PATIENT

Kooper Materasso

SPECIES

Canine

BREED

Pitbull

SEX

MN

AGE

11 years

WEIGHT

84.8 lbs

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Loetitia Saint-Jacques, LVT

HOSPITAL NAME

MountainView

REFERRING VET

Dr. Brown

INVOICE

11785

DATE

4/23/2026

PRESENTING CLINICAL SIGNS

Patient has been having a chronic history of vomiting intermittently with a cough/hack. Radiographs were performed a few weeks ago which did not show anything remarkable, but this week patient has been vomiting and unable to hold any food down. He will vomit hours after eating. He is drinking excessive water as well. On PE, he is tacky in his mm, and is painful with cranial abdominal palpation. Repeat radiographs of the abdomen performed on 4.22.26 which showed scant granular material within the stomach and colon but no obstructive pattern and hepatomegaly. In house SNAP cPL is abnormal, and full blood work is pending. Patient is currently being treated for pancreatitis. Evaluate for a cause of vomiting and confirm pancreatitis vs other cause.

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.

Prostate is normal in size, echotexture, and echogenicity for a neutered male.

The right kidney is normal is size (7.69 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

The left kidney is normal is size (7.14 cm), shape and echogenicity. It has smooth peripheral margination. There is a normal 1:3 cortex to medulla ratio with appropriate corticomedullary distinction. There is no evidence of pyelectasia, mineral or infarcts observed.

Adrenal Glands

The right adrenal gland is normal in size (0.8 cm at cranial pole and 0.68 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is mildly large in size at the cranial pole as a result of a hyperechoic nodule in that area. Normal shape and contour are maintained without evidence of capsular invasion. Corticomedullary structure is unremarkable. Visible surrounding vasculature appears normal. The cranial pole measures 1.2 cm. The caudal pole measures as normal at 0.78 cm. Nodule does not disrupt normal shape and/or architecture.

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 well-demarcated hyperechoic homogenous nodules are noted. Splenic vasculature appears normal.

Liver

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

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The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.

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.

Diffuselt the visible small intestine demonstrates areas of moderate to severely thick muscularis layer relative to mucosa (disruption of the normal 1:3 muscularis:mucosa ratio). Small intestinal submucosa is slightly irregular, thick and hyperechoic. In the right cranial abdomen, involving the very proximal duodenum, there's a focal bowel wall thickening measuring 1.5 cm thick with loss of layering for approximately 7.0 cm in length. The lumen of the small intestine is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction or foreign material noted.

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.

Cranial abdominal and mesenteric lymph nodes are prominent in size with swollen capsular contour. Normal elongated shape (length to width ratio) is maintained. There is no loss of parenchymal detail.

PRIMARY FINDINGS

- The proximal focal bowel/duodenal changes are concerning for infiltrative neoplasia such as round cell neoplasia i.e. lymphoma versus carcinoma versus other. Having said that, a benign inflammatory or aggressive infectious process can't be ruled out without tissue sampling.
- Moderately reactive cranial abdominal and mesenteric lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- Diffusely, the moderate bowel changes trend more in appearance toward benign.
- 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.

SECONDARY FINDINGS

- Hyperechoic splenic nodules – most consistent with benign myelolipomas. Other differentials such as fibrosis or calcification caused by old hematomas or infarcts, chronic inflammation,

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granulomatous disease or metastatic disease cannot be ruled out, but are considered less likely.

- Hyperechoic adrenal nodule in the cranial pole of the left adrenal – Differentials include primary adrenal cortical adenoma or adenocarcinoma, pheochromocytoma, myelolipoma, adrenal hyperplasia secondary to pituitary disease or metastatic disease. Ultrasound alone cannot differentiate between functional and non-functional nodules and/or between benign and malignant disease. Small nodules without other evidence of abdominal disease (to suggest metastatic disease) and/or clinical signs (to suggest adrenal disease) are most often incidental and should be monitored.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

AS is reportedly already pending, a full general metabolic health screen is recommended to include CBC. Chem Panel, electrolytes and urinalysis.

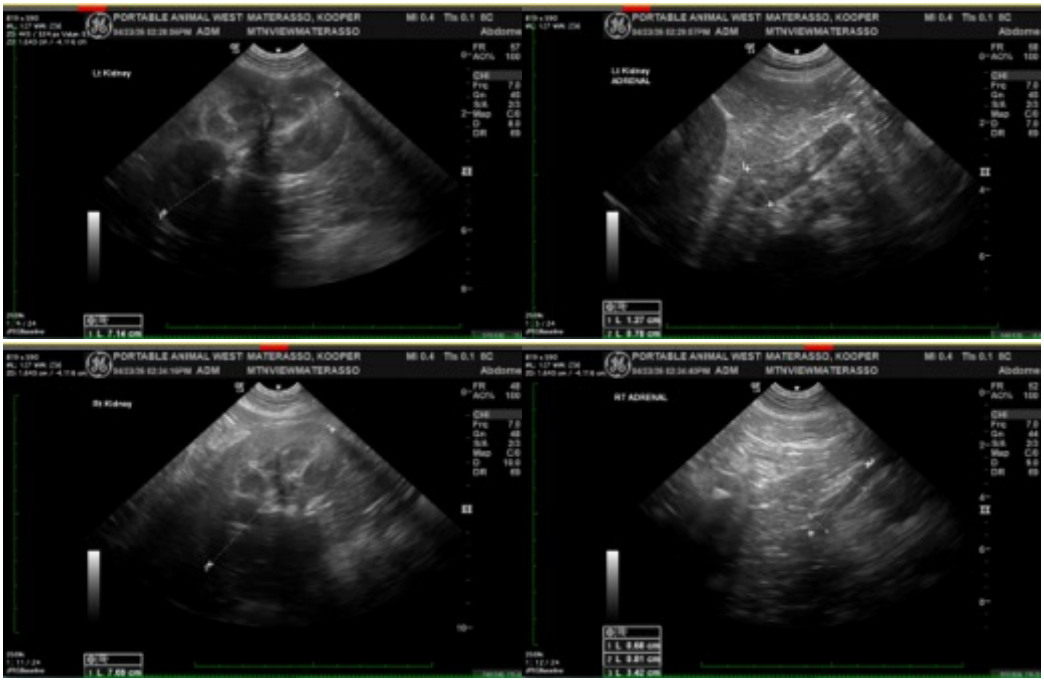
Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

Fine needle aspirates of the proximal duodenal wall +/- liver could be considered if patient's coagulation status is appropriate.

Alternatively, upper GI gastroscopy/endoscopy can be considered for a further visual evaluation and biopsies.

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

Other than supportive/symptomatic medical management of clinical signs, further diagnostic and treatment recommendations are largely dependent on results of the above.



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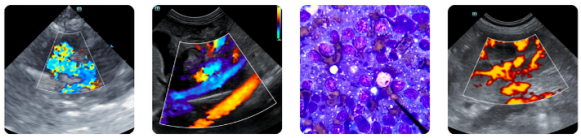

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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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