



**PATIENT**

Simba Anderson

**SPECIES**

Canine

**BREED**

Pomeranian

**SEX**

NM

**AGE**

10 years

**WEIGHT**

5.5 lbs

**INTERPRETED BY**

Tam Mengine, DVM,  
DABVP (canine/feline  
practice)

**IMAGING PERFORMED BY**

Rebecca Hamilton

**HOSPITAL NAME**

Willakenzie Animal  
Clinic Oregon

**REFERRING VET**

Dr. Fischer

**INVOICE**

11083

**DATE**

1/9/2026

**PRESENTING CLINICAL SIGNS**

Diarrhea, inappetence, painful abdomen, lethargy.

Meds: Entyce, Buprenex, Cerenia.

Abnormal PE/Chem/CBC/UA Results: neutrophils - 16, bands present lymphopenia 0.2 nucleated RBCs ALP 620 GGT298 ALT 231 lipase 793 cpl abnormal.

**ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN**

**Urinary System**

The urinary bladder is moderately distended with anechoic urine. The ureteral papillae, trigone and pelvic urethra are of normal appearance, and the ureters are not visible (normal). There is a shadowing uroliths present, measuring up to 1.3 cm. The bladder wall (is normal. No masses are noted. Urethra visualized to 2.0 cm.

The prostate is of appropriate size for patient age and neutering status, with a homogenous parenchyma and smooth capsule. The prostatic urethra is non-dilated with normal margins.

Both kidneys are hyperechoic, and exhibit moderately decreased cortico-medullary differentiation. There is trace pyelectasia present in both kidneys, with anechoic contents. The renal pelvic fat is of normal echogenicity. There is no evidence of nephrolithiasis, mineralization, or hydronephrosis. The proximal ureters are not visible (normal). The left kidney is 3.5 cm in length. The right kidney is 3.3 cm in length.

**Adrenal Glands**

The adrenal glands are both identified in their normal locations. They are normal in size and shape with appropriate parenchymal echogenicity and normal phrenic vasculature. Left adrenal measures 2.8 mm at the cranial pole and 3.4 mm at the caudal pole. Right adrenal measures 3.4 mm at the cranial pole and 5.5 mm at the caudal pole.

**Spleen**

The spleen is of appropriate size and has a normal, homogenous parenchyma that is disrupted by diffuse pinpoint mineralization. The spleen has a smooth, continuous capsular surface. The splenic vasculature is normal with no evidence of congestion or thrombosis, and blood flow through the splenic hilus appears normal.

**Liver**

The liver is diffusely hyperechoic and subjectively enlarged, with rounded margins and a homogenous echotexture. The portal and hepatic vasculature are of normal size and appearance with no evidence of congestion or thrombosis.

The gallbladder is moderately distended with anechoic contents and a small amount of freely-moveable echogenic sludge. The wall was thin and continuous with small focal polypoid lesions. The cystic and common bile ducts are normal / not visible.

**Gastrointestinal**



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The stomach is moderately distended with ingesta, much of which casts an anechoic shadow. The gastric wall is 4.0 mm with normal deviations due to rugal folds, and exhibits appropriate wall layering. The pylorus is of normal appearance.

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The visualized portions of the duodenum, jejunum, and ileum are of normal thickness with intact wall layering that exhibits the appropriate 1:3 muscularis to mucosa ratio. Intestinal motility appears normal.

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The visible portions of the colon are of normal thickness, up to 1.3 mm, with intact wall layering. The ileocecal junction is not visualized.

**Pancreas**

**SEX**

NM

The right limb of the pancreas is hypoechoic to the surrounding mesenteric fat, with an inhomogenous parenchyma and normal capsular appearance. There is evidence of peripancreatic inflammation. The pancreatic duct appears normal.

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**Free Abdomen**

**WEIGHT**

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There is no evidence of free fluid within the peritoneal cavity. The omentum and intra-abdominal fat are of appropriate echogenicity. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

**PRIMARY FINDINGS**

- Diffusely hyperechoic rounded liver consistent with non-specific hepatopathy.
- Mottled right pancreas, suggesting possible chronic pancreatitis.
- Diffuse pinpoint splenic mineralization, which is not pathologic, but which often indicates underlying endocrine disease.

**SECONDARY FINDINGS**

- Bilateral chronic renal changes.
- 1.3 cm non-obstructive bladder stone.
- Shadowing ingesta, which may be dense food, but which may also indicate foreign material.

**INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS**

The appearance of the pancreas would support a diagnosis of chronic pancreatitis. Supportive care for pancreatitis would be recommended, including low-fat diet, antiemetics, fluid therapy, and analgesia, which is consistent with the current medical therapy. If the patient has any symptoms to support Cushing's disease, this could be considered given the splenic mineralization, however the adrenal glands are not typical for a patient with Cushing's disease, and so unless compelling signs are present, I would consider the splenic mineralization to be incidental.

The presence of shadowing ingesta may be incidental, however if the patient is fasted, the possibility of foreign material cannot be excluded. If the patient's symptoms persist then re-check ultrasound would be recommended to determine whether this material remains in the stomach, ideally with a 12 hour fast prior to the ultrasound.

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The changes in the liver are non-specific and could be attributed to endocrine disease, other vacuolar hepatopathies, reactive hepatopathy, storage hepatopathy, chronic infectious or inflammatory disease (including leptospirosis), hepatic lipidosis, or less likely neoplasia. Additional recommendations include:

- Screening for hyperlipidemia with a fasted triglyceride level is recommended, if not already performed.
- Bile acid testing is recommended to further assess severity of hepatic disease - if elevated then liver biopsies are strongly recommended.
- If bile acids are normal, then initiation of liver support therapies such as SAMe, Vitamin E and ursodiol, along with serial monitoring of liver enzyme levels every 2-3 months, could be initiated.
- Ultrasound-guided or laparoscopic biopsies would be needed for definitive diagnosis. Fine needle aspirate for cytology could also be performed, but is less likely to yield a definitive diagnosis.





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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.

**Tam Mengine, DVM, DABVP (canine/feline practice)**

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