



PATIENT

Leah Aponte

SPECIES

Canine

BREED

Mini Schnauzer

SEX

Spayed Female

AGE

13 years

WEIGHT

18 lbs

INTERPRETED BY

Dr Brittany Sinclair,
BVSc(hons),
DACVECC

IMAGING PERFORMED BY

Dr. Gabriel Ferrer

HOSPITAL NAME

Pulse Pet Ultrasound
Services

REFERRING VET

Dr. Jaclyn Neron
Amador

INVOICE

10984

DATE

12/19/2025

PRESENTING CLINICAL SIGNS

Presented a referral for an abdominal ultrasound to evaluate icterus, elevated liver enzymes, anorexia, vomiting and possible abdominal mass. Pt started to vomit 5 days ago (undigested food) and it was about 5 times. Then developed anorexia and lethargy with abdominal discomfort. Pt was managed with SQ fluids, cerenia, famotidine, Denamarin, Fenbenzaole and sent Ursodial. Pt had previously in March 2025 elevation of liver enzymes and vomiting. PT before getting sick 5 days ago, pt was very PU/PD and PP (cannot stop eating). An endocrine test for Cushing's was performed in March 2025 and by O it was normal. Pt became blind suddenly 4 yrs ago.

Abnormal PE/Chem/CBC/UA Results: PE: Very icterus Fecal: Hookworms CHEM: non readable ALP and ALT after dilution 664 BUN 38, Glob4.6, CBC: Mono 1.68.

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 left kidney has a smooth capsule and with mild hazing of corticomedullary definition. No evidence of pelvic dilation was present. Spherical anechoic fluid accumulation consistent with cortical cysts. Hyperechoic, shadowing foci present in renal parenchyma and calyces consistent with nephrocalcinosis. Left kidney measures 5.51 cm in length.

The right kidney has a smooth capsule and with hazing of corticomedullary definition to the point of inability to determine cortical/medullary ratio. No evidence of pelvic dilation was present with a spherical anechoic fluid accumulation consistent with a cortical cyst. Right kidney measures 5.06 cm in length.

Adrenal Glands

Both adrenal glands were visualized and recognized as having normal shape, size, position and echogenicity for this breed and age. The visible phrenic vasculature was unremarkable. The right adrenal gland contains a hyperechoic nodule in the cranial pole measuring approximately 0.45 cm x 0.47 cm. Left adrenal measures 1.91 cm in length, 0.55 cm at the caudal pole and 0.57 cm at the cranial pole. Right adrenal measures 1.91 cm in length, 0.55 cm at the caudal pole and 0.60 cm at the cranial pole.

Spleen

The spleen had a generally smooth homogeneous parenchyma and a smooth capsule with perivascular hyperechoic nodules visualized most consistent with benign myelolipomas. There was 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



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The liver is subjectively enlarged in size with slight rounding of lobes and homogenous hyperechoic parenchyma with no specific nodules or masses. Vascular and biliary tracts are of normal volume with no evidence of congestion. No pathological hepatic lymphadenopathy observed.

The gall bladder is moderately distended with anechoic fluid, with hyperechoic non-shadowing debris present. The cystic duct is significantly dilated and tortuous measuring up to 0.88 cm in diameter. Common bile duct is distended to the level of the papillae and measures approximately 0.36 cm at the level of the duodenal papillae.

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.

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

Pancreas

The right limb of the pancreas near the duodenal papillae has an irregular, hypoechoic to heterogenous area measuring approximately 1.48 cm x 2.0 cm, which abuts the duodenal papillae. Remainder of pancreatic tissue appears normal.

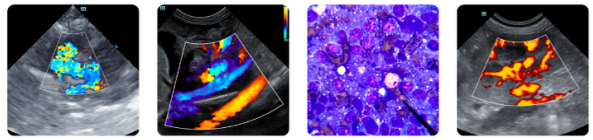
ULTRASONOGRAPHIC FINDINGS

- Distended gallbladder and cystic and common bile ducts to the level of the duodenal papillae.
- Pancreatic mass effect at the level of the duodenal papillae – Suspected to be causing at least partial extra hepatic biliary duct obstruction.
- Right adrenal nodule.
- Bilateral degenerative renal changes with cysts and nephrocalcinosis.
- Hyperechoic hepatomegaly.

INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

The hypoechoic heterogenous area in the right limb of the pancreas near the duodenal papillae, is concerning for a pancreatic mass. Given the gallbladder, cystic duct and common bile duct distension and reported blood work changes, I'm concerning that this mass is causing an extrahepatic biliary duct obstruction. It is possible that this mass effect is caused by focal inflammation/non-neoplastic pathology such as acute pancreatitis.

Ultimately, pancreatic aspirate and/or biopsy would be required to further differentiate. Aspiration technique should be used when obtaining cytologic samples of the pancreas. Pancreatic tissue does



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not always exfoliate well, and more invasive biopsy may be required for more definitive diagnosis. Medical treatment for cholangiohepatitis/pancreatitis is not unreasonable prior to pursuing more invasive surgery.

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The clinical significance of the right adrenal nodule is uncertain. It may represent a cortisol secreting nodule given blood work changes and reported PU/PD and polyphagia. When patient has recovered from this episode of illness, adrenal gland function testing should be considered.

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Liver aspirate should also be considered given parenchymal changes and bloodwork abnormalities.

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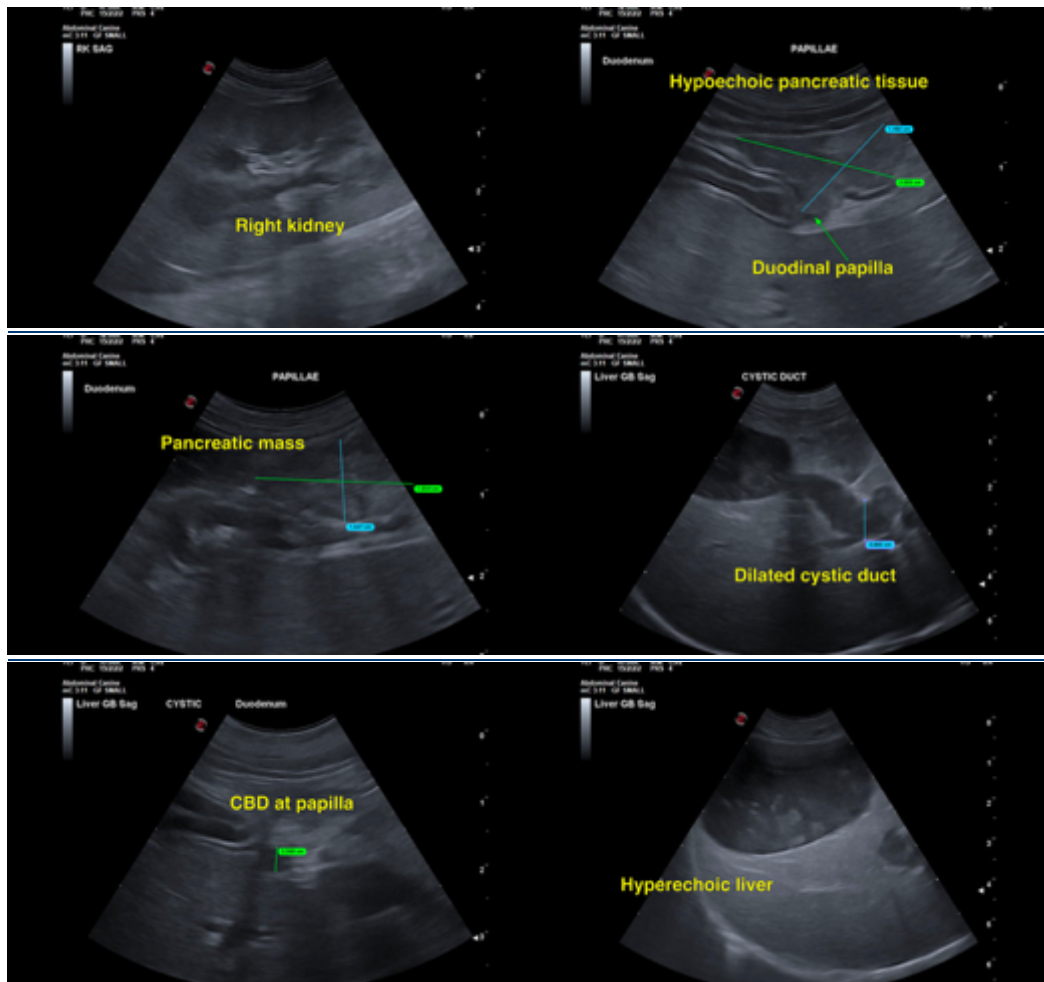
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The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

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.

Dr Brittany Sinclair, BVSc(hons), DACVECC

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