



PATIENT PRESENTING CLINICAL SIGNS

Jazy Torres
SPECIES History: Px presented as a referral for an abdominal ultrasound to rule out a possible foreign body. Px presented to emergency vet 5/17/26 with acute onset of lethargy, anorexia, and pasty feces. Recent change in diet. No Hx of vomiting or diarrhea. Vx UTD. So far have: CBC - severe leukopenia, neutropenia. chem - severe hypoglycemia. fecal NOS. 4dx neg x 4. cPL normal. Abd rads - odd gas pattern in SI. concerns w/ possible linear FB. Currently hospitalized w/ Unasyn 22mg/kg IV tid, Baytril 10mg/kg IV SID, Cerenia 1mg/kg iv SID, famotidine 1mg/kg iv sid, LRS + 5% dextrose maint. NPO. No improvement noted since yesterday. BG continues mildly decreased 68, temp still 104.8.

Canine

BREED

Mix

Abnormal PE/Chem/CBC/UA Results: Mild anemia. Hematocrit 36 %, nonregenerative. (Bloodwork attached below for your reference).

SEX

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Female Spayed

Urinary System

AGE

8

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 the proximal urethra, visible to a depth of 1.5 cm, are normal.

WEIGHT

8.4 lbs

The left kidney is normal in size (4.02 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.

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The right kidney is normal in size (4.24 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.

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

Adrenal Glands

IMAGING PERFORMED BY

The left adrenal gland is enlarged at the cranial pole and normal-in-size at the caudal pole (0.97 cm at cranial pole) (0.50 cm at caudal pole). A 1.43 x 0.84 cm hyperechoic- to heterogenous nodule is observed at the cranial- to mid-aspect. Glandular echogenicity and detail at the caudal aspect are normal. The phrenicoabdominal vein and surrounding vasculature are normal.

Dr. Gabriel Ferrer

The right adrenal gland is normal in size (0.61 cm at cranial pole) (0.40 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.

HOSPITAL NAME

Pulse Pet
 Ultrasound Services

Spleen

REFERRING VET

Dr. Alma Alicea

The spleen is normal in size (1.07 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.

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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.

DATE

5-18-26

The gallbladder lumen is moderately distended. The wall is thin and smooth. A small- to moderate-amount of mostly gravity-dependent echogenic debris observed within the lumen. The cystic and common bile ducts are normal/not seen. The duodenal papilla is normal-in-size (0.22 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 duodenal wall is normal in thickness with a normal layering pattern and appropriate mural detail. The jejunal wall is normal in thickness. There is disruption in the normal 1:3 muscularis:mucosal ratio. Discreet masses are not identified. The ileocecolic junction and colonic wall are normal. There is no obvious evidence of an obstructive pattern.

Pancreas

The region of the pancreas is isoechoic relative to surrounding omental fat. No obvious parenchymal abnormalities are observed. There is no evidence of regional 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.

Other

The uterine stump is visible and is subjectively normal-in-size (0.37 cm in width). No obvious pathology is observed.

ULTRASONOGRAPHIC FINDINGS

Primary Findings

- The small intestinal wall changes could be consistent with inflammatory bowel disease or may be a normal variant for this patient. Correlation with the patient's clinical history is recommended.

Secondary Findings

- Minor bilateral age-related renal changes
- The left adrenal nodule could be consistent with focal nodular hyperplasia, adenoma, emerging adenocarcinoma, pheochromocytoma, other.

*An obvious cause for the patient's hypoglycemia is not identified in this study. Considerations include sepsis, insulinoma, atypical hypoadrenocorticism, hepatic dysfunction, toxicity (i.e., xylitol), other.

**An obvious cause for the patient's leukopenia and neutropenia is also not identified in this study. Considerations include sepsis or other infection, decreased bone marrow production, other.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

- A resting cortisol level to screen for hypoadrenocorticism. If resting cortisol level is < 2.0 mcg/dL, an ACTH stimulation test is recommended.
- A fecal evaluation for ova and Giardia should be considered.
- Pre- and postprandial serum bile acids are recommended to assess hepatic function.
- Consider an insulin: glucose ratio to further evaluate for insulinoma.



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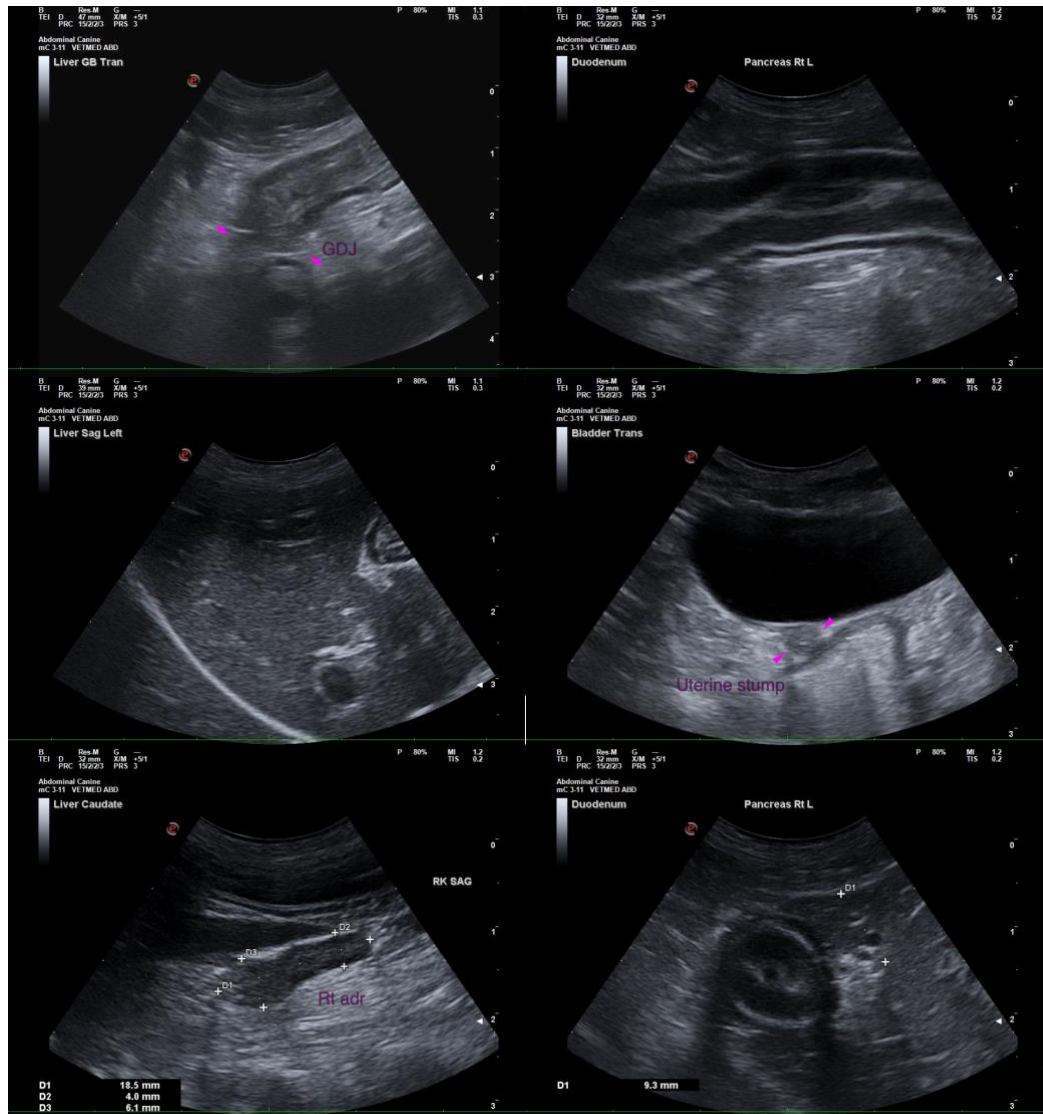
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- Three-view thoracic radiographs are also recommended to assess for a nidus of infection in the thorax.
- While awaiting test results, continued aggressive supportive care, including broad-spectrum antibiotic therapy is recommended.
- If patient remains bicytopenic, a bone marrow aspirate may be warranted.



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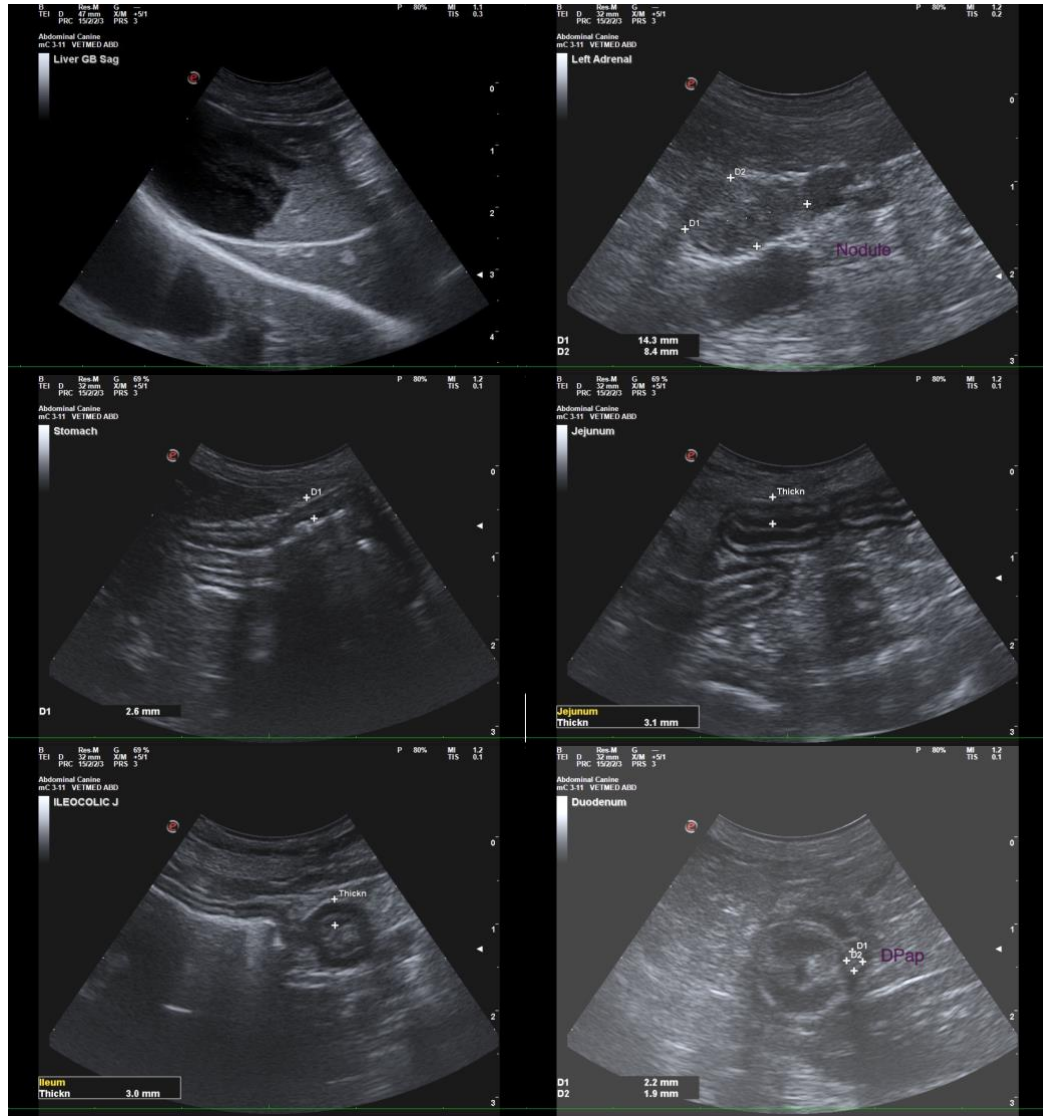
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

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