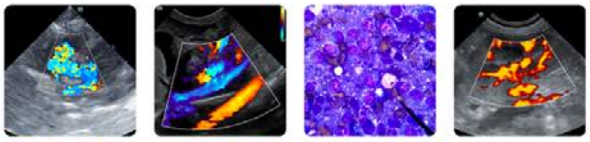


PATIENT

Suki Acevedo Vila

SPECIES

Canine

BREED

Shih Tzu

SEX

Spayed Female

AGE

14

WEIGHT

13 lb

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Gabriel Ferrer, DVM

HOSPITAL NAME

Pulse: Pet Ultrasound

REFERRING VET

Dr. Diaz Umpierre

INVOICE

72009

DATE

1/7/26

PRESENTING CLINICAL SIGNS

Px presented as a referral for polydipsia and polyuria. Additionally, Px had episodes of hematuria on December 27, 2025. No episodes of diarrhea or vomiting were reported.

Abnormal PE/Chem/CBC/UA Results: Bloodwork panels have been attached as supporting documents. Elevated Ca++ Elevated Glob Elevated ALT Elevated ALKP Elevated MON

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

Urinary bladder is adequately distended with primarily anechoic contents and occasional echogenic non-shadowing debris. Apical urinary bladder wall is diffusely thick (0.42 cm). Mucosa is hyperechoic and irregular. No masses or cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface.

Kidneys are bilaterally irregular and diffusely echogenic with decreased corticomedullary distinction and poor visualization of internal architecture. The left kidney is small-normal at 3.72 cm with trace pyelectasia noted. The right kidney is normal in size at4.3 cm with mild pyelectasia measuring 0.30 cm in the transverse view. Non-obstructive linear multifocal hyperechoic diverticular foci with acoustic shadowing are noted bilaterally.

Adrenal Glands

The right adrenal gland is plump/swollen in size, measuring 0.91 cm at the cranial pole and 0.88 cm at the caudal pole. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal.

The left adrenal gland is enlarged in size (3.3 cm x 4.7 cm), with moderate heterogeneous parenchymal changes and suspect pinpoint mineralization. Swollen capsular expansion is noted. No vascular invasion is visible in these images at this time. However, early or subtle vascular invasion can't be definitively ruled out.

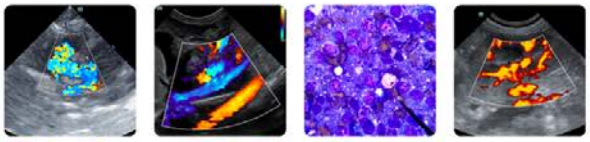
Spleen

Spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). Multifocal mineral foci are noted. Additionally, at the hilus there is an approximately 0.09 cm x 1.2 cm homogeneous hypoechoic "bulge", potential accessory spleen versus nodule versus other. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is moderately heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion

Gallbladder is mildly overdistended with a moderate amount of non-dependent, mildly aggregated/inspissated sludge. Hypo to anechoic cystic areas are noted between the gallbladder sludge and luminal wall. The wall is otherwise smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion.



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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is empty with no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

Pancreas is prominent (enlarged) in size and mildly irregular in shape with a slightly undulating contour. Parenchyma is coarse in echotexture and heterogenous to hypoechoic in echogenicity.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

ULTRASONOGRAPHIC FINDINGS

- The left adrenal mass is concerning for primary adrenal disease/neoplasia, including both benign adenoma as well as adenocarcinoma versus pheochromocytoma versus other. Adrenal hyperplasia secondary to pituitary dependent hyperadrenocorticism, especially given the concurrent right adrenomegaly can't be ruled out but is considered less likely to be a sole cause. Both adrenal dependent and pituitary dependent hyperadrenocorticism can occur simultaneously.

- Moderately Heterogenous Liver – These changes are most consistent with benign processes such as nodular hyperplasia, steroid (vacuolar) hepatopathy, extramedullary hematopoiesis or possibly chronic inflammatory disease and less commonly infiltrative round cell or metastatic neoplasia.

- Spleen mineralization – This is a benign change but can be associated with endocrinopathies, especially hyperadrenocorticism. The density described at the hilus could represent a benign nodule or even benign accessory spleen. Infiltrative neoplasia can't be ruled out but is considered less likely.

- Emerging mucocele – Cholecystic debris is of unknown clinical significance. It can be seen with biliary stasis from fasting or illness. Cholecystic debris is not necessarily related to hepatobiliary disease. The non-dependent nature of this sludge combined with the cystic areas are suggestive, however, of possible emerging cystic mucosal hyperplasia or early gallbladder mucocele.

- Chronic low-grade pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs.

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- Moderate chronic kidney disease changes with non-obstructive dystrophic mineralization and pyelectasia noted bilaterally – This finding could be in part normal aging change and should be interpreted in combination with laboratory results, etc.

- Chronic Cystitis - Urinary bladder wall changes are most consistent with chronic cystitis. Infiltrative neoplasia cannot be ruled out but is considered less likely give the location and diffuse nature of the changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given the bilateral adrenal changes, it is difficult to determine pituitary versus adrenal disease based on ultrasound alone if hyperadrenocorticism is diagnosed. Therefore, additional testing is recommended, beginning with a low-dose Dexamethasone suppression test. In the meantime, if not recently evaluated, a blood pressure is also recommended.

Urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ration is recommended.

Ultimately, however, advanced imaging such as an abdominal CT scan may be helpful, especially to further investigate vascular invasion if present, pre-stage for surgery if elected, etc.

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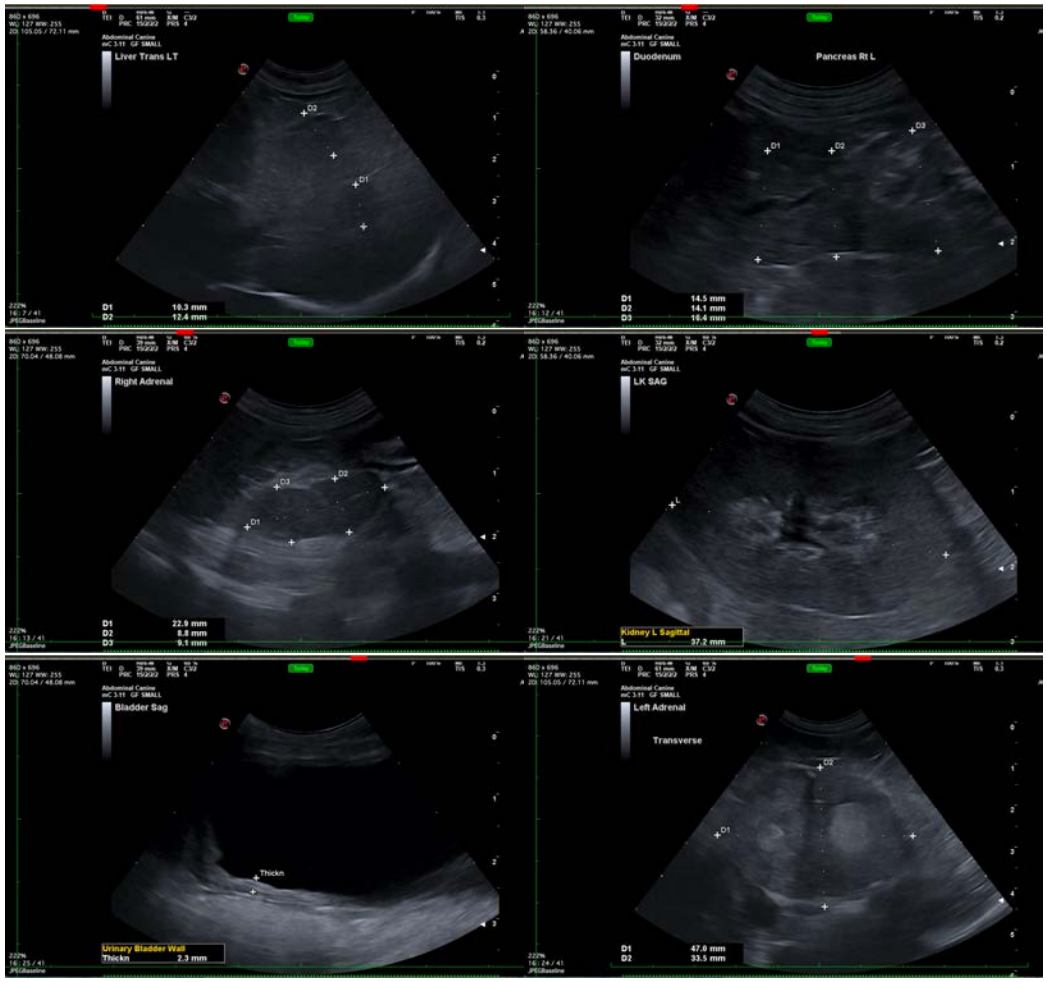

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
info@sonopath.com