



PATIENT

Charlotte Torres

SPECIES

Canine

BREED

Toy Poodle

SEX

Spayed Female

AGE

12 Years

WEIGHT

6.8 pounds

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Gabriel Ferrer
DVM

HOSPITAL NAME

Pulse Pet Ultrasound
Services

REFERRING VET

Dra. Marilyn Davila

INVOICE

13527

DATE

02/02/26

PRESENTING CLINICAL SIGNS

- Px presented as a referral for an abdominal ultrasound due to Hx of vomiting and soft bloody stool around 2 weeks ago
- Some episodes of hematuria
- Cystocentesis was performed by rDVM
- Px is BAR
- Px currently taking Cranainidin, Famotidine, and Metronidazole

Abnormal PE/Chem/CBC/UA Results: Bloodwork and Urinalysis attached below for your reference:
CBC WNL SMA WNL CPL Normal (182U/L) Sedivue WNL

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. Pinpoint to focal areas of medullary mineral were present. The left kidney measured 3.6 cm in length. The right kidney measured 3.9 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 0.37 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 0.38 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. A solitary to intermittent noncapsule deforming hypoechoic nodules were present with an example measuring 0.34 cm in diameter.

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.



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The gallbladder was non distended in size with moderate non-dependent variably congealed yet non-organized hyperechoic biliary sludge. No evidence of gallbladder inflammation or wall edema. The cystic duct and common bile ducts were normal without evidence of dilation.

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

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The small intestine presented intact wall layering exhibiting subjective propensity for mildly prominent jejunal mucosa layer with mild increased jejunal mucosa echogenicity. The duodenum wall measured 0.42 cm wall width. The jejunum wall measured 0.42 cm wall width. No evidence of pathology at the level of the ileocolic junction.

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

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The pancreas was normal in size and contour with isoechoic to heterogeneous parenchyma compared to adjacent omentum. No signs of active inflammation or neoplasia.

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Free Abdomen

No visualized significant omental lymphadenopathy or peritoneal effusion was present.

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ULTRASONOGRAPHIC FINDINGS

- Normal stomach with mild lumen gas.
- Non-specific enterocolonopathy exhibiting mild increased jejunal mucosa echogenicity and semi formed/soft fecal matter in colon.
- Mild pancreatic remodeling.
- Congealed gallbladder debris/early immature gallbladder mucocele.
- Sonographically normal urinary bladder and visible proximal urethra.
- Mild age-related renal changes with focal medullary mineral.
- Noncapsule deforming splenic nodules.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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The appearance of the gastrointestinal tract is non-specific with considerations including dietary intolerance / food hypersensitivity, infectious disease, dysbiosis, enterotoxin, inflammatory bowel disease, mild pancreatitis, occult parasitism, occult Addison's Disease, occult neoplasia, or other. Protein losing enteropathy is considered less likely give normal albumin levels, although monitoring is suggested.

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Empirically, a limited antigen or hydrolyzed diet trial with potential long term dietary therapy, prophylactic deworming (Panacur 50 mg/kg SID x 5 consecutive days with repeat protocol in 3 weeks even if fecal testing is negative), high colony count probiotic (Provable or Visbiome), and as needed gastroprotectants is suggested with clinical monitoring. Note that recent research has shown that indiscriminate use of antibiotics may actually cause harm.

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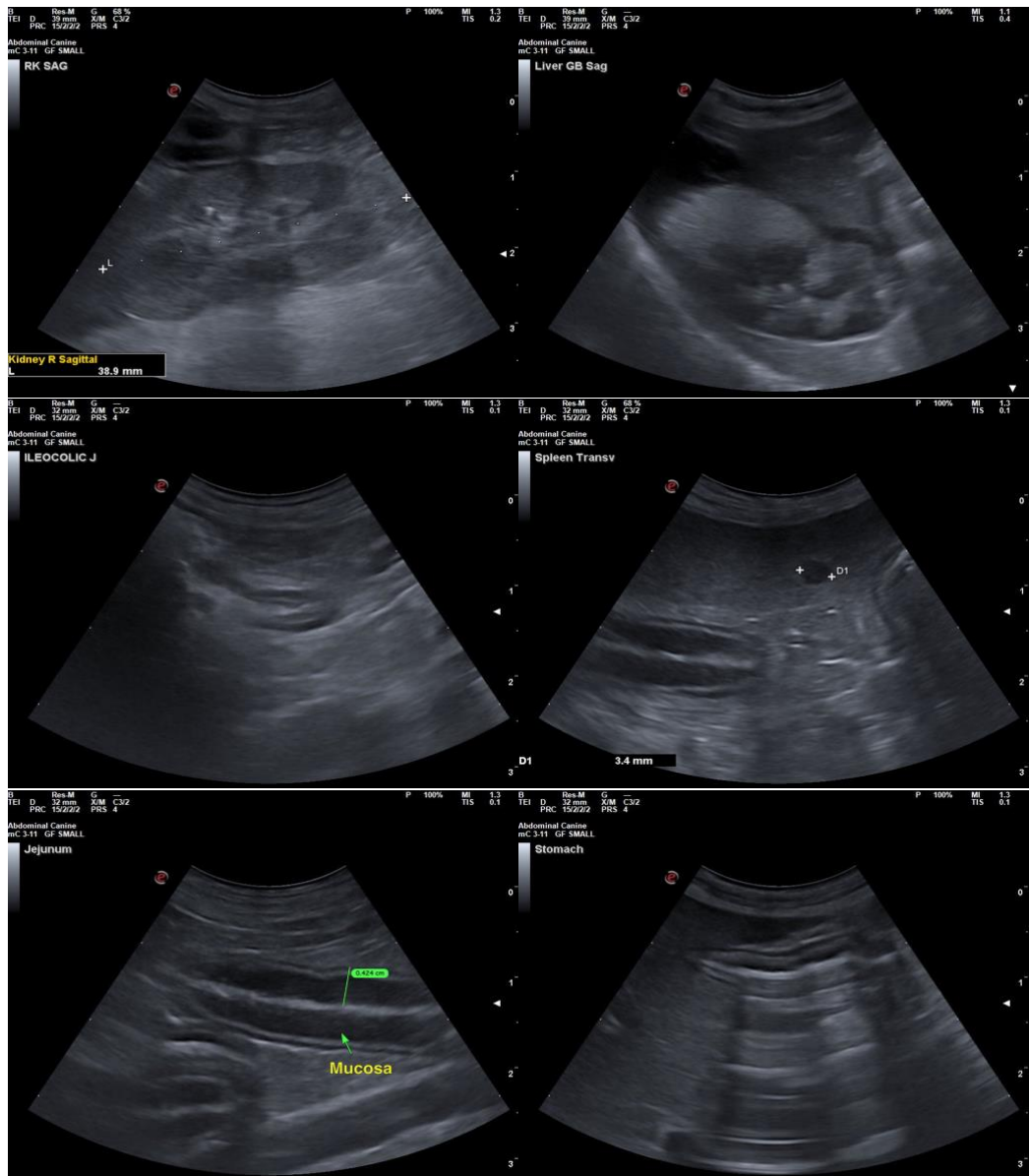
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The gallbladder debris/immature mucocele does not appear to be a clinical issue at this stage. Ursodiol therapy if tolerated and sonographic reassessment if cholestasis arises is recommended. Screening urine culture and sensitivity on a sterile urine sample may be considered.

Potential etiologies for the splenic nodules may include benign processes such as nodular hyperplasia, extramedullary hematopoiesis, hematoma, infection, infarction, or neoplasia. Ultrasound guided FNA of the nodule using 25-gauge needle and assuming normal coagulation parameters may be considered. Otherwise, sonographic monitoring of the splenic nodules for any changes in size or appearance with initial recheck in 3-4 weeks would be a more conservative approach.





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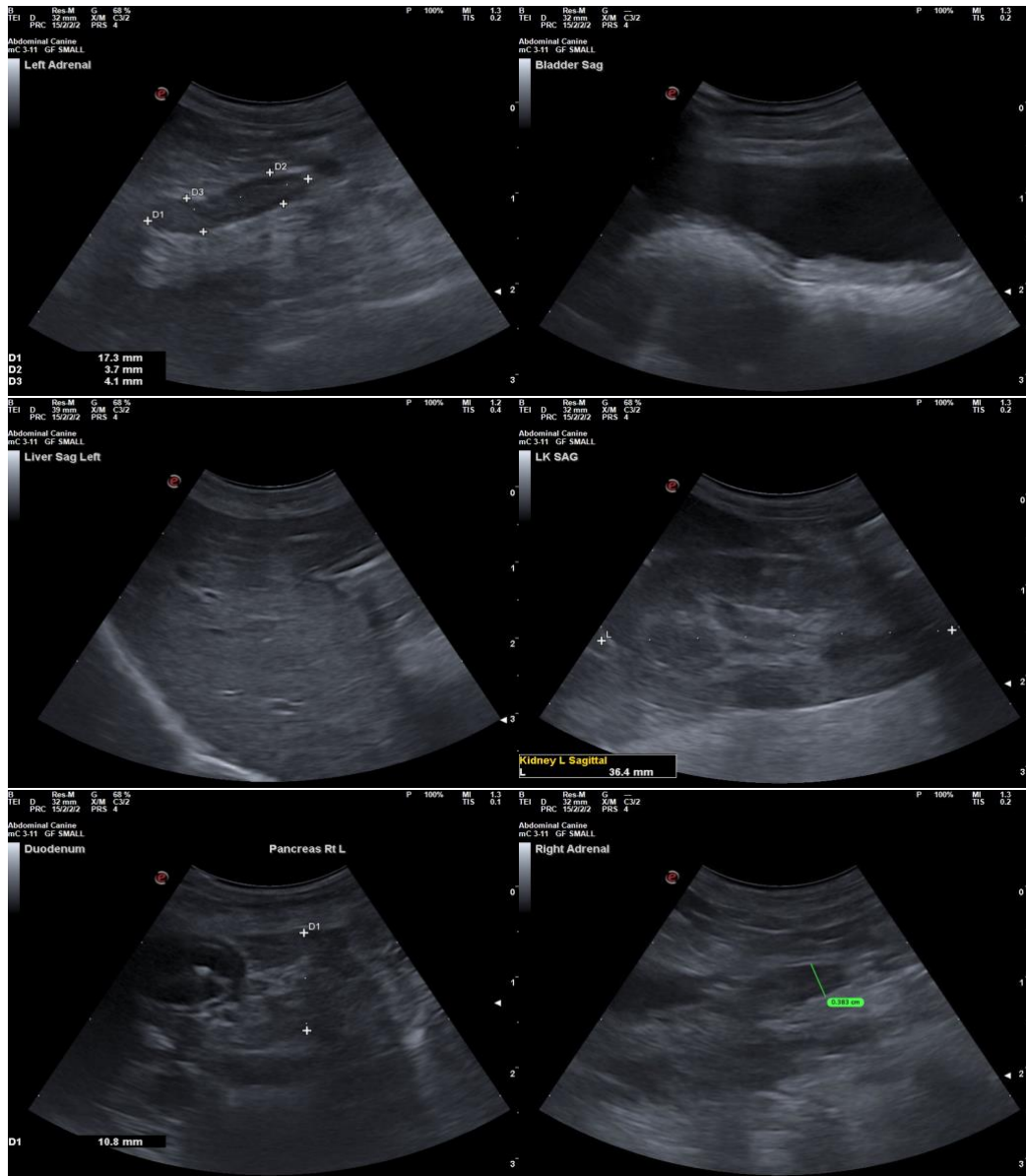
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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