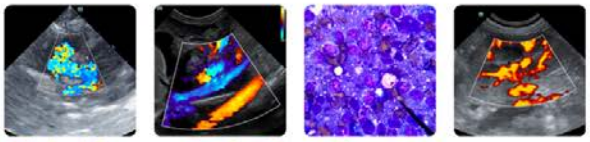


PATIENT

Jerry Gonzalez

SPECIES

Canine

BREED

Chihuahua

SEX

Intact Male

AGE

15 Years

WEIGHT

4.0 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Gabriel Ferrer, DVM

HOSPITAL NAME

Pulse: Pet Ultrasound

REFERRING VET

Dr. Andrea Negron

INVOICE

73846

DATE

3/19/26

PRESENTING CLINICAL SIGNS

Px presented as a referral. rDVM reported the following: P presented at clinic on 3/11/26 as a follow up appointment. They were seen on ER on February 22, 2026 due to weakness, lethargy and 2 days of anorexia. On ER P had, CBC (Mild Monocytosis and Moderate Thrombocytopenia) Chem (Moderately elevated Liver enzymes), Radiographs (Mild to moderate hepatomegaly), U/A (Hypersthenuria, remainder wnl). P was hospitalized for 2 days with IV fluids and started on Denamarin, Ursodiol and entyce. P was discharged and asked to repeat BW in 14d. Per O, P never really improved much after hospitalization: P was still lethargic and would only eat when entyce was given. On 3/11/26, P had recheck BW: CBC (Mild anemia, Marked thrombocytopenia, Mild neutrophilia) Chem (No improvement on liver values). A-Fast was done in clinic and a large round hyperechoic structure was noted inside gall bladder. Recommended continuing liver medications and supplements and getting full abdominal U/S.

Abnormal PE/Chem/CBC/UA Results: Bloodwork and radiographs attached below for your reference

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

The prostate has a relatively normal appearance for an intact dog, measuring 1.5 cm wide in the transverse view.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of pyelectasia, mineral or infarcts observed. Left kidney measures 3.34 cm. Right kidney measures 3.3 cm.

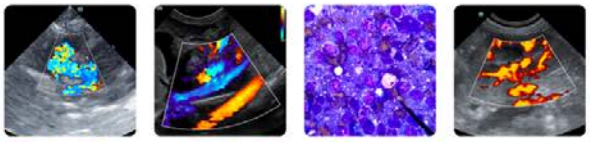
Adrenal Glands

The right adrenal gland is normal in size (0.62 cm at cranial pole and 0.51 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal. *See other.

The left adrenal gland is normal in size (0.66 cm at cranial pole and 0.61 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

The 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), except for an approximately 1.1 cm x 1.2 cm homogeneous, hypo- to anechoic, expansive but non-capsule disrupting nodule/mass near the caudal aspect of the spleen. Splenic vasculature appears normal.



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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. The common bile duct is mildly dilated, measuring 0.50 cm at the duodenal papilla. There is no evidence of effusion.

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

The pancreas that is observed appears appropriately isoechoic to surrounding omental fat. Visible capsule is smooth and normal in contour. Visible pancreatic parenchyma is homogenous and unremarkable. There is no visible pancreatic duct dilation. There is no evidence of active peripancreatic inflammation.

Free Abdomen

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

There is no apparent pathologic lymphadenopathy noted in these images.

In the right cranial abdomen, there is an approximately 2.0-2.2 cm x 2.5-3.5 cm heterogeneous, hypoechoic mass that is difficult to determine the origin of. Differentials include attachment to the right adrenal/right adrenal mass, potentially liver or pancreas, or even the reportedly cryptorchid right testicle/testicular mass can't be ruled out. Having said that, in other images labeled "possible right testicle", there is an approximately 0.70 cm x 1.0 cm hypoechoic structure that could also potentially represent a cryptorchid testicle.

PRIMARY FINDINGS

- 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.

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- 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.

- The splenic nodule/mass could represent a benign hematoma, extramedullary hematopoiesis, other, or an infiltrative primary or metastatic neoplastic nodule or mass can't be ruled out.

- The right cranial abdominal mass is of unknown origin. It is difficult to determine which of the labeled right testicle structures are the right testicle, with either of them being possible. As described above, a mass in the right cranial abdomen of other origin such as liver, adrenal, pancreas, etc. is also possible.

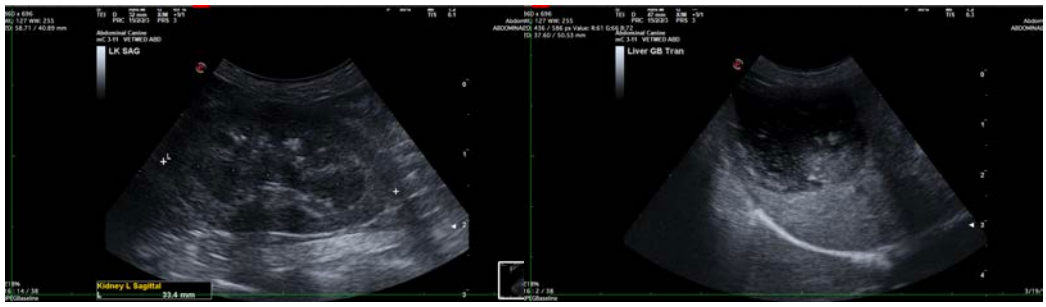
SECONDARY FINDINGS

- Age related kidney changes.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Given patient's history of cryptorchid combined with the cytopenias, a retained testicle/testicular tumor, possibly Sertoli cell tumor, contributing to the cytopenias is a differential. Other causes of the cytopenias, however, are also differentials. Given the difficulty determining the origin of especially the right cranial mass, advanced imaging such as an abdominal CT scan could be considered. Alternatively, tissue sampling of the abnormal structures including that mass, the spleen, the liver, etc. could be considered if/when patient's coagulation status is appropriate, or an exploratory laparotomy to more definitively find and remove the right testicle as well as further assess and potentially remove the gallbladder may be warranted, as the emerging gallbladder mucocele could also be contributing to patient's reported clinical signs, as well as the liver enzyme changes, etc.

In the meantime, if not recently evaluated, three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.



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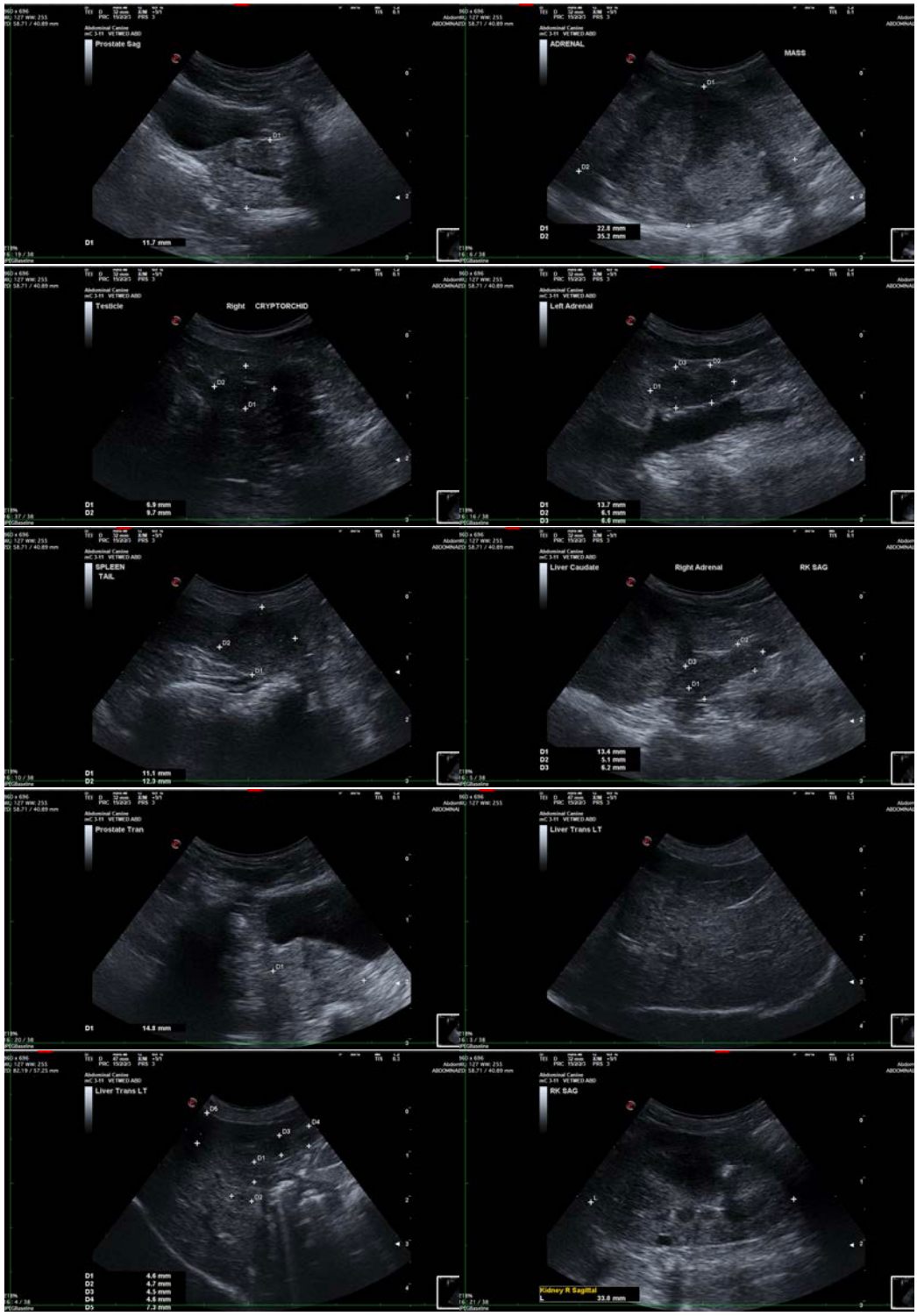

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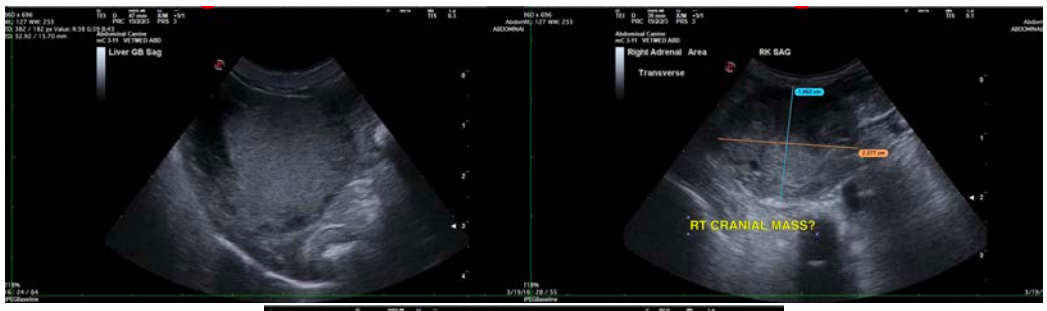

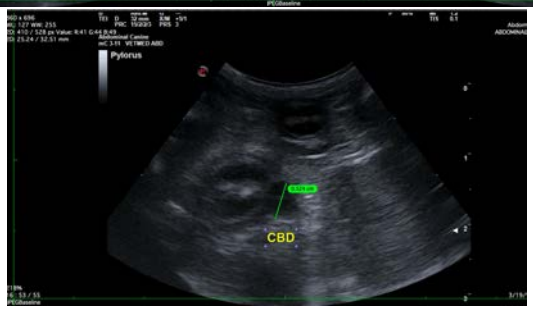

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
info@sonopath.com