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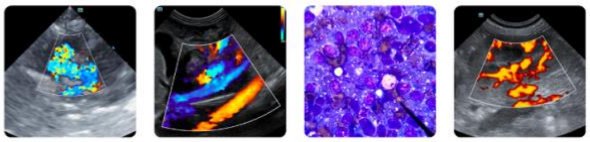
FOSTERING THE ART OF VETERINARY MEDICINE™



Clinical Sonography & Telecytology
Educational Teleconsultation Services™

SonoPath.com info@sonopath.com 1.800.838.4268

PATIENT

Bony Figueroa

SPECIES

Canine

BREED

Mixed

SEX

Female Spayed

AGE

12

WEIGHT

44.8 lbs

INTERPRETED BY

Andrea Nicastro, DVM, Diplomate ACVIM (Small Animal Internal Medicine)

IMAGING PERFORMED BY

Gabriel Ferrer DVM

HOSPITAL NAME

Pulse Pet Ultrasound Services

REFERRING VET

Dra. Soley Gonzalez

INVOICE

22305

DATE

12-22-25

PRESENTING CLINICAL SIGNS

History: Presented as a referral for an abdominal ultrasound to evaluate elevated liver enzymes, and hypoglycemia. PT presented to rDVM for routine exam and blood test and showed elevated ALP, ALT and hypoglycemia. Pt is not clinical and doing well at home. O did mention that pt is PU/PD and PP and recently developed urinary incontinence. DDx: insulinoma, liver or GB disease. Pt is currently no taking medications.

Abnormal PE/Chem/CBC/UA Results: Bloodwork: Attached as supporting documents ALT: 122, ALP: 294, Glucose 61, USG: 1.026, Protein 3+

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder wall is normal in thickness. 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 visible portion of the proximal urethra are normal.

The left kidney is normal in size (6.44 cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

The right kidney is normal in size (6.98cm in length) with a normal shape, architecture and smooth peripheral margins. There is a normal 1:3 cortex to medulla ratio with minimal to mild loss of corticomedullary distinction. There is no evidence of pyelectasia, nephroliths, infarcts or hydroureter.

Adrenal Glands

The left adrenal gland is mildly enlarged (0.63 cm at cranial pole) (0.73 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

The right adrenal gland is normal in size (0.59 cm at cranial pole) (0.58 cm at caudal pole) with a normal shape and homogenous parenchyma. The glandular echogenicity and detail are unremarkable. Capsule, cortex, and medullary definition are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

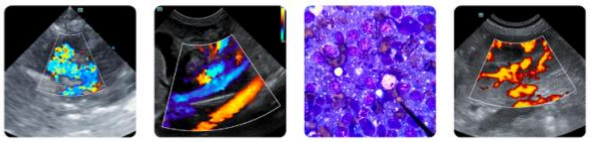
Spleen

The spleen is normal in size (1.90 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- to prominent-in-size with normal peripheral contours. The parenchyma is isoechoic relative to the spleen. A 2.7. 1.1 cm ill-defined, hypoechoic area is observed on the left side. The remaining parenchyma is homogenous. Hepatic vasculature and intrahepatic 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 lumen is moderately distended. The wall is thin and smooth. A 0.91 cm polypoid-like lesions is arising from the mucosal surface. A small amount of mobile echogenic debris is observed within the lumen. The cystic and common bile ducts are normal/not seen. The duodenal papilla is normal-in-size (0.30 cm in width).



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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 ileocecocolic junction and colonic wall are normal. There is no evidence of an obstructive pattern.

Pancreas

The right limb is visible, with minimal deviation from the normal peripheral contours. The parenchyma is isoechoic relative to surrounding omental fat. A 0.68 cm ill-defined, hypoechoic nodule/area is observed w/ the parenchyma. The pancreatic duct is not overtly dilated. There is no evidence of peripancreatic inflammation or effusion.

Lymph Nodes

The abdominal lymph nodes are normal/not visible.

Free Abdomen

The peritoneal cavity is normal. There is no evidence of inflammation or effusion.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The diffuse hepatic changes are most consistent with vacuolar hepatopathy (i.e., endocrine, idiopathic) with a lower possibility of inflammatory disease, infiltrative neoplasia, or other hepatopathy. The ill-defined hypoechoic nodule/area on the left side likely represents a benign process (i.e., regenerative nodule, inflammatory focus). However, an emerging tumor cannot be excluded.
- Suspected gall bladder polyp with gravity-dependent debris (non-mucocele)
- The hypoechoic nodule/area within the pancreas may represent a benign regenerative nodule, emerging tumor, other.
- Mild left adrenomegaly

Secondary Findings

- Minor bilateral nonspecific age-related renal changes
- The prominent mesenteric lymph node is likely reactive, with a low possibility of emerging neoplasia.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- Regarding the hypoglycemia, consider a repeat blood glucose (preferably on a glucometer). If hypoglycemia is persistent, an insulin: glucose ratio is recommended to further evaluate for insulinoma.
- Regarding the PU/PD, consider the following:

1. Urine culture and sensitivity to assess for occult infection
2. UPC to quantify the proteinuria

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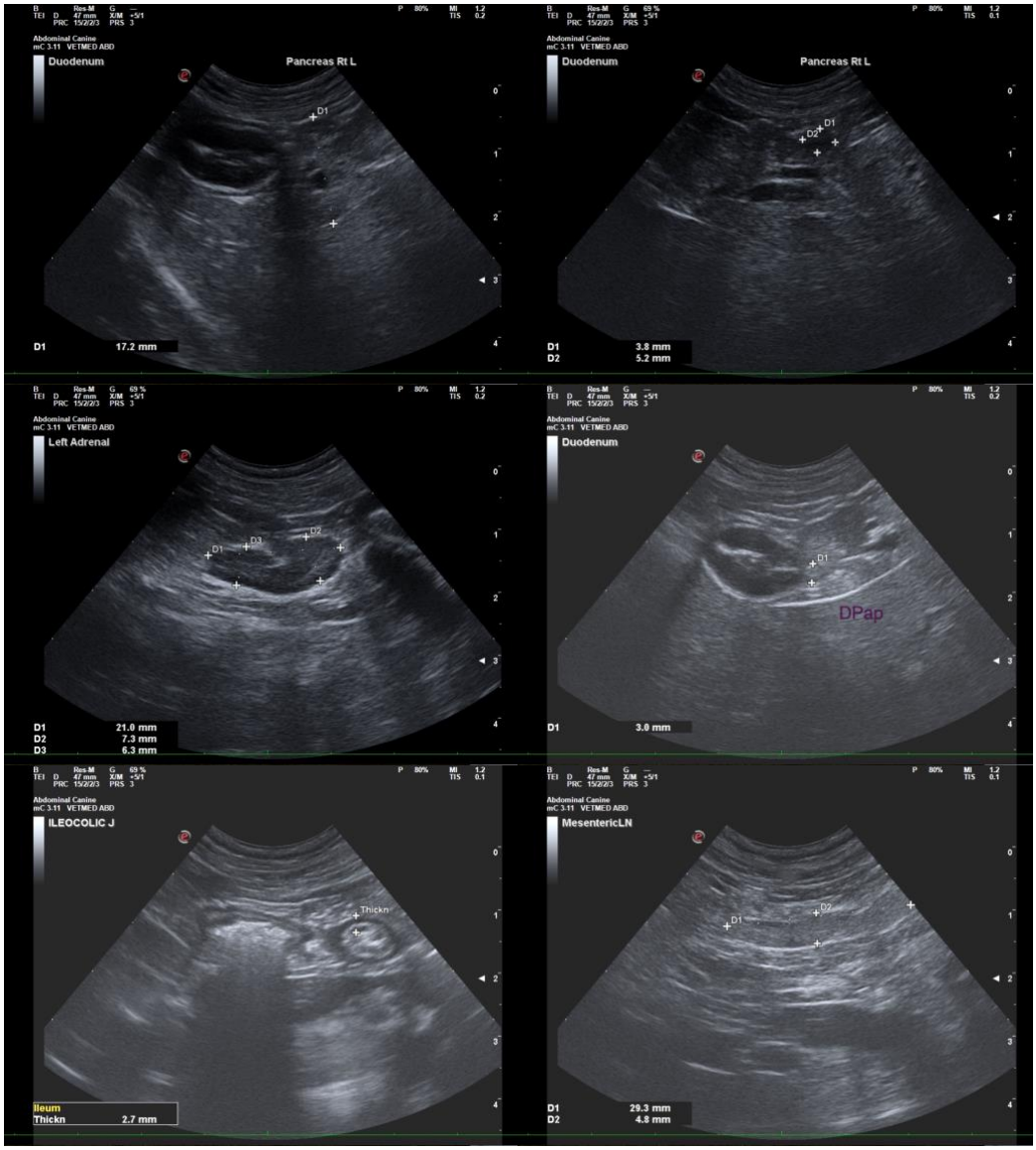
3. Consider testing for hyperadrenocorticism with a low-dose dexamethasone suppression test or ACTH stimulation test if clinical signs (i.e., PU/PD) develop in the future.
4. Depending on the results of the above diagnostics, further work-up (serial bile acids, DDAVP trial, +/- modified water deprivation test) may be indicated.



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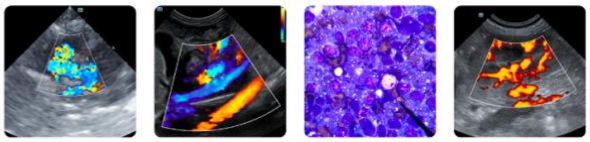

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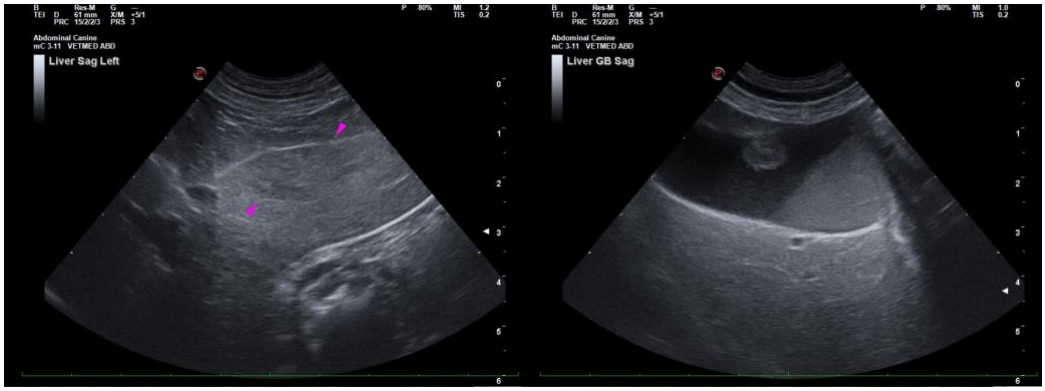

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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