



PATIENT

Scout Caragiulo

SPECIES

Canine

BREED

Jack Russel Mix

SEX

MN

AGE

11 years

WEIGHT

20 lbs

INTERPRETED BY

Beth Johnson, DVM
DACVIM

IMAGING PERFORMED BY

Dr. Julia Bakker

HOSPITAL NAME

Orange Blossom
Veterinary Imaging

REFERRING VET

Dr. Zachary Pearl

INVOICE

11926

DATE

5/11/2026

PRESENTING CLINICAL SIGNS

4/22: Presented for 1–2 wk lethargy, hunched posture, slow movement, urinary accidents, PU/PD, panting. Exam noted cervical/spinal discomfort, severe periodontal disease, luxating patellas. Started on carprofen, methocarbamol, and gabapentin for suspected back pain. Started Clopidogrel and telmisartan for stroke risk. Labs that visit: significant proteinuria, isosthenuria, mildly elevated globulin. Systolic BP 180 mmHg. 5/5: Witnessed seizure-like / collapse event while urinating – fell laterally, shook 2–10 sec, recovered but persistently dull and ataxic since. Systolic BP 220 mmHg. Suspected small mass at the tail of the spleen. Working clinical picture: Suspected hypertensive vascular event (stroke). DDx for the hypertension include idiopathic, renal disease, hyperadrenocorticism, and pheochromocytoma. Splenic mass possibly incidental but unconfirmed. Radiographs: Thoracic and abdominal films unremarkable.

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.

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 4.61 cm and the right kidney measures 5.23 cm.

Adrenal Glands

The right adrenal gland is enlarged (2.57 cm at the cranial pole and 0.46 cm at the caudal pole) with mild heterogenous parenchymal changes. Swollen capsular expansion is noted (at the cranial pole measuring 2.5 cm x 3.0 cm overall in size) without evident capsular escape or vascular invasion.

The left adrenal gland is normal in size (0.59 cm at cranial pole and 0.5 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

Spleen

Near the mid to caudal aspect of the spleen is an expansive, disruptive, approximately 4.1 cm x 2.0 cm in size irregular, hypoechoic density/mass. The cranial aspect of the spleen has a more normal shape, size, and overall appearance except for an additional 0.5 cm x 1.0 cm non-capsular disrupting, hypo- to anechoic density in that area.

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 moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. Some mineral/sand debris and non-visibly obstructive pinpoint cholecystoliths can't



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be ruled out. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach 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. 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 a small amount of free fluid noted primarily adjacent to the caudal aspect of the spleen.

There is no apparent pathologic lymphadenopathy noted in these images.

The visible heart base (RA) and pericardium are unremarkable without obvious pathology noted in these images at this time. If cardiac function evaluation is desired, a full echocardiogram is recommended.

PRIMARY FINDINGS

- Right adrenal mass with a concurrently normal left adrenal gland – most consistent with an adenoma (vs adenocarcinoma) given the concurrent flat contralateral adrenal gland. Hyperplasia secondary to pituitary dependent hyperadrenocorticism is possible but considered less likely. There are no characteristics of malignancy to rank malignancy over benign disease. While considered less likely, pheochromocytoma also cannot be ruled out. Interpret in combination with clinical signs of hyperadrenocorticism or other adrenal disease.
- The splenic changes may or may not be related to patient's reported clinical history and/or the right adrenal mass and could represent either benign processes such as hematomas, extramedullary hematopoiesis, etc. or infiltrative neoplasia such as sarcoma, round cell neoplasia, metastatic disease, other, can't be ruled out without tissue sampling. Especially in the face of concurrent free fluid.

SECONDARY FINDINGS

- Moderate age-related kidney changes.
- Moderate gallbladder debris - 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



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hepatobiliary disease. Echogenic bile is most commonly an incidental finding in dogs and should be interpreted in combination with clinical signs such as nausea, inappetence, cranial abdominal discomfort and/or laboratory changes such as increased ALP and/or increased Tbili. Non-visibly obstructive mineral/sand debris is suspected within the gallbladder.

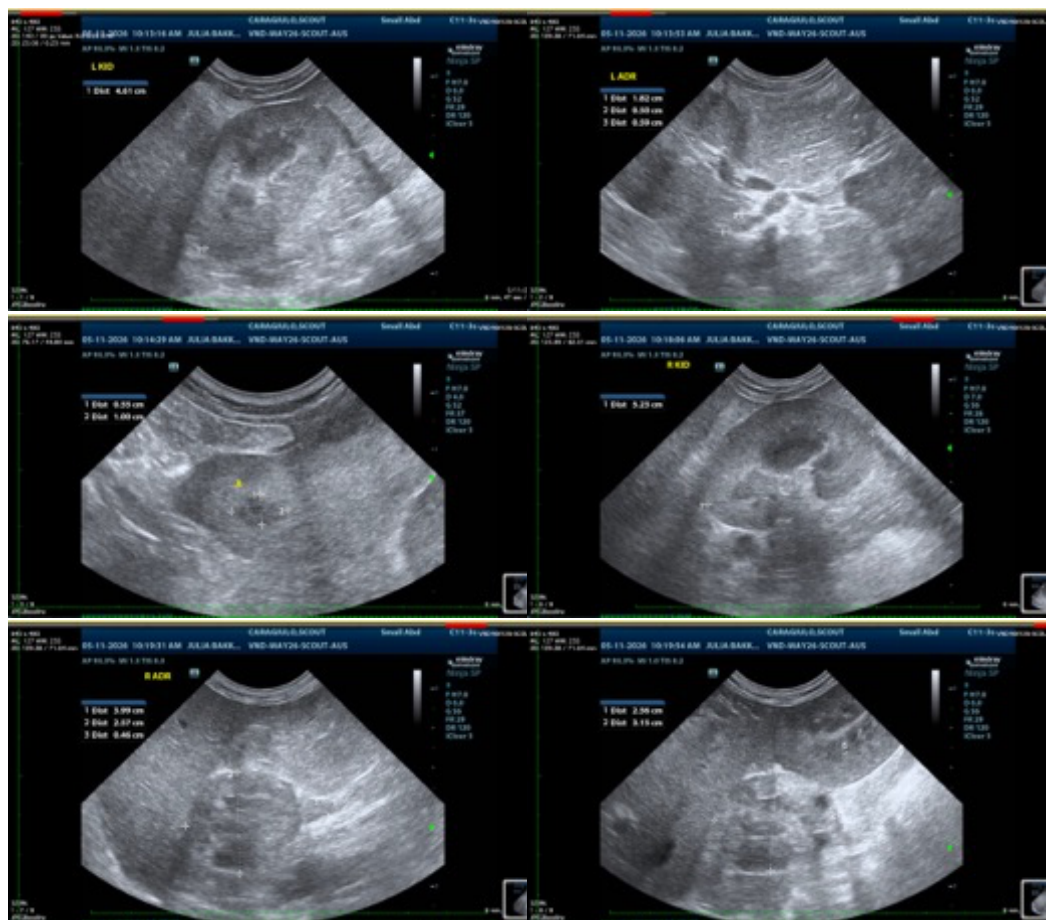
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

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 splenic masses +/- the right adrenal mass could be considered if patient's coagulation status is appropriate.

In the meantime, hormone testing beginning with a low dose dexamethasone suppression test is recommended.

Ultimately, pending results of above workup combined with pending treatments elected, etc. advanced imaging such as an abdominal +/- concurrent thoracic contrast CT scan(s) may be warranted.





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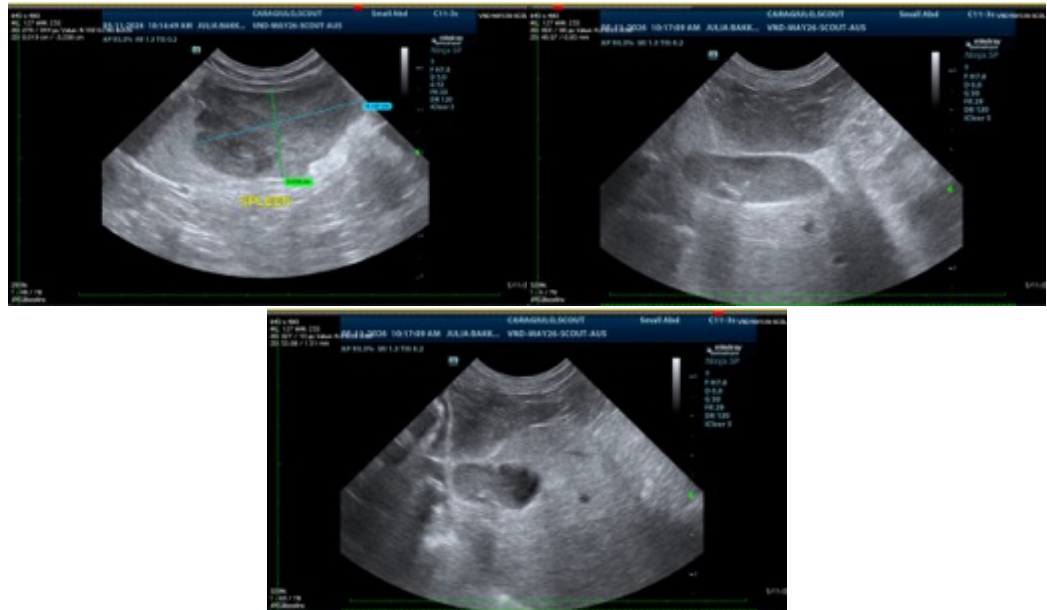
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Beth Johnson, DVM, DACVIM
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