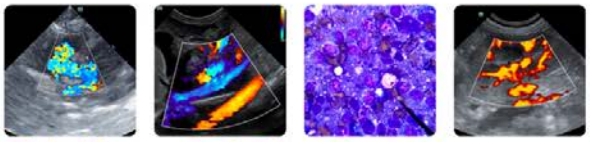


PATIENT

Mia Delgado

SPECIES

Canine

BREED

Yorkshire Terrier

SEX

Spayed Female

AGE

11 Years 5 Months

WEIGHT

5.8 lbs

INTERPRETED BY

Dr Brittany Sinclair, BVSc(hons), DACVECC

IMAGING PERFORMED BY

Gabriel Ferrer, DVM

HOSPITAL NAME

Pulse: Pet Ultrasound

REFERRING VET

Dr. Juan Giusti

INVOICE

72523

DATE

12/12/25

PRESENTING CLINICAL SIGNS

Presented as a referral for an abdominal ultrasound to evaluate vomiting, lethargy and inappetence and diarrhea. Pt started to develop this problem on Dec 3rd,2025. Pt vomited about 3 times on that day. Pt has previous hx of nasal adenocarcinoma and managed and treated with radiation therapy. Radiographs showed possible left perineal hernia.

Abnormal PE/Chem/CBC/UA Results: PE: grade 4/6 systolic HM. Bloodwork and U/A attached as supporting documents. Radiographs and report: not provided.

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder, trigone, and visible pelvic urethra were of normal thickness. The ureters were not visible which is normal. There was normal wall layering with no masses, uroliths or abnormal thickening visualized. Urine was anechoic. No evidence of inflammatory or neoplastic changes were noted.

The kidneys have a smooth capsule and with hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. Pyelectasia is noted bilaterally. The left pelvis measures 0.41 cm. The right pelvis measures 0.35 cm. Ureters are not dilated. A left renal cyst is noted measuring 1.06 cm x 0.94 cm. Additionally there are multiple small, spherical, anechoic fluid accumulations consistent with diffuse renal cysts bilaterally. Left kidney measures 3.78 cm. Right kidney measures 3.95 cm.

Adrenal Glands

The left adrenal gland caudal pole is significantly enlarged and rounded with slightly heterogenous parenchyma disrupting normal architecture of the gland, most consistent with a developing mass. The capsule is somewhat irregular but does not appear to be invading surrounding vasculature. Left measures 1.71 cm in length x 1.1 cm at the caudal pole and 0.48 cm at the cranial pole.

The right adrenal gland is visualized and recognized as having normal shape, size, position and echogenicity for this breed and age. The visible phrenic vasculature was unremarkable. Right measures 1.37 cm in length x 0.54 cm at the caudal pole and 0.76 cm at the cranial pole.

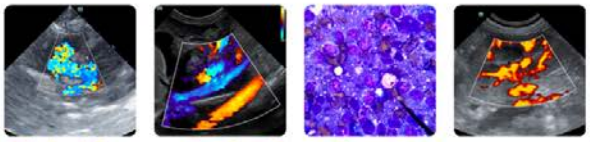
Spleen

The spleen was normal with age appropriate homogeneous parenchyma and a smooth capsule with normal splenic vasculature with no signs of congestion or thrombosis. No sonographic evidence of acute or chronic inflammatory, neoplastic, or infarct changes were noted.

Liver

The liver is subjectively normal in size with normal contours and structure. There is age appropriate echogenicity and echotexture. No overt structural evidence of inflammatory, infiltrative or regenerative pathology is evident. Vascular and biliary tracts are of normal volume with no evidence of congestion.

The gall bladder is moderately distended with anechoic fluid, with hyperechoic non-shadowing gravity dependent debris present. There is no surrounding free fluid or signs of active inflammation.



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Gastrointestinal

The stomach contains minimal luminal contents. It measures at a normal thickness of with some variability due to the presence of rugal folds. The distinction of the gastric wall layers is adequate. No masses or focal lesions were observed.

The visualized areas of duodenum, jejunum and ileum have a relatively uniform diameter with minimal fluid distension. Wall thickness is normal. Bowel loops follow a curvilinear path with distinct wall layering maintaining the typical 1:3 muscularis:mucosa layer ratio. There were no focal lesions consistent with obstruction or a mass effect observed. Some loops of jejunum had a slightly corrugated appearance with no plication, no distention, and no shadowing material.

The ileocecal junction was visualized and exhibited normal intact wall layering and is subjectively of normal thickness. Sections of colon are visualized with gas shadowing. There is no observed focal or generalized colon wall thickening or loss of layering.

Pancreas

The visible pancreas was observed to be largely isoechoic to surrounding omental fat.

Lymph Nodes

No clinically significant lymphadenopathy or abnormalities noted.

Free Abdomen

No masses or free fluid were noted.

ULTRASONOGRAPHIC FINDINGS

- Focal corrugation within jejunum – most consistent with non-obstructive gastroenteritis.
- Degenerative changes with multifocal renal cysts.
- Mild bilateral pyelectasia.
- Left adrenal mass.
- Gallbladder debris.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

GI changes are consistent with nonobstructive gastroenteritis and in the absence of chronic GI signs, acute gastroenteritis is most likely. While the pancreas appeared sonographically normal, pancreatitis cannot be definitively ruled out. Consideration for dietary indiscretion, food sensitivity/allergy, toxin, infectious (bacterial, viral, parasitic) or mild inflammatory bowel disease is reasonable. Treatment is supportive and involves fluid support, GI support (anti-nausea, appetite stimulant), analgesia and enteral nutrition as needed. Antibiotics are generally not warranted. Serial imaging is indicated if clinical signs are not resolving. Current chem/lytes/CBC, GI panel (TLI/PLI/cobalamin/folate), baseline cortisol +/- ACTH stimulation test, fecal pathogen PCR, and empiric broad spectrum deworming and treatment with probiotics should be considered as clinically warranted. Ultimately GI biopsy may be required for more definitive diagnosis.

The left adrenal gland pole changes are most consistent with an adrenal mass which may be malignant or benign. It appears subjectively resectable with capsular expansion without obvious capsular escape or vascular invasion. Pre-surgical abdominal CT for surgical planning and thoracic CT for metastasis screen is recommended. Differentials owing to sonographic architecture and clinical history include

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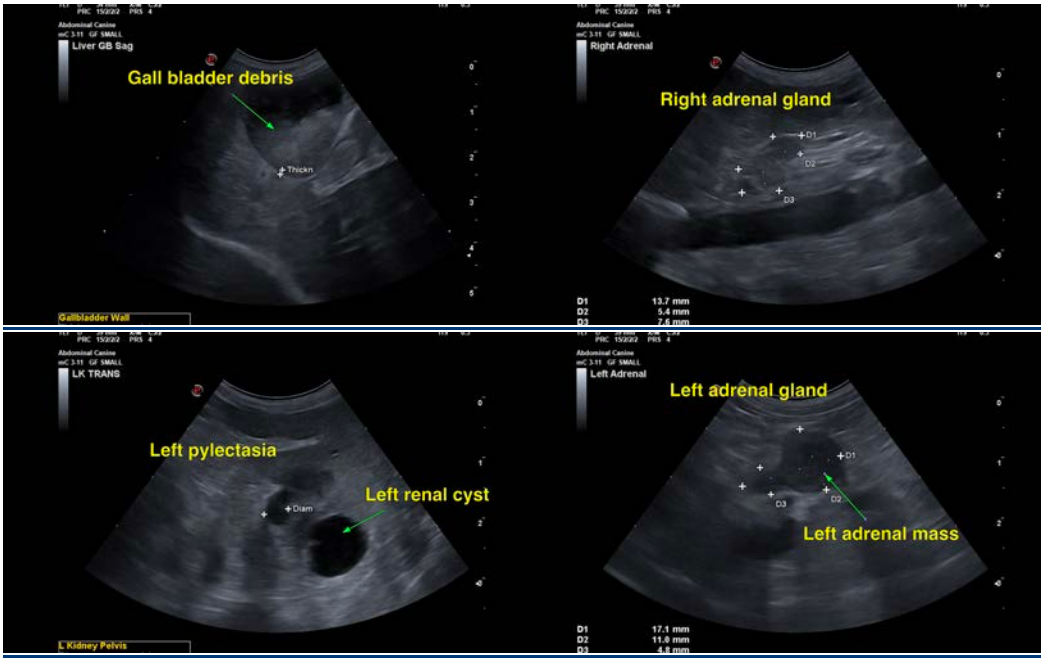
carcinoma, pheochromocytoma, adenoma, hyperplasia, cortisol secreting tumor, myelolipoma less likely. Adrenal gland function testing (ACTH stimulation test and/or LDDST and urine metanephrine screen) should be considered to further evaluate functionality. I recommend urine catecholamine screen for pheochromocytoma detection if surgical removal is pursued as pre-surgical treatment of pheochromocytoma is essential. It is possible to have both cortisol and catecholamine secretion from the same adrenal tumor so presence of hypercortisolemia does not obviate the need for presurgical urine metanephrine screening. Serial ultrasound in evaluations (every 2-3 months) for progression could alternatively be considered

The renal parenchymal changes including cortical cysts are likely chronic age related degeneration. Pyelectasia may represent polyuria from decreased renal function. It may also represent acute pyelonephritis. It can also represent obstructive ureterolithiasis, either present or resolved, leptospirosis, toxin exposure, increased urine production from fluid diuresis, or other causes of polyuria/polydipsia. Urine culture is recommended to further assess.



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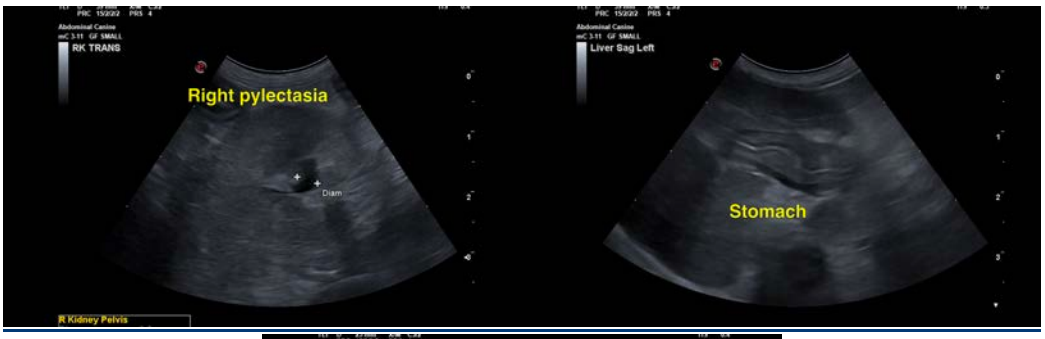

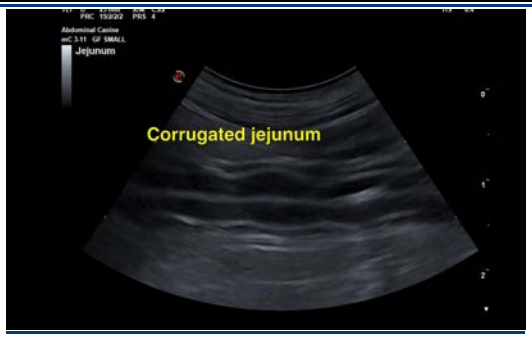

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC

info@SonoPath.com