



PATIENT

Baz Shivji

SPECIES

Canine

BREED

Chihuahua

SEX

MN

AGE

14 years

WEIGHT

3.3 kg

INTERPRETED BY

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

IMAGING PERFORMED BY

Dr. Gira

HOSPITAL NAME

Petzoic Emergency

REFERRING VET

Dr. Ehab Hamed

INVOICE

12045

DATE

5/29/2026

PRESENTING CLINICAL SIGNS

Presented for Vomiting and diarrhea 05/25/26 (score 7 and started 2 days prior to visit) with noted blood. Hx of CHF, Giardia in March (treated with Metronidazole for 5 days). Appetite decreased - ate dinner yesterday but refused breakfast may 25th, not taking treats. Constipation issues due to medications.

Abnormal PE/Chem/CBC/UA Results: Diagnostics from May 25, 2026: - Bloodwork: - BUN: 11.4 (normal 2.5-9.6) - Amylase: 2101 (normal 500-1500) - Lipase: 4579 (normal 200-1800) - Canine Pancreatic Lipase: 1237 (normal 0-200) - Hemoconcentration was noted. - Urinalysis: - Specific gravity: 1.038 - Sediment: Clear.

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 are of normal appearance, and the ureters are not visible (normal). No masses, calculi or mucosal irregularities are noted. Urethra visualized to 3.0 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 exhibit moderately decreased corticomedullary differentiation. There are small, non-obstructed nephrolith present within the renal medulla of both kidneys. There is no evidence of pyelectasia or hydronephrosis. The proximal ureters are not visible (normal). There are small anechoic cysts within the cortex of the left kidney. The left kidney is 3.2 cm in length. The right kidney is 3.7 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 5.0 mm at the cranial pole and 5.8 mm at the caudal pole. Right adrenal measures 6.5 mm at the cranial pole and 4.5 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 parenchyma is diffusely heterogeneous and subjectively enlarged, with sharp borders. 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. The wall was thin and continuous with no focal lesions. The cystic and common bile ducts are normal / not visible.

Gastrointestinal



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The stomach is mildly distended with gas. The gastric wall is 1.9 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 (3.3 mm), jejunum (2.4 mm), 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 are of normal thickness, up to 1.2 mm, with intact wall layering. The ileocecal junction is visualized and appears normal.

Pancreas

Both limbs of the pancreas is swollen and hypoechoic, surrounded by hyperechoic mesenteric fat. The pancreatic duct appear normal.

Free Abdomen

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

PRIMARY FINDINGS

- Hypoechoic pancreas with steatitis, consistent with pancreatitis.

SECONDARY FINDINGS

- Diffusely heterogenous liver, consistent with non-specific hepatopathy.
- Bilateral chronic renal changes with nephrolithiasis.

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. Recommendations include:

- 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.
- Complications such as hypoalbuminemia, hyperglycemia and hypokalemia should be managed as they arise.
- 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.

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, hepatic lipidosis, or less likely neoplasia. In the absence of elevated liver enzymes, a benign etiology is favored. Liver biopsy would be needed for definitive diagnosis. Bile acid testing could be considered, and if normal, this further decreases the likelihood of serious liver pathology.

Additional recommendations include:



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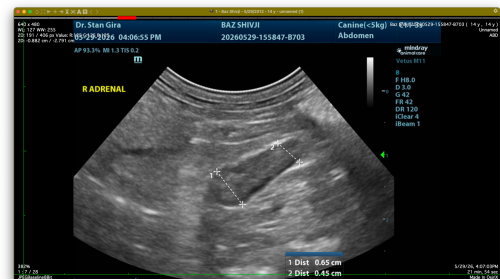
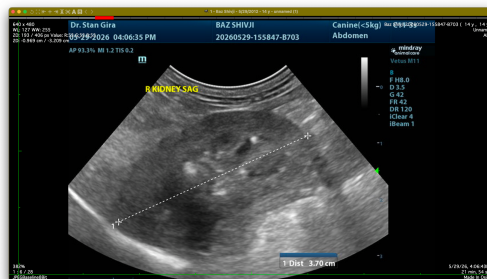
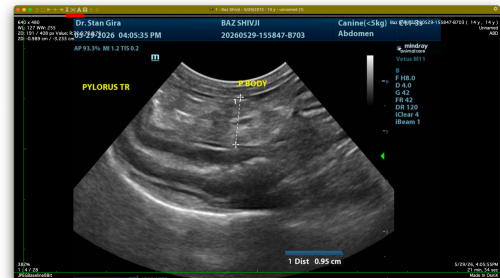
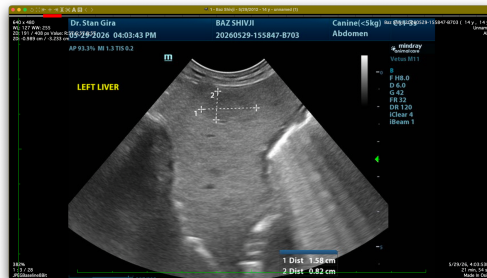
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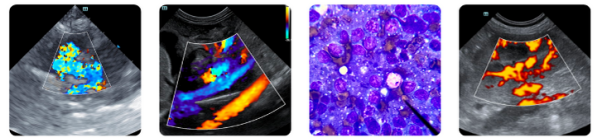
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- Screening for hyperlipidemia with a fasted triglyceride level is recommended, if not already performed
- Testing for Cushing's disease is recommended only if clinical signs support the diagnosis.
- Bile acid testing is recommended to further assess 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.

The changes in the kidneys are consistent with chronic nephrolithiasis and age related degenerative change. Unfortunately, there is no specific cure for this chronic problem. Recommendations include:

- Blood pressure measurement.
- Diuresis, either in-hospital or with regular subcutaneous fluid boluses, may be of benefit. Similarly, a high-moisture diet, such as canned food with added water, may help decrease stone formation.
- Clients should monitor for acute abdominal pain, vomiting, or anorexia, which could indicate an obstructive nephrolith.





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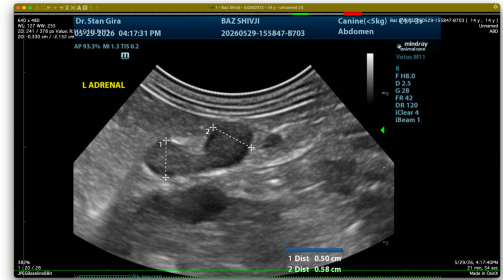
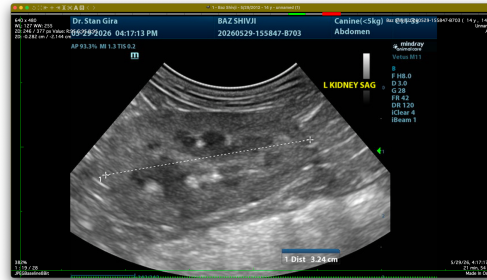
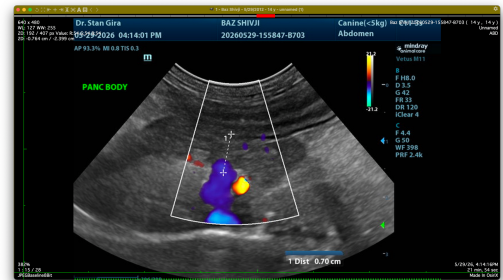
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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