PATIENT

Paco Martinez

SPECIES

Canine

BREED

TerrierX

SEX

Male Neutered

AGE

06/15/2012

WEIGHT

16 lb

INTERPRETED BY

Andrea Nicastro DVM
Diplomate ACVIM
(Sm Animal Internal Med)

IMAGING PERFORMED BY

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Diplomate ACVIM
(Sm Animal Internal Med)

HOSPITAL NAME

Southside AH

REFERRING VET

Michael Forcier, DVM

INVOICE

22228

DATE

11-7-25

PRESENTING CLINICAL SIGNS

Clinical Exam Findings: Vomiting bloody diarrhea, inappetence, lethargy, anorexia. Temperature normal today.
* Clinical signs began on 11/03/2025 with two episodes of emesis.
* Patient has been anorexic since 11/03/2025.
* Diarrhea is described as having a mucoid consistency with hematochezia.
* Patient is lethargic at home.

Abnormal lab-work values: Mildly elevated liver values and a white count of 20,000.
CBC - Leukocytosis (20k)
* Neutrophilia (12.6k)
* Lymphocytosis (>5k)
* Monocytosis (>2k)

CHEMISTRY
* Increased ALT 146, increased AST 68.
ENDOCRINE
* TT4 is LOW @ 0.8 (suspect euthyroid)
URINALYSIS
* pH 5.5
* Proteinuria 1+
* Bilirubinuria 2+
* Ketonuria 1+ (spurious).
* No casts, crystals or bacteria noted.

IDEXX 4dx - All assay results are NEG
Current Medications: Mirtazipine, Metronidazole
Radiographic Findings: n/a

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is minimally distended with anechoic urine. The wall is mostly thickened (up to 0.62 cm) with a slightly irregular mucosal surface. No cystic calculi are observed. The region of the trigone and the proximal urethra, visible to a depth of 2 cm, are normal.

The prostate is normal in size (0.68 cm in width) and shape. Parenchyma is homogenous. The prostatic urethra appears normal without evidence of dilation or obstruction.

The left kidney is normal in size (4.52 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. At least one small cortical cyst is seen. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

The right kidney is normal in size (4.26 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. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter. Renal vasculature is normal.

Adrenal Glands

The left adrenal gland is severely enlarged (2.35 cm at cranial pole) (0.90 cm at caudal pole) (3.71 cm in length) with an irregular shape and a mass effect. The parenchyma is diffusely heterogenous, with a few

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cavitated areas. Surrounding mesentery is hyperechoic. There is no obvious evidence of invasion into the caudal vena cava.

The right adrenal gland is mildly enlarged (1.01 cm at cranial pole) (0.56 cm at caudal pole) with a normal shape. A 0.90 x 0.85 cm hyperechoic nodule is observed within the cranial aspect. Glandular echogenicity and detail at the caudal aspect are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Spleen

The spleen is normal in size (0.82 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 normal in size with normal contours and structure. There is appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative, or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion. The portal vein to caudal vena cava ratio is approximately 1: 1.

The gallbladder is severely distended. The wall is normal in thickness. The lumen is almost completely filled with organized suspended sludge. The mesentery effacing the serosal surface of the gallbladder is hyperechoic. A scant amount of free fluid is observed adjacent to the gallbladder. The cystic and common bile ducts are visible but not overtly dilated. The duodenal papilla is normal-in-size (0.29 cm in width).

Gastrointestinal

The gastric lumen is not distended. The gastric wall is normal to moderately severely thickened (up to 1.46 cm) with questionable retention of the 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. The ileocecocolic junction is normal. The wall of the descending colon is mildly thickened (up to 0.40 cm). The colonic lumen is empty with no obvious evidence of an obstructive pattern.

Pancreas

The pancreas is diffusely prominent-in-size with minimal deviation from the normal peripheral contours. The parenchyma is hypoechoic relative to surrounding omental fat and subtly mottled in appearance. The pancreatic duct is overtly dilated. The mesentery effacing the serosal surface of the right limb is mildly hyperechoic.

Lymph Nodes

A 1.95 x 0.37 cm medial iliac lymph node is visualized. At least two mid- to caudal abdominal lymph nodes are also seen (one measuring 2.64 x 0.56 cm).

Free Abdomen

Trace free fluid is observed.

Other

A brief echocardiogram reveals no obvious evidence of right atrial or auricular mass. There is no obvious evidence of pericardial effusion. The cardiac contractility is subjectively inadequate.

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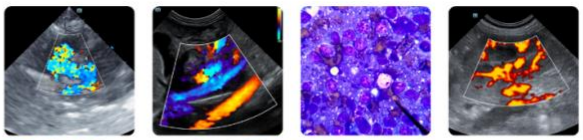

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ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The gallbladder changes are consistent with a fully-formed mucocele with adjacent peritonitis. Rupture or impending rupture are possible. Concurrent bacterial cholecystitis is also a consideration.
- The pancreatic changes are consistent with mild pancreatitis with minor parenchymal remodeling. Mild adjacent peritonitis is also present.
- Left adrenal mass. Neoplasia (i.e., adenocarcinoma, pheochromocytoma, hemangiosarcoma) is suspected, with a low possibility of a non-neoplastic process. Mild adjacent peritonitis is present. The right adrenal nodule could be consistent with focal nodular hyperplasia, adenoma, emerging adenocarcinoma, pheochromocytoma, other.
- The gastric wall changes could be consistent with gastritis or emerging neoplasia (i.e., lymphoma, adenocarcinoma).
- The subjective cardiac hypocontractility may be secondary shock/sepsis, dilated cardiomyopathy, electrolyte derangements, other.

Secondary Findings

- Bilateral nonspecific age-related renal changes
- The urinary bladder wall changes could be consistent with cystitis or may be artifactual due to lack of full repletion. Correlation with the patient's clinical history is recommended.
- The colonic wall changes are most consistent with colitis with a lower possibility of emerging neoplasia.
- The prominent medial iliac lymph node is likely reactive with a low possibility of emerging neoplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Referral to a 24-hour facility for aggressive supportive care and possible cholecystectomy/pancreatitis treatment is recommended. Three-view thoracic radiographs and clotting times should be performed prior to anesthesia.
- Regarding the left adrenal mass, consider the following:

  1. Baseline blood pressure measurement
  2. Further testing for a functional tumor (i.e., low-dose dexamethasone suppression test, urine/blood metanephrine levels)
  3. Abdominal CT scan to assess invasiveness of the mass, particularly if a left adrenalectomy is to be considered in the future.

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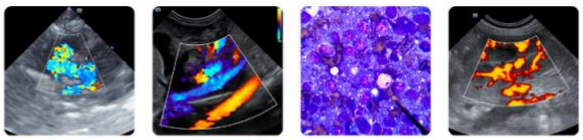

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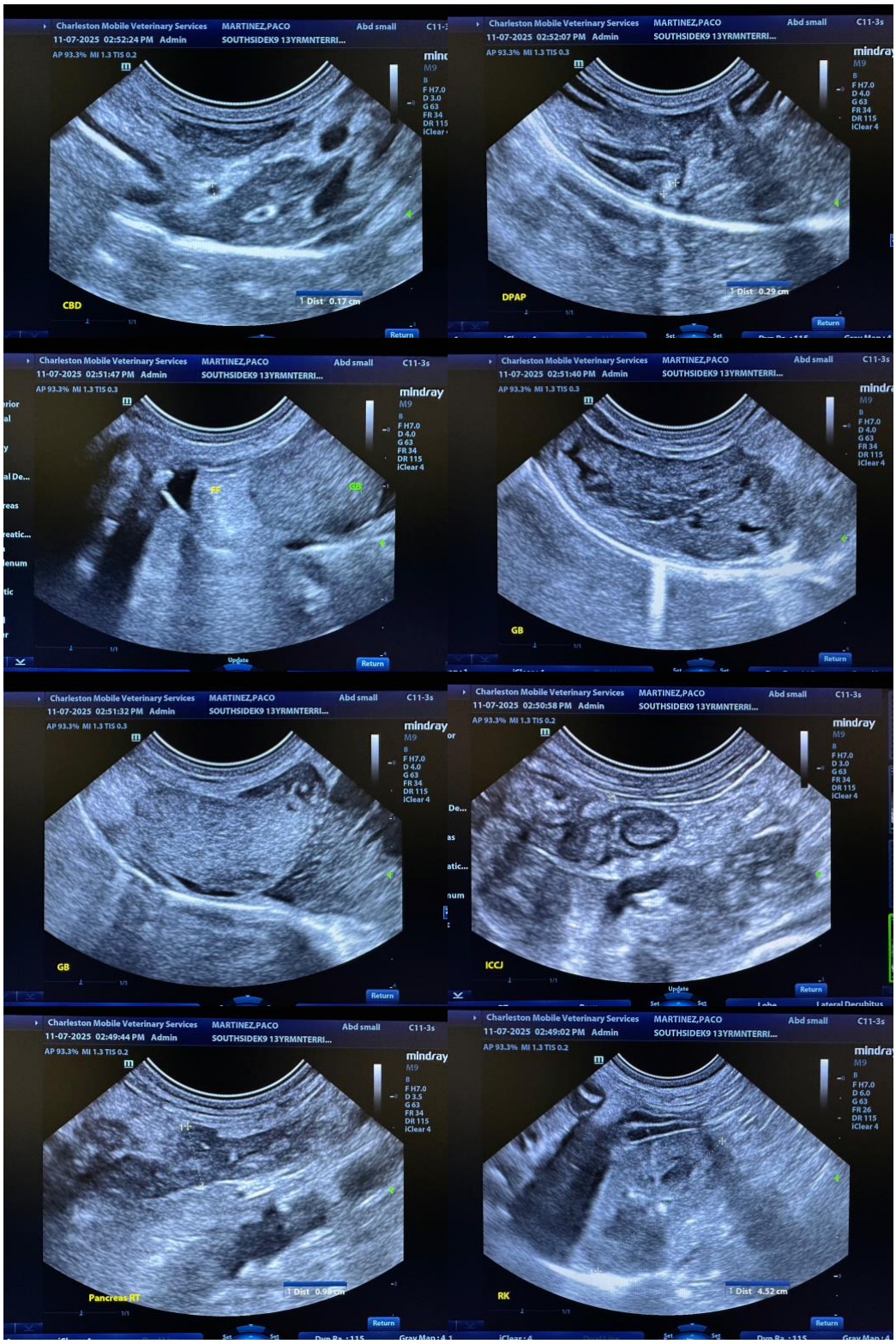

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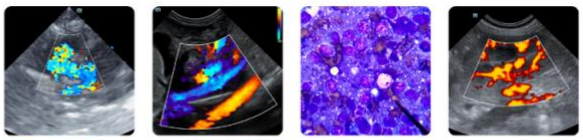

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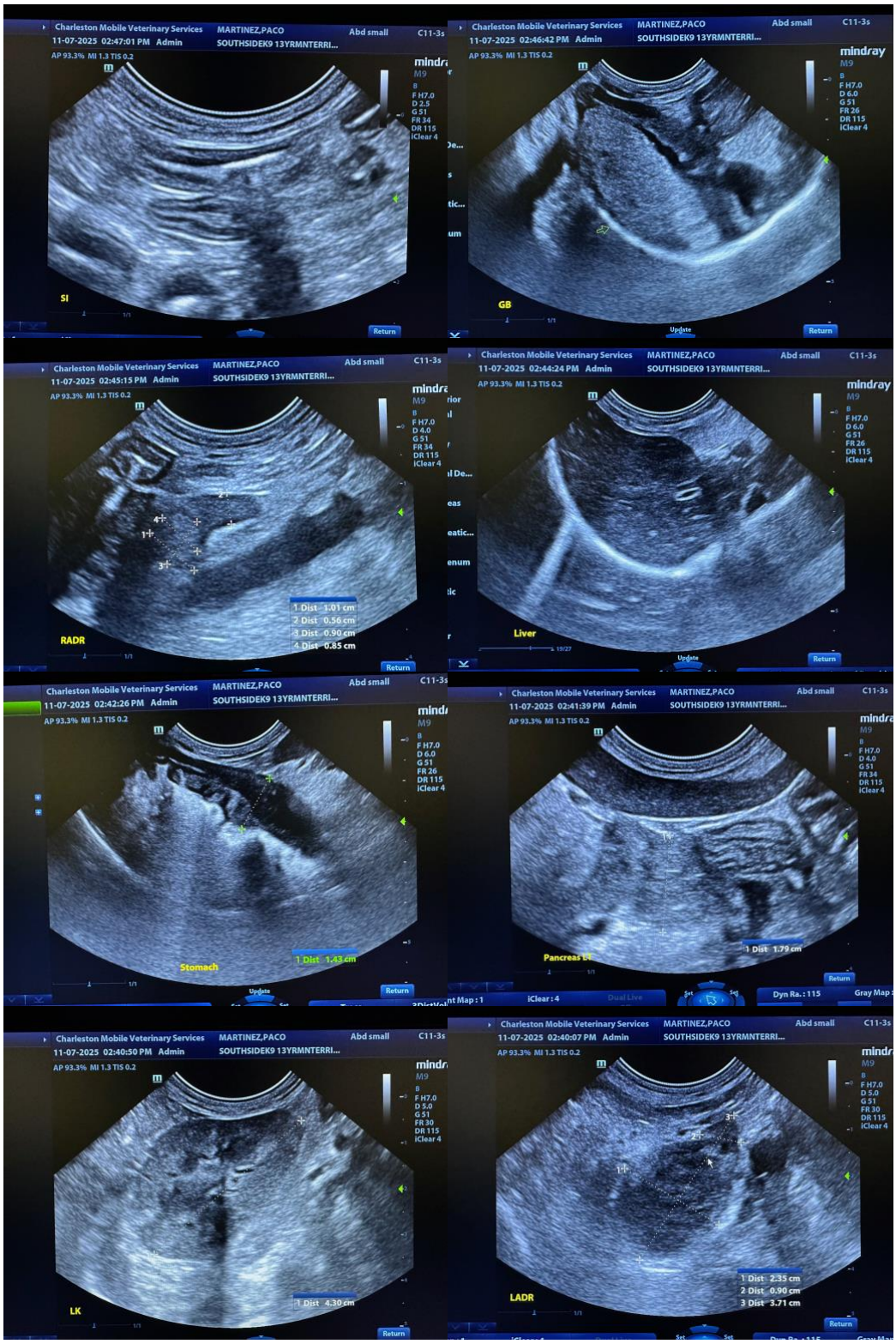

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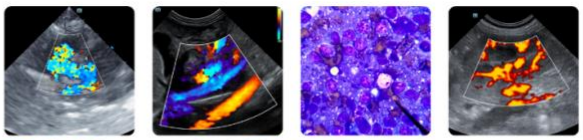

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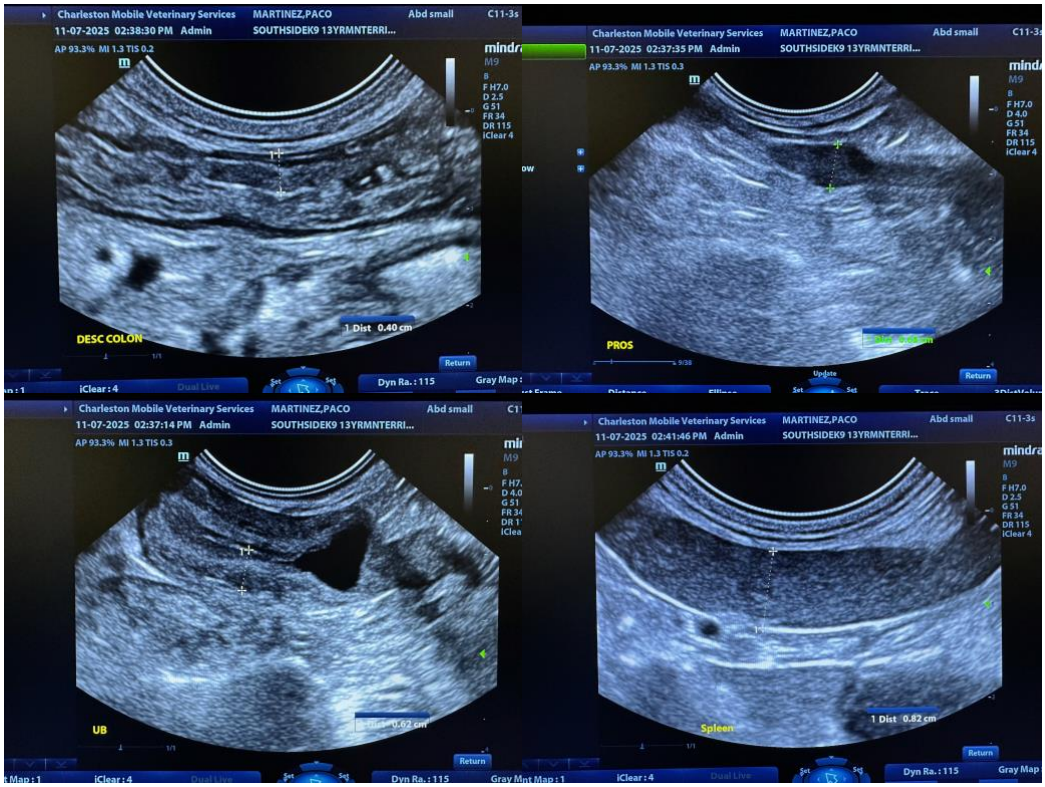

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Andrea Nicastro, MPH, DVM, Diplomate DACVIM (Small Animal Internal Medicine)
info@SonoPath.com