



PATIENT

Lolita Laos Tomas Laos

SPECIES

Canine

BREED

Chihuahua

SEX

Spayed Female

AGE

12 years

WEIGHT

9.8 lbs

INTERPRETED BY

Alicia Angosto
Guerrero, DMV,
PgDip, MSc.

IMAGING PERFORMED BY

Arun Kutagulla

HOSPITAL NAME

Union Park AH

REFERRING VET

Arun Kutagulla

INVOICE

78306

DATE

6/2/26

PRESENTING CLINICAL SIGNS

History: pet is presented for abdominal ultrasound after being treated at ER for lethargy, vomiting and diarrhea. on PE pet has normal heart rate and rhythm, normal RR, normal temp and pulse, soft abdominal palpation, normal CRT, pink and moist gums.

Pet has history of urolithiasis per owner but never had abdominal ultrasound

Abnormal PE/Chem/CBC/UA Results: left kidney is small and hypotrophic, left adrenal glands appears enlarged bloodwork shows thrombocytopenia(100k/uL), ALT - 200, ALKP- 222 U/L blood pressure- 109/85 -93

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder lumen is normally distended, and the urinary bladder wall appears thin and smooth. The urine is anechoic. Normal appearance of the bladder neck and proximal urethra. No calculi or evidence of inflammatory or neoplastic disease are identified.

The left kidney is small and mildly irregular in contour, measuring 2.70×1.01 cm, with a cortical thickness of 0.29 cm in the sagittal plane. Cortical echogenicity is increased relative to the liver, and corticomedullary definition is mildly reduced. No pyelectasia, nephrolithiasis, or hydronephrosis is identified. Color Doppler evaluation is unremarkable.

The right kidney is enlarged and mildly irregular in contour, measuring 4.61×3.01 cm. Multifocal small triangular cortical hyperechoic foci are present and likely represent areas of fibrosis or previous ischemic injury. A small cortical cyst measuring approximately 2.53×4.14 mm is identified. Mild pyelectasia measuring approximately 1.43 mm is present. No nephrolithiasis or hydronephrosis is identified. Color Doppler evaluation is unremarkable.

Adrenal Glands

A large heterogeneous left adrenal mass measuring approximately 1.99×2.08 cm is present and completely distorts the normal adrenal architecture.

The right adrenal gland measures approximately 0.95 cm at the cranial pole and 0.48 cm at the caudal pole. A well-defined hyperechoic nodule measuring approximately 4.82×5.03 mm is present within the cranial aspect of the gland.

Spleen

Splenic thickness is 0.82 cm. The parenchyma demonstrates normal echogenicity and fine homogeneous echotexture without focal parenchymal abnormalities. The splenic capsule is smooth and regular.



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Liver

The liver is mildly enlarged with rounded margins and a regular contour. The hepatic parenchyma is mildly heterogeneous and isoechoic to mildly hyperechoic relative to the falciform fat. No focal hepatic lesions are identified. No hepatic lymphadenopathy is observed.

The gallbladder lumen is normally distended. Mild mucosal (mucinous gland) hyperplasia is present with a small amount of biliary sludge. No evidence of cystic duct or common bile duct dilation is identified.

Gastrointestinal tract

The stomach is empty and folded with a mural thickness of 1.92 mm and preserved wall layering.

The pylorus measures 5.16 mm. The duodenum measures 2.81 mm. The jejunum measures 2.85 mm. Wall layering is preserved throughout the examined small intestine.

No sonographic evidence of gastrointestinal obstruction, foreign material, or infiltrative intestinal disease is identified.

The colon measures 1.10 mm and contains a small amount of fecal material.

Pancreas

The pancreas measures approximately 5.03 mm in thickness. The pancreatic parenchyma is mildly hypoechoic relative to the surrounding mesenteric fat. No peripancreatic fat inflammation, regional effusion, or pancreatic mass lesion is identified.

Free Abdomen

No sonographic evidence of abdominal effusion, peritonitis, or lymphadenomegaly is identified. The iliac trifurcation is normal.

PRIMARY FINDINGS

- Large heterogeneous left adrenal mass (1.99×2.08 cm) resulting in marked distortion of normal adrenal architecture.
- Small hyperechoic right adrenal nodule (4.82×5.03 mm).
- Marked chronic left renal atrophy with increased cortical echogenicity and reduced corticomedullary definition.
- Probable compensatory hypertrophy of the right kidney with multifocal small cortical scars/fibrotic changes and a small cortical cyst.

SECONDARY FINDINGS

- Mild right pyelectasia (1.43 mm).
- Mild pancreatic enlargement and diffuse hypoechoicogenicity.
- Hepatomegaly and mucinous gland hyperplasia and biliary sludge.



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INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A large heterogeneous left adrenal mass is present and replaces the normal adrenal architecture. Differential diagnoses include adrenal adenocarcinoma, adrenal adenoma, and less likely based on the ultrasonographic appearance and the absence of documented systemic hypertension, pheochromocytoma.

A small hyperechoic nodule is also present within the right adrenal gland, consistent with nodular hyperplasia or myelolipoma.

The ultrasonographic appearance and clinicopathologic findings raise concern for a functional adrenal tumor; however, the patient does not demonstrate the classic clinical or ultrasonographic features typically associated with hyperadrenocorticism, and adrenal function cannot be determined sonographically. Further endocrine testing would be required to establish hormonal activity.

The chronic severe atrophy of the left kidney and compensatory enlargement of the right kidney are most consistent with longstanding unilateral renal disease. The contribution of renal disease to the recent episode of lethargy, vomiting, and diarrhea cannot be completely determined. The multifocal cortical hyperechoic foci within the right kidney are most consistent with chronic fibrotic or ischemic change.

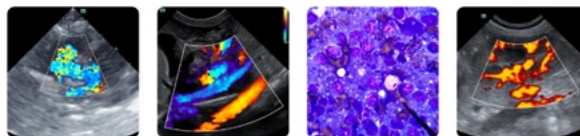
Hepatomegaly and gallbladder mucosal hyperplasia with biliary sludge are present. These findings may reflect chronic hepatobiliary change but can also be seen secondary to underlying endocrinopathies, including hyperadrenocorticism.

Mild diffuse pancreatic hypoechogenicity is present. Although no peripancreatic inflammation, regional effusion, or other secondary changes commonly associated with severe acute pancreatitis are identified, mild or chronic pancreatic disease cannot be excluded. In the context of the patient's recent lethargy, vomiting, and diarrhea, pancreatic disease remains a possible contributor to the reported clinical signs.

Recommendations

- Correlation with endocrine testing is recommended to determine whether the adrenal mass is functional.
- Blood pressure monitoring.
- Clinical correlation with platelet count and coagulation status is recommended prior to any invasive procedures.
- Supportive therapy (low-fat diet, antiemetics, and other treatments at the discretion of the attending veterinarian) may be considered if gastrointestinal signs recur.
- Correlation with renal function testing (BUN, creatinine, SDMA, urinalysis, and urine specific gravity if not recently performed) is recommended.

Final diagnostic and therapeutic decisions should be made by the attending veterinarian, who can best integrate these findings with the patient's clinical status.



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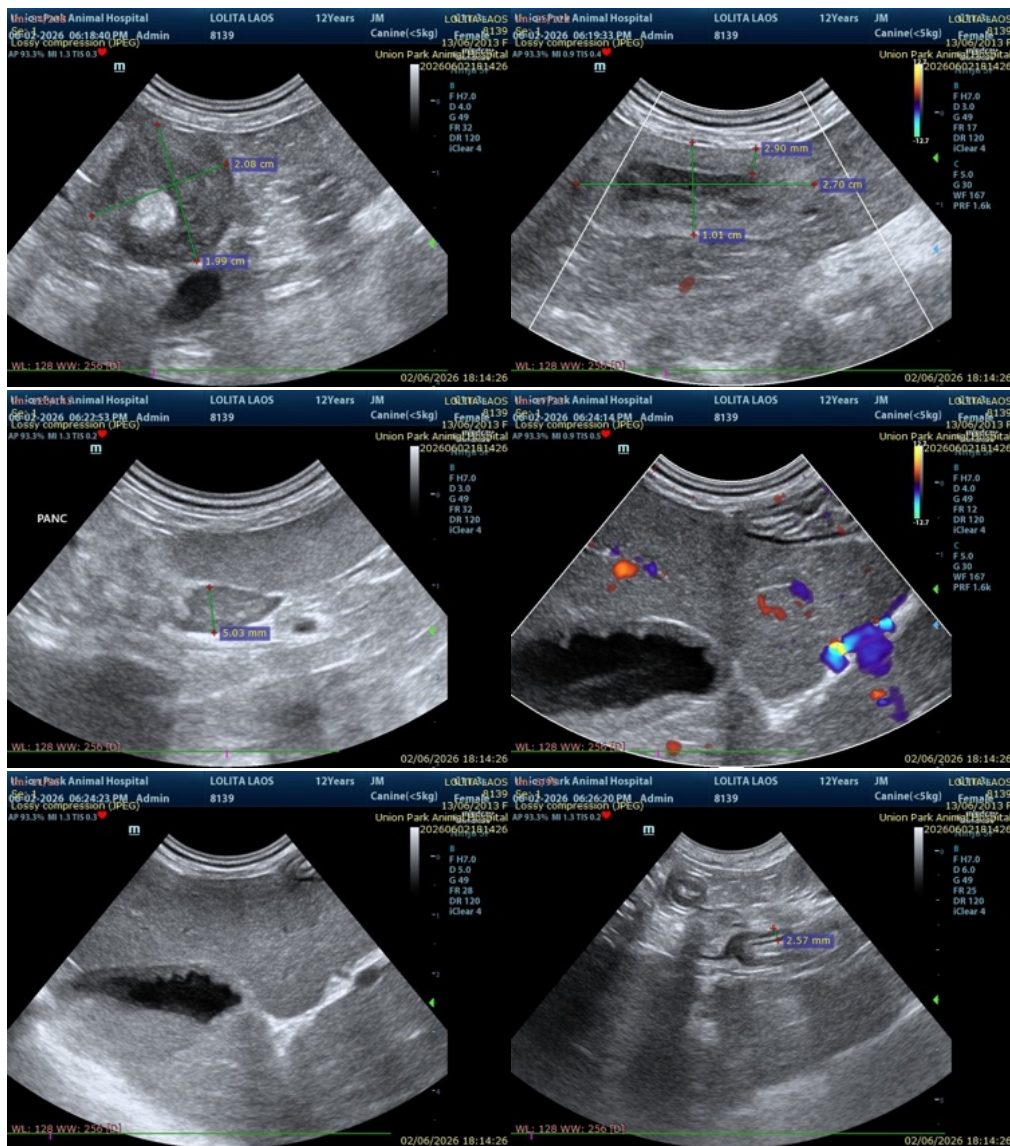
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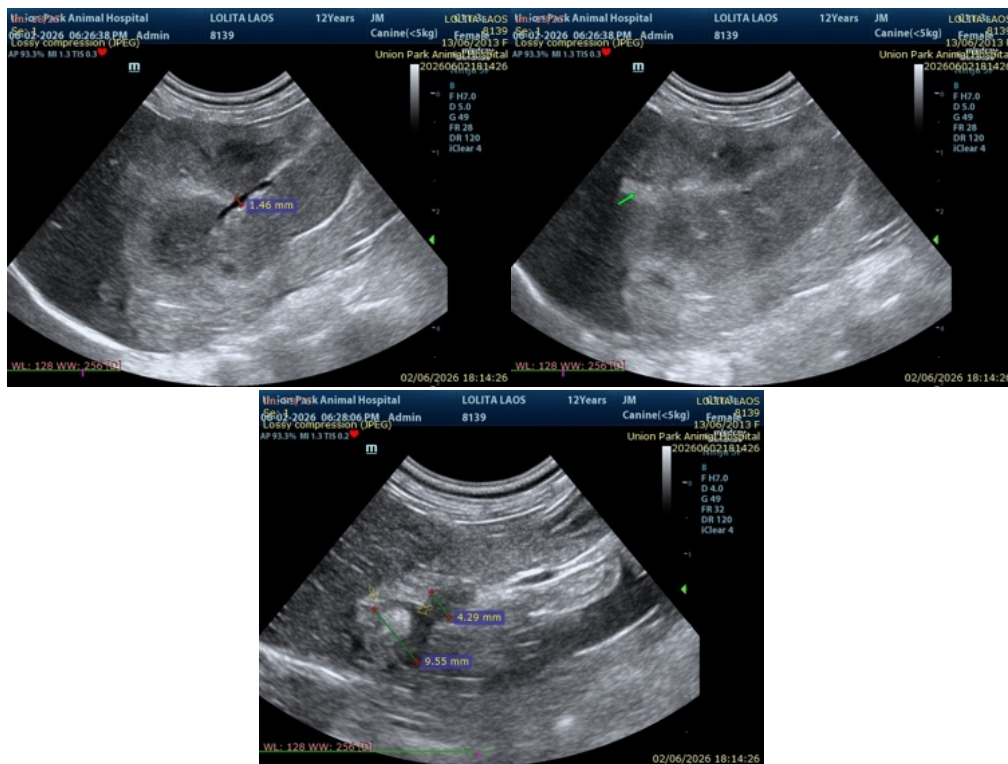
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Alicia Angosto Guerrero, DMV, PgDip, MSc.

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