


DATE PRESENTING CLINICAL SIGNS

11/10/25

Patient History: 10/3/25: Changes in bowel movements. Started to not want canned food, then dry food, and then kibble with rice, and was then eating chicken and pumpkin. P has diarrhea about once a week. On/off normal/soft/mucousy. Wednesday O noticed some blood dripping from hind area. Occasionally vomits. She lost weight (15.4# to then 12#). CBC/IOF: WNL; Fecal: Negative; UA: NSF; Place of Proviabile and hydrolyzed diet. 10/25/25: p presented for diarrhea. Owner stated that p has been having diarrhea its bloody, o stated that sometimes p will get in the position to poop and blood just drips out. O stated that hydrolyzed diet was initially working but doesn't seem to be working now. No dietary indiscretion. P is still on the proviable and that's not seeming to work. They also have put pumpkin in the diet (not new) and that's not working either. Diet: hydrolyzed protein + pumpkin. Medication: Proviabile. Started liquid metronidazole that Jewels will not take. Prescribed Metronidazole tablets on 10/28/25. Rec Pro-pectalin: O declined

PATIENT

Jewels Chinn

SPECIES

Canine

BREED

Shih Tzu

SEX

Female, spayed

AGE

2/10/2011

WEIGHT

5.35 kg.

INTERPRETED BY

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HOSPITAL NAME

Banfield Columbia

REFERRING VET

Dr. Landon

INVOICE

13322

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN
Urinary System

The urinary bladder wall is normal in thickness and the mucosal surface is smooth. The bladder is moderately distended. Luminal contents are anechoic. No cystic calculi are observed. The region of the trigone and the visible portion of the proximal urethra are normal.

The left kidney is normal in size (4.10 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. Moderate pyelectasia is present (0.40 cm in the longitudinal plane). Several small non-obstructive nephroliths are visualized. There is no evidence of infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (4.31 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with mild loss of corticomedullary distinction. Several small non-obstructive nephroliths are visualized. There is no evidence of pyelectasia, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

A 2.5 x 2.2 cm heterogeneous mass is arising from the mid to caudal aspect. The mass does not obviously appear to invade into the caudal vena cava. The tip of the cranial pole is visualized and is subjectively normal in size with normal glandular echogenicity and detail.

The right adrenal gland is borderline small in size (0.37 cm at cranial pole) (0.38 cm at caudal pole) with a normal shape, glandular echogenicity and detail. Surrounding vasculature appears normal.

Spleen

The spleen is normal in size (0.64 cm in width at the level of the hilus) with a normal capsular contour. There is appropriate echogenicity and echotexture. No focal lesions are observed. Splenic vasculature is normal.

Liver

The liver is subjectively prominent in size with swollen curvilinear peripheral contours. The parenchyma is isoechoic relative to the spleen and exhibits mild heterogeneity. No distinct focal lesions are observed. Hepatic vasculature and biliary tracts are of normal volume with no evidence of congestion.

The gall bladder lumen is moderately distended. The wall is thin and smooth. A moderate amount of mobile echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen.

Gastrointestinal

The gastric lumen is not distended. The gastric wall and pylorus are normal in thickness with a normal layering pattern. The pyloric outflow tract is patent. The small intestinal lumen is not dilated. The small intestinal wall is normal in thickness with a normal layering pattern and appropriate mural detail. Discreet masses are not identified. The colonic wall is normal. There is no evidence of an obstructive pattern.

Pancreas

The right limb is visible with normal peripheral contours. The parenchyma is slightly hypoechoic relative to surrounding omental. No focal lesions are observed. The pancreatic duct is not overtly dilated.

Lymph nodes

The abdominal lymph nodes are normal/not visible.

Free Abdomen

There is no obvious evidence of free fluid.

Other

A portion of the body wall near the inguinal region appears thickened (up to 0.52 cm), hypoechoic and slightly irregular.

ULTRASONOGRAPHIC FINDINGS

Primary Findings:

- Bilateral nonspecific chronic renal changes with non-obstructive nephrocalcinosis and moderate left pyelectasia. The pyelectasia may be secondary to parenchymal remodeling, pyelonephritis, PU/PD (if applicable) or some combination thereof.
- The diffuse hepatic changes are non-specific and could be consistent with vacuolar hepatopathy, regenerative nodular hyperplasia, and/or age-related remodeling. Inflammatory disease, infiltrative neoplasia and other hepatopathies are considered less likely.
- The left adrenal mass. Neoplasia (i.e., adenocarcinoma, pheochromocytoma) is suspected with a lower possibility of an adenoma or focal nodular hyperplasia. The right adrenal gland is borderline small in size which may be due to atrophy (i.e., from a functional left adrenal tumor).

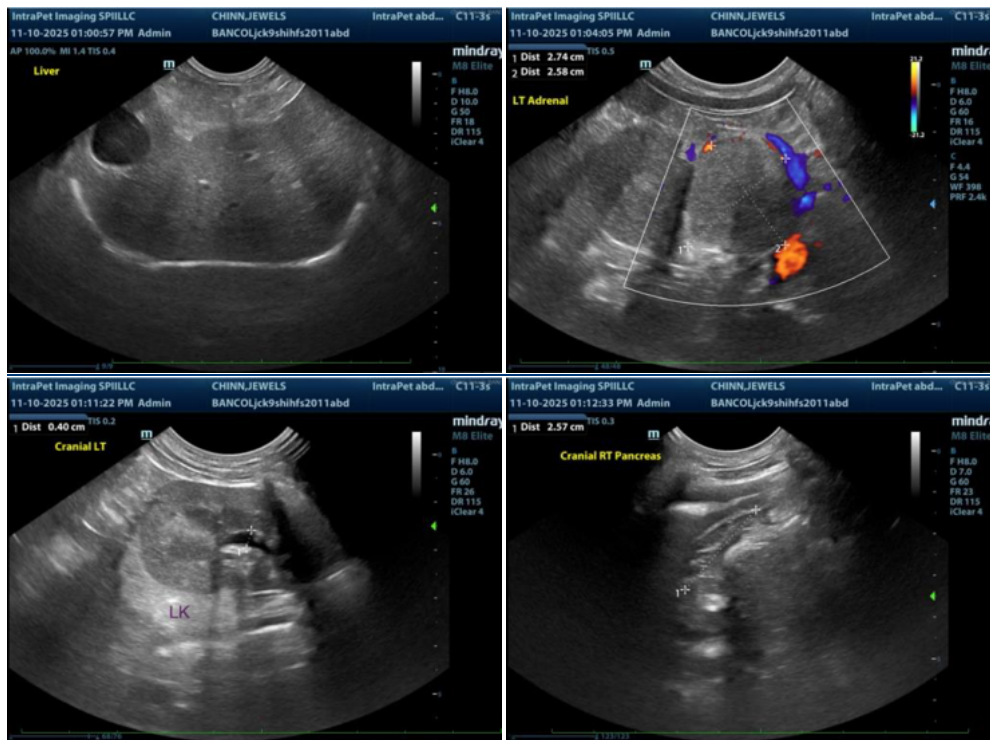
Secondary Findings:

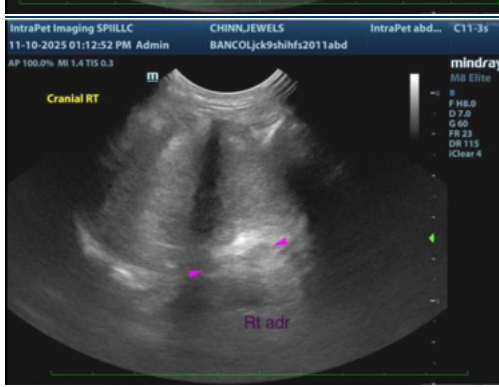
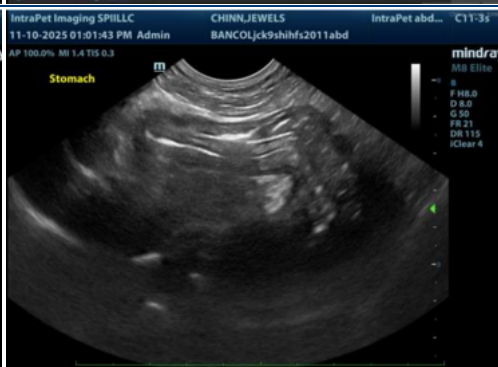
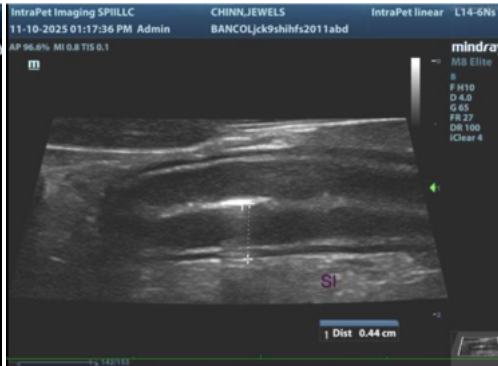
- The pancreatic changes may be a normal variant for this patient or could be consistent with mild, chronic pancreatitis. Correlation with clinical findings is recommended.
- Gallbladder debris, non-mucocele
- The thickening of the body wall in the caudoventral abdominal region may be a normal variant for this patient or may be secondary to inflammation, fibrous tissue, emerging neoplasia, other.

* An obvious cause for the patient's GI signs is not definitively identified in this study. Considerations include a primary enteropathy (i.e., infectious/parasitic disease, food allergy/intolerance, inflammatory bowel disease), underlying metabolic issue, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the GI signs, consider the following:
 1. Prophylactic deworming with Fenbendazole (despite the negative fecal evaluation)
 2. GI panel including serum cobalamin, folate, TLI and PLI
 3. Transition to a prescription limited antigen or hydrolyzed protein diet
 4. Continuation of a probiotic along with a fiber supplement (i.e., psyllium)
 5. Ultimately, endoscopic or surgical GI biopsies may be necessary to get a definitive diagnosis.
- Regarding the left adrenal mass, consider the following:
 1. Three-view thoracic radiographs are recommended to assess for pulmonary metastases.
 2. Baseline blood pressure measurement
 3. Further testing for a functional tumor (i.e., low-dose dexamethasone suppression test, urine/blood metanephrine levels)
+/- abdominal CT scan, particularly if a left adrenalectomy is to be considered
- Regarding the body wall thickening in the caudal abdominal region, palpation +/- aspiration is recommended.





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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