



PATIENT

Rita Robbins

SPECIES

Canine

BREED

Terrier x

SEX

Spayed Female

AGE

9 Years

WEIGHT

10.5 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Sarah Barthelemy

HOSPITAL NAME

Alpine 24 Hour
Pet Hospital

REFERRING VET

Dr. Karagic

INVOICE

71503

DATE

11/2/25

PRESENTING CLINICAL SIGNS

Presented as ADR and vomiting
Abnormal PE/Chem/CBC/UA Results: Marked ALT elevation 600 and mild ALP elevation. No available pancreatic values Hemoconcentration

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is moderately distended with anechoic urine, and no luminal sediment is present. The ureteral papillae, trigone and pelvic urethra (visible to 3.0 cm) are of normal appearance, and the ureters are not visible (normal). No masses, calculi or mucosal irregularities are noted.

The kidneys exhibit adequate corticomedullary differentiation. There is a small, non-obstructed nephrolith present within the renal cortex of the right kidney. There is a small cortical cyst noted within the left kidney. There is no evidence of pyelectasia or hydronephrosis. The proximal ureters are not visible (normal). The kidneys measure 5.0 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 measures 5.2 mm at the cranial pole and 4.4 mm at the caudal pole. Right measures 7.5 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 with 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 of appropriate size and shape, with sharp borders and a mildly coarse parenchymal echotexture that is hypoechoic to the spleen. The portal and hepatic vasculature are of normal size and appearance with no evidence of congestion or thrombosis.

The gallbladder is distended with anechoic contents. The wall was thin and continuous with no focal lesions. The cystic and common bile ducts are normal / not visible.

Gastrointestinal

The stomach is moderately distended with gas and ingesta. The gastric wall is 3.2 mm with normal deviations due to rugal folds, and exhibits appropriate wall layering. The pylorus is of normal appearance.

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. Duodenum wall measures 4.7 mm. Jejunum wall measures 3.5 mm.

The visible portions of the colon are of normal thickness (1.5 mm) with intact wall layering. The ileocecal junction is normal.



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Pancreas

The pancreas is swollen and hypoechoic, surrounded by hyperechoic mesenteric fat. The pancreatic ducts appear normal.

Free Abdomen

There is focal free fluid present with the abdomen in the region of the bladder and pancreas. The associated omentum and intra-abdominal fat are hyperechoic. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

PRIMARY FINDINGS

- Hypoechoic left and right pancreas, with steatitis
- Minor renal changes, including small cortical cysts and nephrolithiasis (both deemed incidental findings)
- Scant free fluid throughout the abdomen, consistent with peritonitis
- Sonographically normal liver & gallbladder

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The changes in the pancreas are consistent with acute pancreatitis. Concurrent pancreatic neoplasia, while less likely, cannot be ruled out. The liver appears normal, and so the elevated ALT may be due to a reactive hepatopathy secondary to pancreatitis, or there may be microscopic disease present, which would be evident only with biopsy. Recommendations include:

- A quantitative pancreatic marker level is recommended for confirmation and monitoring purposes.
- As leptospirosis can cause both pancreatitis and hepatitis, testing for leptospirosis is recommended if the patient is deemed at risk for exposure.
- Supportive care including fluid therapy, antiemetics, analgesics, appetite stimulants (if needed) are warranted. Panoquel-CA1, a newer, novel injectable treatment for canine pancreatitis, is recommended if available.
- A highly digestible, low fat intestinal diet should be encouraged as soon as vomiting can be controlled.
- Liver support therapies, such as S-AMe and silymarin would be recommend.
- There is evidence to suggest that prednisone at 1 mg/kg/day dosing may improve outcomes in dogs with acute pancreatitis - this could be considered if the patient is not responding to traditional therapies.
- If the patient is not responding to medical management, fine needle aspiration with a 25G needle for cytology could be considered after first checking a coagulation profile.
- If liver values continue to increase despite supportive care, or if bile acid levels are elevated, then live biopsy would be recommended for definitive diagnosis.



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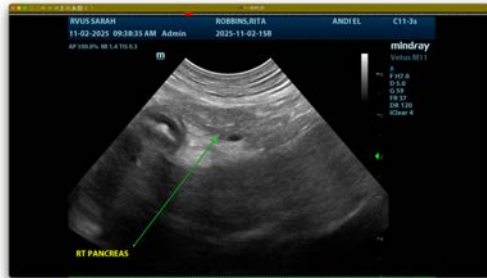
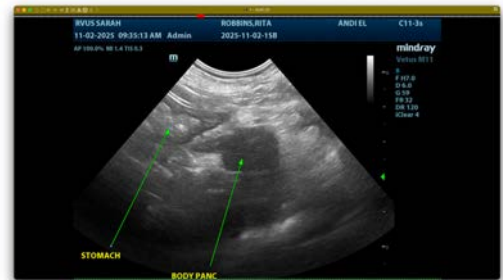
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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

info@SonoPath.com