



## PATIENT

Kylo Cintron

## SPECIES

Canine

## BREED

Mixed

## SEX

Neutered Male

## AGE

12 Years

## WEIGHT

38.6 lbs

## INTERPRETED BY

Beth Johnson, DVM  
DACVIM

## IMAGING PERFORMED BY

Gabriel Ferrer, DVM

## HOSPITAL NAME

Pulse: Pet Ultrasound

## REFERRING VET

Dr. Jose Barrera

## INVOICE

74923

## DATE

5/5/26

## PRESENTING CLINICAL SIGNS

Px presented as a referral for an abdominal ultrasound due to Hx of vomiting and a suspected abdominal mass seen in radiographs. Px originally visited rDVM for annual dental prophylaxis, but on preliminary radiographs there was a suspected mass effect seen on the radiographs. Bloodwork performed was parameters were mostly WNL. No diarrhea, no inappetence, no coughing, no lethargy, no sneezing, occasionally some soft stool.

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

## ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

### Urinary System

Urinary bladder is only mildly distended (empty). Visible contents are anechoic. Urinary bladder wall is unable to be fully assessed for pathology without further distension. No visible masses or definitive cystoliths are observed. The trigone and visible pelvic urethra are normal thickness with a smooth mucosal surface. In the face of urinary signs and/or suspected urinary bladder pathology, reassessment after complete filling is recommended.

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

The right kidney is normal is size (5.5 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 (5.7 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 (0.61 cm at cranial pole and 0.64 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.48 cm at cranial pole and 0.89 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. A hyperechoic nodule is noted in the caudal pole. Nodule does not disrupt normal shape and/or architecture. 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). No focal nodules or masses are observed. Splenic vasculature appears normal.

### Liver

The liver is subjectively normal in size with normal smooth curvilinear peripheral contour. Parenchyma is appropriately hypoechoic to the spleen in echogenicity and appropriately mildly coarse and homogenous in echotexture. No focal lesions are observed. Visible vasculature and biliary tree appear normal without distension or congestion.



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Gallbladder is moderately distended with anechoic bile as well as suspended and gravity dependent echogenic debris. The wall is smooth without visible thickening. There is no evidence of cystic or CBD dilation. There is no evidence of effusion or inflammation.

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### **Gastrointestinal**

The visible stomach wall is normal in thickness and layering. The stomach is moderately distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. If patient was appropriately fasted, delayed gastric emptying could be considered. Non-shadowing foreign material is considered less likely but cannot be definitively ruled out.

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If clinical signs are consistent (vomiting, etc.), recommendations include supportive medical care, 24 hours fasting and re-image.

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The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen is mildly distended with echogenic non-shadowing luminal contents and gas consistent with normal ingesta/chyme. There is no evidence of obstruction, foreign material or infiltrative disease.

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

### **Pancreas**

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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.

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Mesenteric and medial 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.

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### **PRIMARY FINDINGS**

- Chronic smoldering low-grade pancreatitis can't be ruled out and should be suspected in the face of appropriate clinical signs without another underlying cause.
- Mild reactive mesenteric and medial iliac lymph nodes – infiltrative neoplastic disease cannot be ruled out but is considered less likely.
- 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 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.
- This appears to be at least a partial post-prandial study. Having said that, given patient's reported fasting, non-shadowing, non-visibly obstructive foreign material, especially within the

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stomach, while thought less likely can't be definitively ruled out. Some mild delayed gastric emptying could be present, but that would not explain the ingesta within the small bowel.

## SECONDARY FINDINGS

- Hyperechoic adrenal nodule in the caudal pole of the left adrenal gland.

## INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

Recheck imaging of the gastrointestinal tract following an additional 12-24 hours of fasting could be considered to try to examine the empty GI tract and further ruled out pathology resulting in the contents versus some residual ingesta. Beyond that, further gastrointestinal workup recommendations include a routine fecal/giardia exam.

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.

A baseline cortisol is recommended. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.

In the meantime, supportive/symptomatic medical management of clinical signs is recommended, including anti-emetics, gastroprotectants (+/- sucralfate, especially with any history of hematemesis), an appetite stimulant and fluid therapy if indicated, etc.

Additionally, empirical deworming with a 5-day course of Panacur is recommended as is a full course of empirical Helicobacter triple therapy.

Finally, if tolerated, a transition in diet could be considered, based on trial-and-error response with some options to consider including a gastrointestinal biome diet vs a hydrolyzed protein diet (sometimes several trials with different brands are necessary) vs an easy to digest, bland or low-fat diet vs other.





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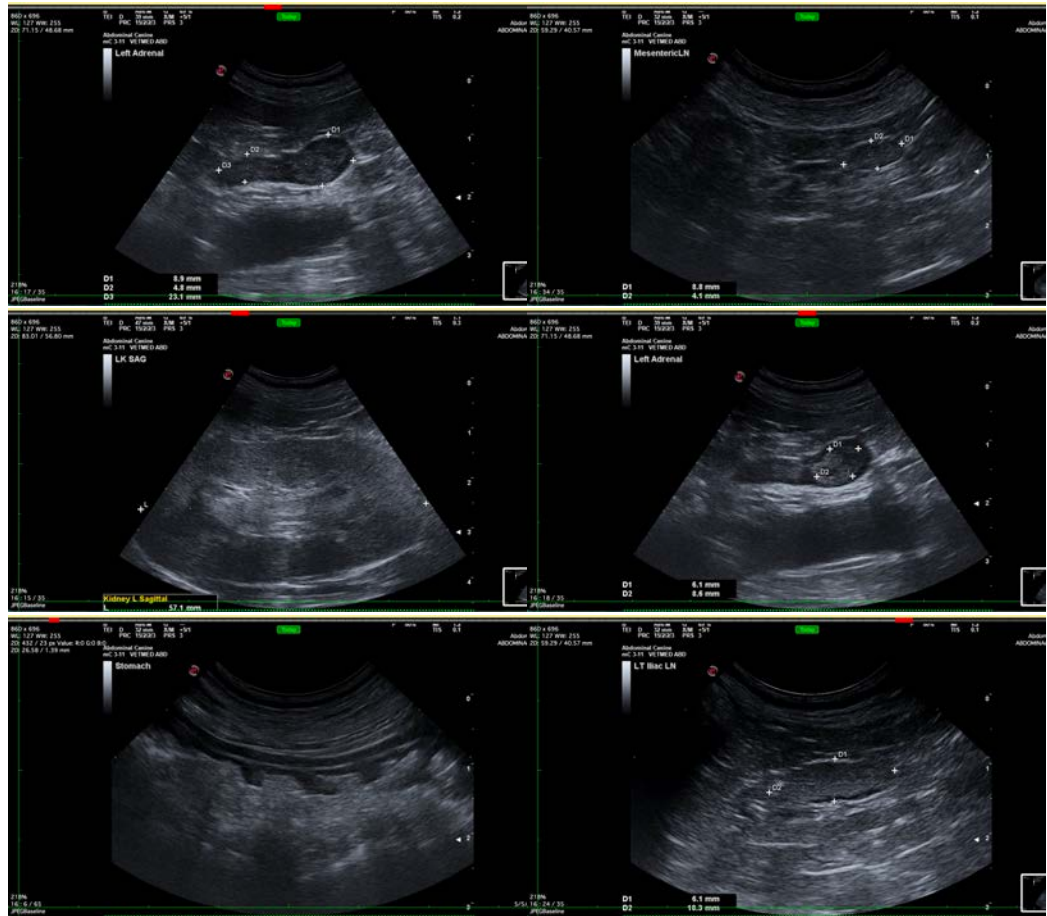
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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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