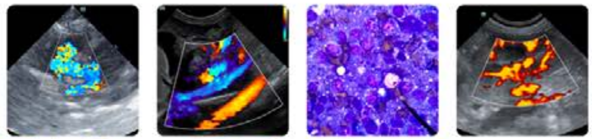


PATIENT

Puddles Quinn

SPECIES

Canine

BREED

Dachshund

SEX

Spayed Female

AGE

11 Years

WEIGHT

17 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Wasserman

HOSPITAL NAME

Highlands Animal Hospital

REFERRING VET

Dr. Frankenberger

INVOICE

72809

DATE

12/27/25

PRESENTING CLINICAL SIGNS

Puddles presented for hematochezia inappetence, polydipsia, and nausea 12/24/25. Initial treatment with metronidazole 125mg PO BID and Cerenia 1mg/kg SC did not resolve symptoms. Returned for diagnostics today at Highlands. Dr. Frankenberger noted thickened stomach on abdominal radiographs. Requested abdominal ultrasound. Fecal test pending.

Abnormal PE/Chem/CBC/UA Results: NA 140mmol/L CL 106 mmol/L ALP 1569 Baseline Cortisol (Idexx snap): 1.95 ud/dL ACTH STIM Post Cortisol (Idexx Snap): 16.62ug/dL 1.010 UR S.G. CPL Truforma 88 ug/dL

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 5.0 cm) are of normal appearance, and the ureters are not visible (normal). No masses, calculi or mucosal irregularities are noted.

The kidneys exhibit moderately decreased corticomedullary differentiation. Infarcts are seen within the renal cortex of the left kidney. There are also small cortical cysts noted within the left kidney. There is no evidence of nephrolithiasis, pyelectasia or hydronephrosis. The proximal ureters are not visible (normal). Left measures 5.2 cm. Right measures 5.0 cm.

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 4.4 mm at the cranial pole and 4.1 mm at the caudal pole. Right measures 5.4 mm at the cranial pole and 4.7 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.

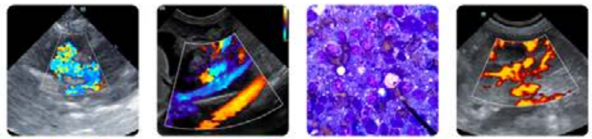
Liver

The liver is diffusely hyperechoic and subjectively enlarged, with sharp borders 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. There is a cholelith present within the gallbladder lumen. The wall was thin and continuous with no focal lesions. The cystic and common bile ducts are normal / not visible.

Gastrointestinal

The stomach is empty. The gastric wall is subjectively normal in thickness, and exhibits appropriate wall layering, but cannot be accurately measured due to normal deviations of the rugal folds. 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.

The visible portions of the colon have increased thickness, up to 2.6 mm with intact wall layering. The ileocecal junction is not visualized.

Pancreas

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

Free Abdomen

There is no free fluid noted within the abdomen. There is hyperechoic, inflamed omental fat noted in the region of the right pancreas. Enlarged abdominal lymph nodes are not observed. The aortic trifurcation has normal blood flow with no evidence of thrombosis.

PRIMARY FINDINGS

- Thickened descending colon, typical of colitis
- Mottled right pancreas with associated steatitis, typical of chronic pancreatitis
- Bilateral chronic renal changes
- Diffusely hyperechoic liver consistent with non-specific hepatopathy

SECONDARY FINDINGS

- Gallbladder cholelith - an incidental finding

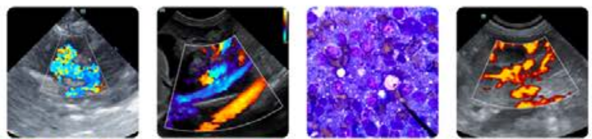
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The thickened colon is typical of non-specific colitis. Supportive care with probiotic therapy and supplemental fiber is recommended, along with the pending fecal parasite test. If symptoms persist, endoscopy would be recommended for colonic biopsy.

The gastric wall appeared subjectively normal in both thickness and wall layering, but could not be accurately measured due to prominent rugal folds.

The appearance of the right pancreas would support chronic pancreatitis, despite the normal CPL level. Thus, a low fat diet would be indicated, and assessment of fasting triglyceride levels is also recommended.

The changes in the kidneys are typical of age-related degenerative change, and would be the most likely explanation for the patient's recent increase in thirst. A urine protein creatinine ratio and blood pressure measurement are recommended. A renal diet should be considered with caution, as many of these are higher in fat and may be less than ideal for a patient with concurrent pancreatitis.



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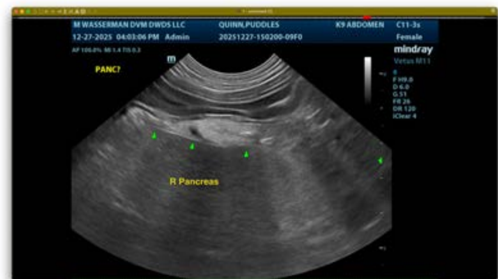
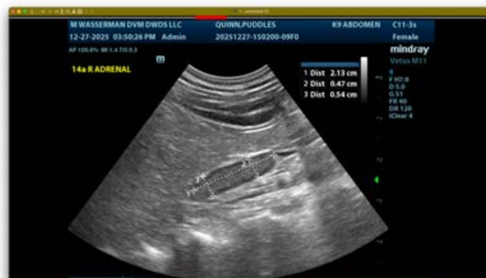
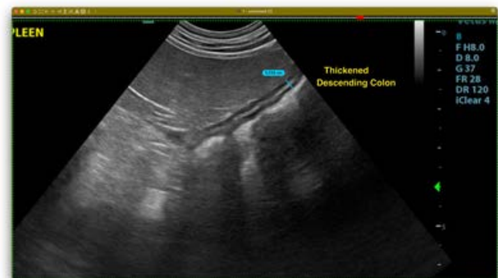
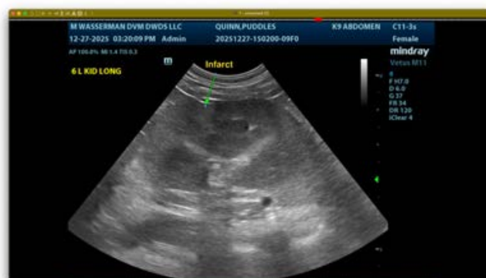
The appearance of the liver and elevated ALP are consistent with a benign reactive hepatopathy. Serial liver chemistry screens, at 3-6 month intervals, are recommended. As long as all other liver laboratory values are normal, then a clinically significant hepatopathy is highly unlikely. However, if ALT or TBili become elevated, then bile acid testing, liver support supplements such as SAMe, milk thistle and ursodiol, as well as recheck ultrasound would all be recommended.

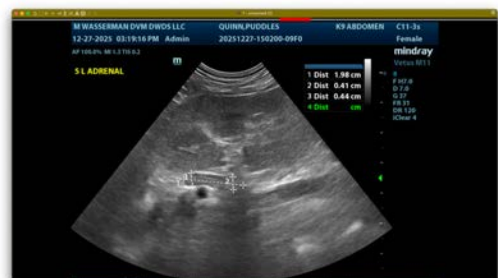
Ultrasound-guided or laparoscopic biopsies would be needed for definitive diagnosis. Fine needle aspirate for cytology could also be performed, but is less likely to yield a definitive diagnosis.

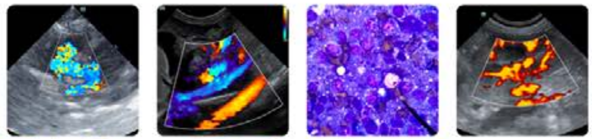












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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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)

info@SonoPath.com