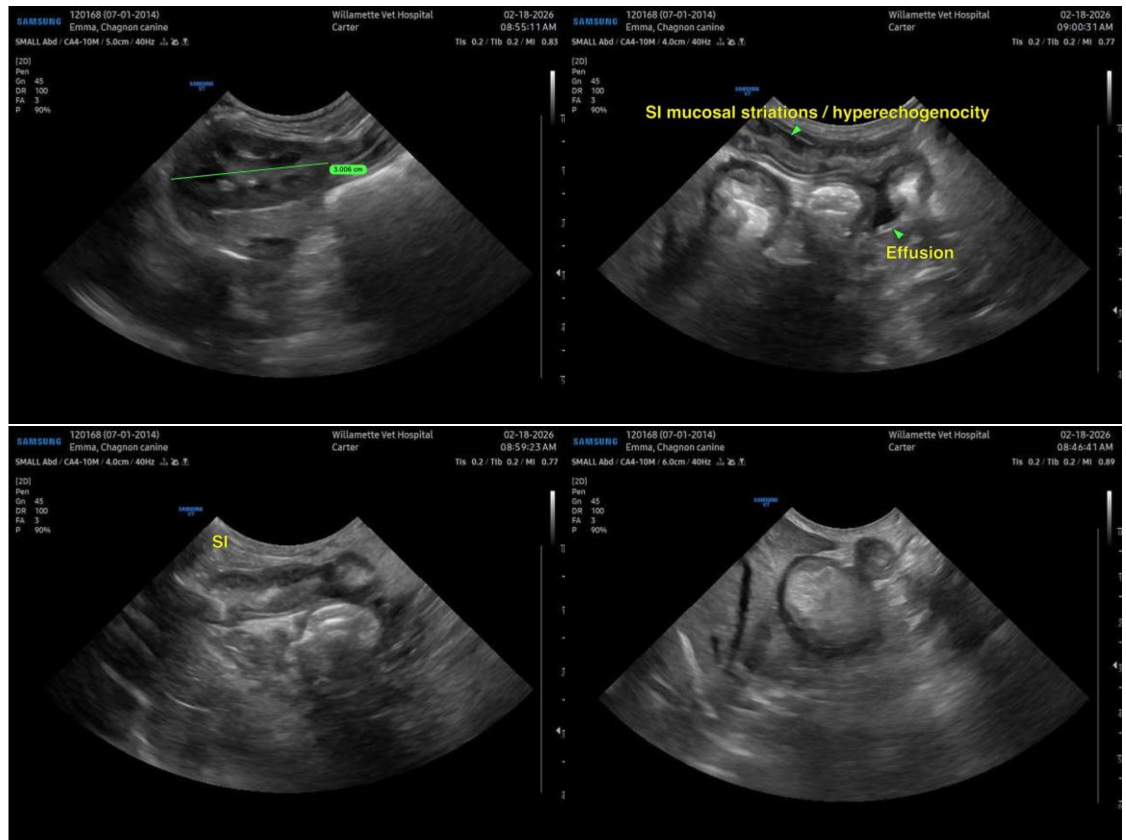

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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