



PATIENT

Arnie Perez

SPECIES

Canine

BREED

Yorkie

SEX

Neutered Male

AGE

9

WEIGHT

10 lbs

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Rachel Flagiello

HOSPITAL NAME

Greater Staten Island
Veterinary Services

REFERRING VET

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16289

DATE

05/16/26

PRESENTING CLINICAL SIGNS

Presenting Complaint: Arni presents for acute onset of diarrhea with hematochezia, vomiting, and anorexia. Patient History: Diarrhea began Thursday, initially watery, progressed to visible blood (hematochezia) by Saturday. Vomiting yellow bile, no food content. Anorexia since Friday; refused chicken and rice, not eating kibble or pate. No recent diet changes; no known ingestion of foreign material, garbage, or house food (except for today). Possible exposure to food dropped by wildlife (raccoons, squirrels) on deck. No recent travel, dog park, or contact with other dogs. History of medial patellar luxation; previously received Cosequin (not given for past few weeks). Rimadyl (carprofen) administered Thursday (approx. 10mg, half tablet with cheese); not given daily, last dose Thursday. Imodium AD (loperamide) given earlier today (dose possibly higher than recommended). Routine wellness exams at Banfield twice yearly; up to date on vaccinations (including Bordetella). Overweight; attempts to reduce ration ongoing. No known history of dietary indiscretion, foreign body ingestion, or toxin exposure. No recent abnormal fecal or parasite tests (as per Banfield records). Sister has diabetes (not relevant to Arni per current diagnostics)

CBC/CHEM: RBC 11.26 M/ μ L 5.65 - 8.87 HIGH, HCT * 69.8 % 37.3 - 61.7 HIGH, HGB 22.5 g/dL 13.1 - 20.5 HIGH, MCH 20.0 pg 21.2 - 25.9 LOW, RDW 25.2 % 13.6 - 21.7 HIGH, RETIC 222.9 K/ μ L 10.0 - 110.0 HIGH, RETIC-HGB 19.4 pg 22.3 - 29.6 LOW, EOS 0.03 K/ μ L 0.06 - 1.23 LOW, MPV 15.2 fL 8.7 - 13.2 HIGH, PCT 0.49 % 0.14 - 0.46 HIGH, ALB 4.2 g/dL 2.2 - 3.9 HIGH, K 5.9mmol/L 3.5-5.8 HIGH CPLI: 457 HIGH (0-200)

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

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.

The kidneys are of normal size and shape and exhibit appropriate corticomedullary differentiation with a normal 1:3 cortex to medulla ratio. There are several small cortical cysts noted within the right kidney. There is no evidence of nephrolithiasis, mineralization, pyelectasia, cystic change or hydronephrosis. The proximal ureter is not visible (normal).

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. The left adrenal gland measures 4.5 mm at the caudal pole. The right adrenal gland measures 4.1 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



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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.

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The gallbladder is moderately distended with anechoic contents and a moderate amount of freely moveable echogenic sludge. The wall was thin and continuous with no focal lesions. The cystic and common bile ducts are normal / not visible.

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Gastrointestinal

The stomach is mildly distended with gas and fluid. The gastric wall is 3.6 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 have increased thickness, up to 2.4 mm, with intact wall layering. The ileocecal junction is not seen.

Pancreas

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The pancreas is not distinctly visualized, but there is hyperechoic omental fat observed in the region of the left limb of the pancreas.

Free Abdomen

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

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PRIMARY FINDINGS

- Steatitis in the region of the left pancreas, supportive of pancreatitis.
- Thickened descending colon consistent with colitis.

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SECONDARY FINDINGS

- Small cortical cysts in the right kidney which are an incidental finding.

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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The patient's clinical history is typical of acute hemorrhagic diarrhea syndrome, however, the elevated pancreatic lipase and steatitis in the region of the left pancreas support the likelihood of concurrent pancreatitis, or pancreatitis as the primary problem. Additional recommendations include:

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- ❖ Supportive care with fluid therapy, probiotic therapy, gastroprotectants, anti-emetics and a bland diet.
- ❖ A low-fat bland diet is recommended.
- ❖ Testing for parvovirus, particularly if unvaccinated.
- ❖ The use of antibiotics in the treatment of AHDS is debated. If the patient is febrile, or not responding to supportive care, then antibiotic therapy such as amoxicillin-clavulanic acid could be considered.



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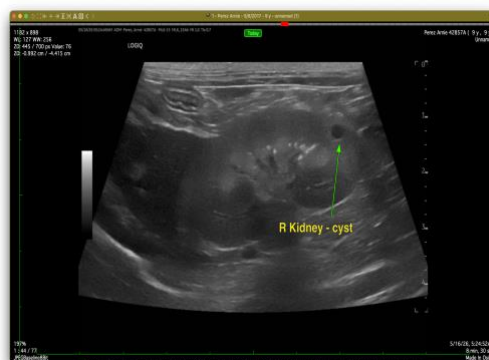
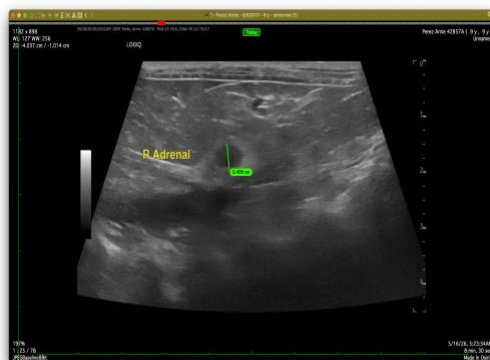
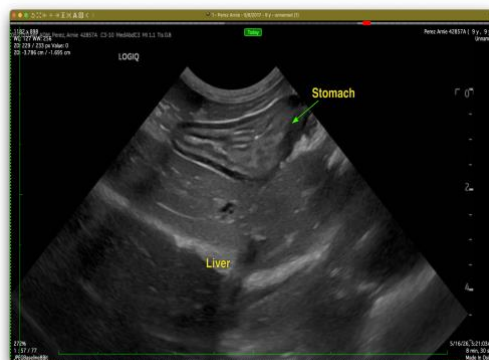
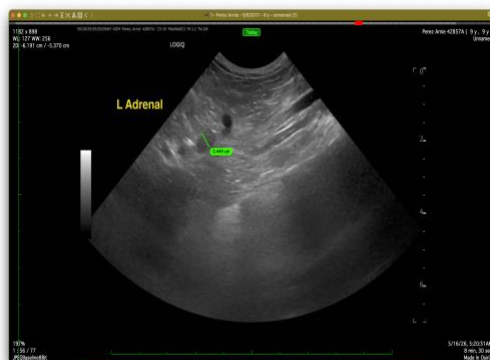
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❖ If symptoms persist, then a gastrointestinal panel and potentially gastrointestinal biopsies would be considered.



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.

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info@SonoPath.com



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