



## PATIENT

Molly Torres

## SPECIES

Canine

## BREED

Yorkshire Terrier

## SEX

FS

## AGE

13yr

## WEIGHT

17.0lb

## INTERPRETED BY

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

## IMAGING PERFORMED BY

Dr. Gabriel Ferrer  
DVM

## HOSPITAL NAME

Pulse Pet Ultrasound  
Services

## REFERRING VET

Dr. Mayra Fonseca

## INVOICE 24393

## DATE

04/06/2026

## PRESENTING CLINICAL SIGNS

- Px presented as a referral for an abdominal ultrasound due to vomiting, anorexia, and lethargy.
- Px originally visited rDVM on Thursday due to vomiting, anorexia, and lethargy and abdominal radiographs were performed but did not show any significant change.
- Px was then Dx with renal disease based on bloodwork and is currently on the following Mx: IV fluids 15mL/Hr, Cerenia 0.6cc IV SID, Famotidine, 0.6cc IV SID, Metronidazole 12cc IV BID, Unasyn 3cc IV BID, Butorphanol 0.12cc IV BID, Propectalin PO TID, Gabapentin 0.6cc PO TID.
- Renal values are improving, but Amylase keeps increasing.
- Abnormal PE/Chem/CBC/UA Results: Radiographs and rDVM records attached below for your reference

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

The urinary bladder, trigone, 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 no evidence of urine/lumen sediment, mineral, or calculi. The ureteral papillae were normal. The ureters were not visible which is normal. No evidence of inflammatory or neoplastic changes was noted.

Normal kidney size and normal 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 mild to moderate loss of corticomedullary symmetry and definition expected for the age of the patient. No evidence of pelvic dilation was present. Bilateral small cortical cysts were present. The left kidney measured 4.5 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 0.60 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 0.51 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 presented normal in size. The hepatic parenchyma revealed diffuse reduced echogenicity compared to the spleen and renal cortical parenchyma with a mild coarse echotexture. Increased portal vein prominence was evident. The capsule of the liver was normal in margination. Normal vascular volume. Distinct masses or nodules were not evident. The hepatic and portal vasculature were normal



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in appearance. The gallbladder was non-distended in size. The gallbladder wall was thickened in appearance consisting of an echogenic double rim corresponding to the inner and outer portions of the wall. This is consistent with gallbladder wall edema. Possible causes may include acute inflammation, edema and anaphylaxis. Dependent lumen non-obstructive hyperechoic sediment /mineral was present in the gallbladder. The common bile duct was not visualized without overt evidence of dilation or post hepatic obstructive criteria.

### **Gastrointestinal**

The stomach presented intact wall layering with a normal wall layer ratio. The lumen of the stomach contained mild retained anechoic fluid and gas with no signs of obstruction or foreign material.

The small intestine presented intact wall layering exhibiting prominent intestinal mucosa. Empty intestinal lumen without mechanical /metabolic ileus to the level of the colon. The duodenum wall measured 0.52 cm width. The jejunum wall measured 0.42 cm width. No evidence of obstructive pathology in the area of the duodenal papilla.

The colon walls presented intact yet mild thickened wall layering. Generalized soft fecal matter was present in the non-distended colon lumen.

### **Pancreas**

The pancreas presented hypoechoic to heterogeneous echogenicity compared to adjacent omental fat. Mild asymmetrical capsule margination was present with mild variable parenchymal swelling and mild peripancreatic reactivity / inflammation. No overt evidence of neoplasia.

### **Free Abdomen**

Mild volume peritoneal effusion.

Intermittent mildly prominent to enlarged mesenteric and medial iliac 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).

## **ULTRASONOGRAPHIC FINDINGS**

### **Primary**

- Enlarged non-congested hypoechoic liver suggestive of acute hepatopathy
- Edematous gallbladder with non-obstructive lumen mineral
- Pancreatitis
- Gastroenterocolopathy exhibiting mild non-obstructive hypomotile stomach and soft fecal matter in colon
- Intermittent mild mesenteric / medial iliac lymphadenopathy
- Mild volume peritoneal effusion

### **Secondary**

- Bilateral chronic renal changes exhibiting small cortical cysts

## **INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**



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Pancreatitis with concurrent acute hepatopathy and gallbladder wall edema possibly secondary to inflammation, non-cardiogenic congestion and associated gastroenterocolopathy is probable. No evidence of mechanical gastrointestinal or post-hepatic obstruction. Minor potential for anaphylaxis or occult to emerging neoplasia thought less likely.

Further assessment may include assuming normal clotting status, hepatic FNA cytology and if accessible effusion analysis cytology +/- C/S. Continued supportive care for pancreatitis and acute hepatopathy with concurrent gastrointestinal support with clinical monitoring and sonographic reassessment if progressive hepatopathy, clinical signs or peritoneal effusion is recommended.

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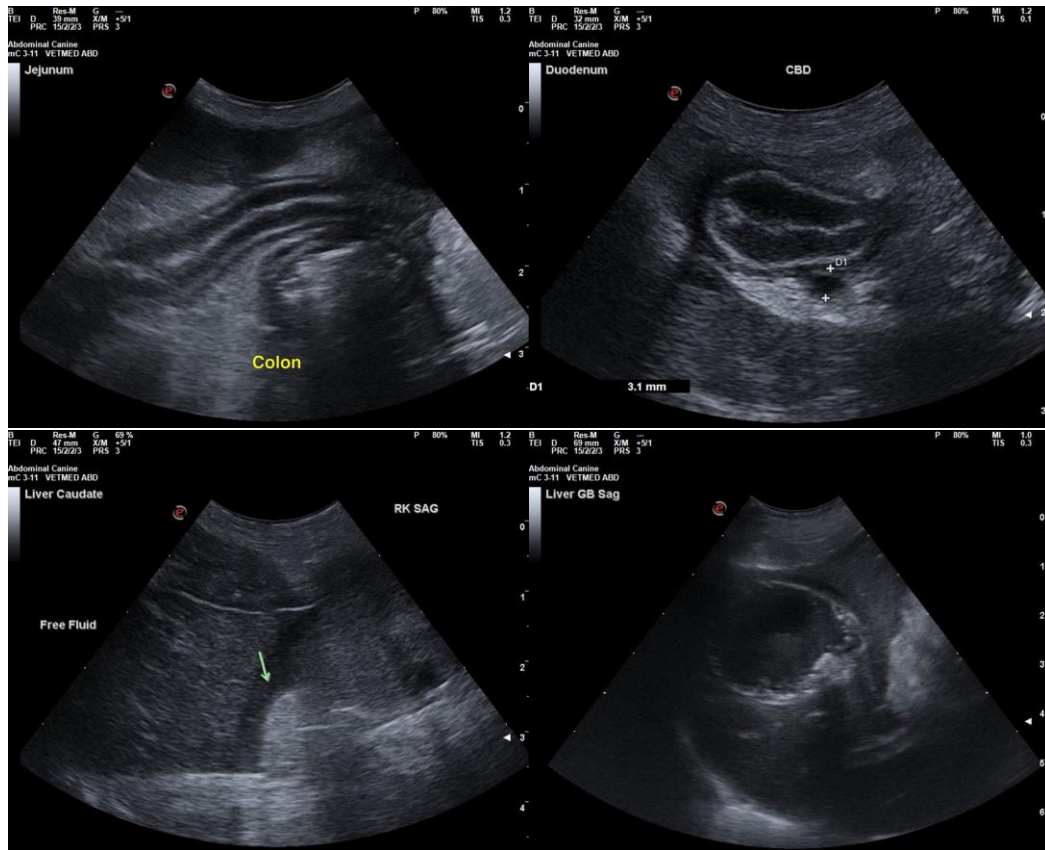
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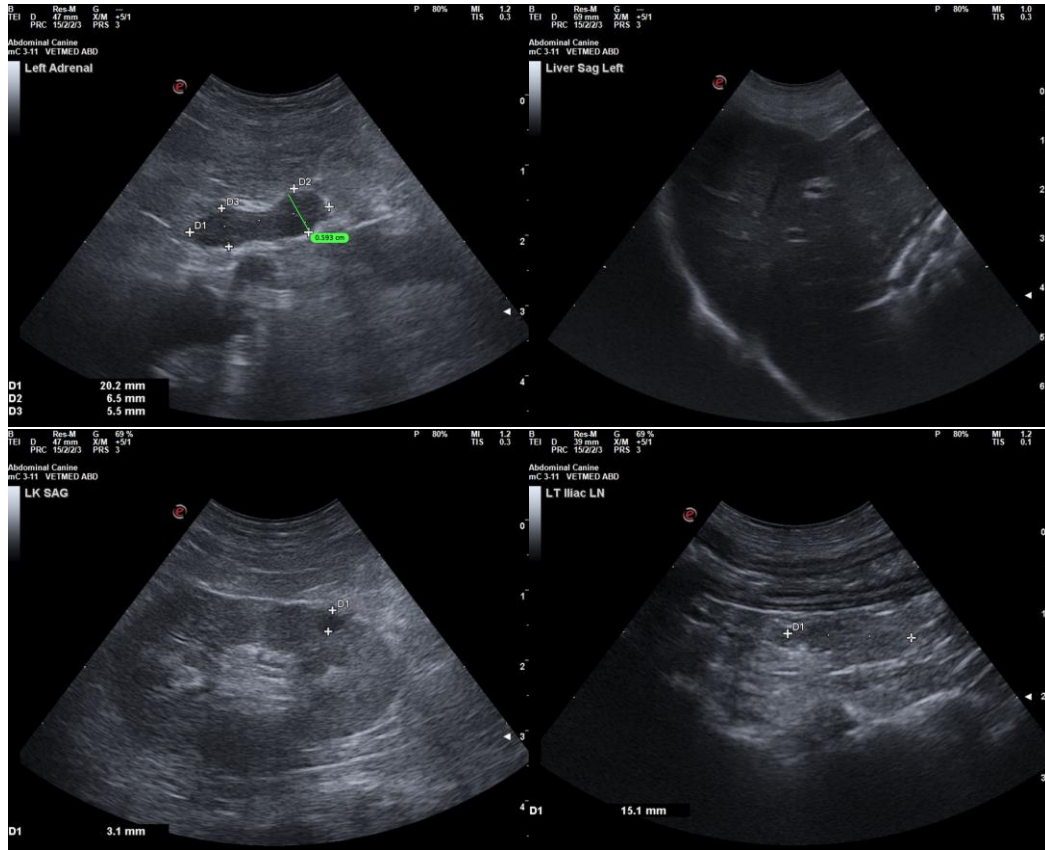
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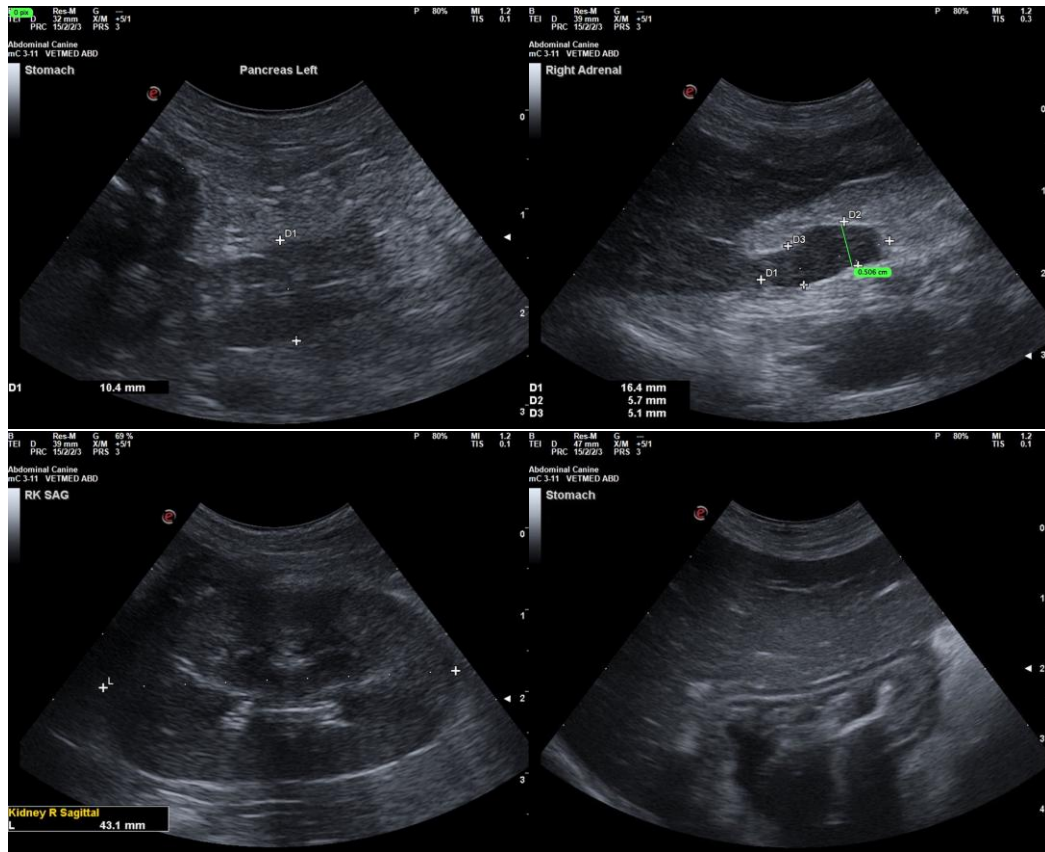
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)